

**STATE OF MICHIGAN**  
**DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

In the matter of

XXXXX

Petitioner

File No. 102876-001

v

Golden Rule Insurance Company  
Respondent

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Issued and entered  
this 30<sup>th</sup> day of March 2009  
by Ken Ross  
Commissioner

**ORDER**

**I**  
**PROCEDURAL BACKGROUND**

On February 6, 2009, XXXXX, on behalf of XXXXX (Petitioner), filed a request for external with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On February 13, 2009, after a preliminary review of the material submitted, the Commissioner accepted the request.

The Commissioner notified Golden Rule Insurance Company (Golden Rule) of the external review and requested the information used in making its adverse determination. The company provided its information on February 24, 2008.

The issue in this matter can be resolved by analyzing the Golden Rule certificate of coverage (the certificate), the contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). No medical issues are presented requiring analysis by an independent medical review organization.

## II BACKGROUND

The Petitioner receives health care benefits as a dependent under his father's individually underwritten policy from Golden Rule.

On November 21, 2008, the Petitioner had a benign cyst removed from his nose. The total charge was \$689.00. The surgery was performed at the XXXXX by XXXXX, MD.

Golden Rule denied coverage, saying it does not cover outpatient surgical procedures performed in a doctor's office. After the Petitioner appealed, Golden Rule reviewed the claim but upheld its decision. The Petitioner completed the first step in Golden Rule's internal grievance process and received an adverse determination dated February 2, 2009.<sup>1</sup>

## III ISSUE

Did Golden Rule correctly deny coverage for the surgery provided by Dr. XXXXX at the XXXXX?

## IV ANALYSIS

### Petitioner's Argument

On November 21, 2008, the Petitioner had outpatient surgery to remove a cyst on his nose. The Petitioner argues that this surgery was medically necessary and therefore covered under the certificate. He wants Golden Rule to pay for this care.

### Respondent's Argument

It is Golden Rule's position that the Petitioner's surgery is not a covered benefit because it was performed in a physician's office. In its adverse determination, Golden Rule cited language in

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<sup>1</sup> After receiving Golden Rule's February 2, 2009, adverse determination, the Petitioner requested an external review even though he had not completed Golden Rule's internal grievance process. The Commissioner accepted the request without objection from Golden Rule.

the certificate regarding the outpatient surgical expense benefits that it says limits outpatient surgery charges to those “charges made by an *outpatient surgical facility* or a separate identifiable outpatient unit of a hospital for services and supplies related to an *outpatient* surgery.” [Italics in original]

Golden Rule also cited this exclusion in the certificate’s “General Exclusions and Limitations” section (page 26-27):

Covered expenses will not include, and no benefits will be paid for any charges which are incurred:

\* \* \*

- (O) for any *outpatient*, office or home medical services or supplies, unless expressly provided for by the policy;

Golden Rule says because the surgical services were provided in a physician’s office, they are excluded under the terms of the certificate.

#### Commissioner’s Review

There is no question that outpatient surgery is a covered benefit. The certificate (pages 18-19) contains this provision, quoted in pertinent part, relating to outpatient surgery:

**Outpatient Surgical Expenses:** Under this clause, *covered expenses* for *outpatient surgery* are limited to:

- (A) the fee charged by the primary surgeon for professional services (all reasonable pre-operative and post-operative care must be included in this fee);
- (B) the fee charged for an assistant surgeon, up to 20 percent of the primary surgeon’s *reasonable and customary charge*;
- (C) the professional fee for administration of an anesthetic; and
- (D) charges made by an *outpatient surgical facility* or a separate identifiable outpatient unit of a hospital for services and supplies related to an *outpatient* surgery.

\* \* \*

#### **DEFINITION:**

As used in this provision:

“*Outpatient surgical facility*” means any establishment which operates pursuant to law with:

- (A) an organized medical staff of *doctors*;
- (B) permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- (C) continuous *doctor* services and the services of a *registered nurse* whenever a patient is in the facility; and
- (D) no accommodations for patients to stay overnight.

This does not include facilities such as: acute care clinics, urgent-care clinics, ambulatory care clinics, urgent centers, free-standing emergency facilities, and doctor's offices.

**EXCLUSIONS:** No benefits are payable under these Outpatient Surgical Expense Benefits for charges:

- (A) incurred in any facility other than an *outpatient surgical facility*;
- (B) which exceed the *reasonable and customary* charges;
- (C) related to, or in preparation for, tissue or organ transplants...;
- (D) made by *doctors* or *medical practitioners* for stand-by availability; or
- (E) which are excluded in Section 7 of the *policy*.

The above-quoted provision does not exclude coverage for outpatient surgery that is performed in a doctor's office. What it does exclude is any facility charge for outpatient surgery unless the surgery was performed in an "outpatient surgical facility." However, Dr. XXXXX did not bill a facility charge for the services he performed in his office.

The Petitioner's outpatient surgery consisted of two procedures: Dr. XXXXX billed for CPT code 11400 (excision of a benign lesion) and CPT code 12051 (layer closure of nose wound). The "Outpatient Surgical Expense Benefits" provision clearly says that it covers "the fee charged by the primary surgeon for professional services (all reasonable pre-operative and post-operative care must be included in this fee)." Golden Rule has not argued that the surgery was not medically necessary and so the Commissioner concludes that Dr. XXXXX's professional fee is a covered benefit under the certificate.

The Commissioner finds Golden Rule incorrectly applied the terms and conditions of the Petitioner's certificate when it denied coverage for the Petitioner's surgery on November 21, 2008.

#### **IV ORDER**

The Commissioner reverses Golden Rule's adverse determination of February 2, 2009. Golden Rule shall cover the Petitioner's outpatient surgery on November 21, 2008, subject to any copayment, coinsurance, and deductible requirements in the certificate.

Golden Rule shall provide coverage within 60 days from the date of this Order and shall provide the Commissioner with proof that it has complied with this Order within seven days of compliance. To enforce this Order, the Petitioner may report any complaint regarding compliance to the Office of Financial and Insurance Regulation, Health Plans Division, at this toll-free number: (877)-999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, P. O. Box 30220, Lansing, MI 48909-7720.