

North Carolina Department of Insurance



Healthcare Review Program Semiannual Report

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Commissioner of Insurance

A REPORT ON EXTERNAL REVIEW REQUESTS IN NORTH CAROLINA

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Table of Contents

Executive Summary	i
I. Introduction	1
II. Background of the Healthcare Review Program	1
A. Legislative Intent of External Review Law.....	1
B. Summary of External Review Process (NCGS 58-50-75 through 58-50-84).....	1
III. External Review Program Development Activities	1
A. Contracting for Independent Review Organization Services	1
Request for Proposal.....	
Evaluation & Selection Process	
B. Development of Consumer Request Forms and Other Resources	1
C. Development of HCR Program Operating Procedures.....	1
D. Insurer Education	1
E. External Review Data Tracking.....	1
F. Medical Professional Consultant.....	1
G. HCR Program Staffing.....	1
IV. Continuing Program Activities.....	1
A. External Review Community Outreach and Education.....	1
B. Consumer Counseling on UR and Internal Appeal and Grievance Procedures.....	1
C. Oversight of IROs.....	10
Timeliness of Decisions.....	11
Content of Notice	11
Minimum Qualifications for IRO and Individual Reviewers	11
IRO and Individual Reviewer Conflicts of Interest.....	13
IRO Reporting Requirements	13
D. Oversight of Insurers.....	14
V. Program Activity Data.....	14
A. Consumer Contacts	14
Consumer Telephone Calls	14

	<i>Figure 1: External Review and Consumer Counseling Calls Received by the Healthcare Review Program.....</i>	15
	Consumer Web Site Contacts	15
	<i>Figure 2: Frequency of External Review Web Site Page Access</i>	15
B.	Consumer Counseling Activity (Utilization Review, Appeals & Grievances).....	16
	<i>Figure 3: Consumer Counseling Cases Received by the HCR Program</i>	16
C.	External Review Requests	16
	<i>Figure 4: External Review Requests Received by the HCR Program.....</i>	17
D.	Disposition of Requests for External Review.....	17
	<i>Figure 5: Status of All External Review Requests as of December 31, 2002.....</i>	18
	<i>Figure 6: Eligibility Determinations for Requests Received in 2002.....</i>	18
	<i>Table 1: Reasons for Non-acceptance by Type of Review Requested.....</i>	19
E.	Outcomes of Accepted Cases.....	
	<i>Figure 7: Outcomes of Accepted Cases</i>	
	<i>Figure 8: Outcomes of Accepted Cases by Type of Review Requested.....</i>	21
F.	Average Time to Process Accepted Cases.....	21
	<i>Table 2: Average Length of Time to Reach Expedited Review Determination</i>	21
	<i>Table 3: Average Length of Time to Reach Standard Review Determination.....</i>	
G.	Average Costs of Reviewed Cases.....	
	Cost of IRO Services	
	<i>Table 4: Average Cost of IRO Review by Diagnostic Category.....</i>	
	Cost of Services Required to be Covered.....	
	<i>Table 5: Average Cost of Allowed Charges Paid by Insurer for Reversed or Overturned Cases.....</i>	
VI.	Activity by Diagnostic Category	
A.	Number and Distribution of Eligible Requests and Decisions on Accepted Cases	
	<i>Table 6: Review Activity by Diagnostic Category.....</i>	
	<i>Table 7: Percentage Share of Review Activity by Diagnostic Category</i>	
B.	Review Decisions	
	<i>Table 8: Review Decisions by Diagnostic Category</i>	

VII.	Activity by Insurer.....	
	A. Summary of Activity by Insurer.....	
	<i>Table 9: External Review Cases and Case Outcomes by Insurer.....</i>	
	B. Insurer and Diagnostic Category	
	<i>Table 10: Accepted Cases by Insurer by Diagnostic Category</i>	
	<i>Table 11: Review Decisions by Insurer by Diagnostic Case Type.....</i>	
VIII.	Activity by IRO	
	A. Summary by IRO	
	<i>Table 12: IRO Activity Summary.....</i>	
	B. Decisions by Diagnostic Category and Insurer.....	
	<i>Table 13: IRO Decision by Diagnostic Category</i>	31
	<i>Table 14: IRO Decisions by Insurer.....</i>	
IX.	HCR Program Evaluation	
X.	Conclusion	

Appendix

A.	Consumer Information	A-1
	<i>Instructions for Completing External Review Request Form</i>	
	<i>External Review Request Form</i>	
	<i>Frequently Asked Questions</i>	
	<i>A Consumer’s Guide to External Review</i>	
B.	Flow Diagrams for Standard and Expedited External Review.....	B-1

Executive Summary

External Review is the independent medical review of a health plan denial and offers another option for resolving coverage disputes between a covered person and their insurer. In North Carolina, external review is available to covered persons when their insurer denies coverage for services on the grounds that they are not medically necessary. This type of denial is referred to as a “noncertification decision”. Denials for cosmetic or experimental services may be eligible for external review, depending on the specific circumstances of a case. The law applies to persons covered under fully insured health benefit plans, the North Carolina Teachers’ and State Employees’ Comprehensive Major Medical Plan, and the Health Insurance Program for Children (known as CHIP). Effective July 1, 2002, the North Carolina Department of Insurance’s Healthcare Review (HCR) Program began providing external review services to eligible covered persons.

To be eligible for external review, the covered person generally must have exhausted their health plan’s internal appeals and grievance processes. (Special rules exist for urgent cases that qualify for expedited review.) A covered person or person acting on their behalf, including their health care provider, may request an external review of a health insurer’s decision within 60 days of receiving the decision. Requests for external review are filed directly with the HCR Program.

By law, the Department is required to contract with qualified independent review organizations (IROs) to provide the clinical review of each case. The HCR Program is responsible for reviewing external review requests for eligibility and completeness. This review requires Program staff to obtain information from the insurer whose decision is the subject of the request and, if needed, additional information from the covered person. Once a request is determined to be eligible and complete, the case is assigned to an IRO. Assignment of a case is done on an alphabetical rotation. Case assignments are screened for conflict of interest between the insurer and IRO. The IRO then assigns one or more expert medical professional(s) who have no association with the insurer to perform the review. The IRO issues its determination of the case within the statutory time frame. The determination is binding on both the insured and covered person, except to the extent that the covered person has remedies under State or federal law.

The HCR Program is currently contracted with five IROs. Four of the IROs are multi-specialty and one IRO is a single service provider for mental health and substance abuse cases. Under North Carolina law, an IRO has 45 days from the date the request is received by the Department to review the case and issue a final decision. A total of 4 days is allowed for a decision to be issued on a request for expedited external review.

During the first six months of the Program’s operation, 59 requests for external review were received, 19 of which were deemed eligible for external review. As of December 31, 2002, 16 of the accepted cases were closed. The insurer reversed its noncertification prior to the case being assigned to the IRO in 2 cases, and IRO decisions were issued in the remaining 14 cases. In 7 cases, the IRO overturned the insurer’s decision, and in 7 cases the IRO upheld the insurer’s decision.

The HCR Program has collected external review activity data that supports internal program operations and enables reporting of external review activities and statistics as well as the opportunity to identify trends relating to covered persons, insurers and IROs. However, due to the small number of eligible external review requests received so far, the data is not reliable enough to draw conclusions or identify trends at this time.

North Carolina's new external review law provides an important service to our citizens. The law provides a formal process for eligible covered persons to resolve coverage disputes with their insurers. The external review process is fair, efficient and cost-effective. The process is independent of the disputing parties and results in a final decision that is binding on the insurer, and on the covered person save remedies available to them under State and federal law. It is important to note that (unlike many states), North Carolina law has no features which would act as a barrier to the eligible covered person. The external review law does not require the covered person to pay a fee when filing a request for external review, nor does it require a claims threshold or minimum amount to be in dispute before a case is eligible for external review.

The Department, through its HCR Program, has put in place the staff, policies and procedures, and operating systems necessary to receive, process and report on external review requests. Those requests assigned to an IRO were reviewed and written decisions were rendered within time frames mandated law. No performance issues with the IROs have risen to-date. Furthermore, no concerns have arisen with respect to the cooperation or compliance of the insurers about whom requests for review were made.

During this next year, the HCR Program will continue and increase its efforts to promote consumer awareness of external review services through a comprehensive community outreach and education program. As required under North Carolina law, covered persons are notified by their insurer of their right to external review whenever their insurers' decision to deny reimbursement for covered services based on a medical necessity determination is communicated via an initial noncertification or notice of decision on internal appeal. In many states, this notice is the extent of consumer notification and program awareness activities. In North Carolina, we have begun to use a variety of strategies to educate and inform consumers of the availability of this program. Public speaking engagements, health fairs, newspaper articles, web-based information and other forms of media are being evaluated to determine the most effective means to educate and inform North Carolinians of the availability of external review services.

Finally, the HCR Program has assumed the Department's responsibility for providing consumer counseling with respect to utilization review and insurers' internal appeal and grievance processes. This reallocation of responsibilities was made because of the clinical training of Program staff, and in order to provide for continuity for those cases that are not resolved to the covered person's satisfaction and so progress to external review. The reallocation also allowed maximum utilization of HCR staff time, while freeing up other staff within the Department to handle the increasing number of other consumer inquiries and complaints. Since assuming these responsibilities in April, HCR staff has provided consumer counseling on 148 cases.

I. Introduction

North Carolina's Healthcare External Review Program (HCR Program) became effective July 1, 2002. The law provides for the establishment and maintenance of external review procedures by the Department of Insurance (the Department) to assure that covered persons have the opportunity to request an independent review of their health plan's medical necessity denial (noncertification) if appeals made directly to the plan have failed to win coverage. The HCR Program received 59 requests for external review during its first six months of operation. Of those requests, 19 cases were determined to be eligible for external review.

This report is intended to provide a comprehensive picture of the HCR Program's development, operations and activity beginning in January 2002 and continuing through December 2002. The report also includes information about consumer contact with the HCR Program – primarily, but not limited to those consumers who requested external review. Detailed information is provided about the requests received and, for those cases that were eligible to receive external review, about the nature of the request and its outcome. Data is also provided with respect to the insurers whose decisions were the subject of requests for external review and about the independent review organizations that reviewed accepted cases.

Readers are cautioned that, due to the relatively small number of requests for review and accepted cases, much of the data presented in this report is not suitable for identifying trends or drawing general conclusions about specific clinical services or individual insurers or independent review organizations at this time. The data is presented nonetheless, both in the name of disclosure and because its validity will grow over time as the numbers of requests for review and cases accepted for review grow.

II. Background of the Healthcare Review Program

A. Legislative Intent of External Review Law

During the 2001 Legislative Session, the North Carolina General Assembly established external review rights for insureds and charged the Department with arranging for such reviews. The law took effect on July 1, 2002 and was codified as Part 4 of Article 50 of Chapter 58 of the General Statutes of North Carolina. NCGS 58-50-75 through 58-50-95, known as the Health Benefit Plan External Review Law, governs the independent external review process.

North Carolina's external review rights assure covered persons the opportunity for an independent review of an appeal decision or second-level grievance review decision upholding a health plan's noncertification, subject to certain eligibility requirements. Defined in NCGS 58-50-61(a)(13), "noncertification" is "a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or

effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in NCGS 58-3-190, and the requested service is therefore denied, reduced, or terminated. A ‘noncertification’ is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A ‘noncertification’ includes any situation in which an insurer or its designated agent makes a decision about a covered person’s condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision.”

The external review law applies to the insured business of all insurers, including HMOs, who offer a health benefit plan and provide or perform utilization review pursuant to NCGS 58-50-61, the North Carolina Teachers’ and State Employees’ Comprehensive Major Medical Plan and the Health Insurance Program for Children (known as CHIP).

B. Summary of External Review Process (NCGS 58-50-75 through 58-50-84)

Currently (as well as prior to the enactment of an external review law), North Carolina law grants covered persons the right to up to two levels of internal appeal of a health plan’s utilization review (UR) denial – known as a noncertification. These appeals are filed with and reviewed by the insurer that made the noncertification.

The new external review laws extend covered persons the right to independent external reviews of insurers’ appeal decisions upholding their initial noncertification decisions to deny reimbursement for covered services based on medical necessity determinations. Requests for review are to be made to the HCR Program, but the actual external reviews are conducted by independent review organizations (IROs) under contract with the Department.

The law requires each insurer to notify a covered person of their right to external review at the time that it issues a UR noncertification, an appeal decision upholding a noncertification, or a second-level grievance review upholding a noncertification. This notice is required to include a statement of the covered person’s right to a standard external review or, based on the covered person’s medical condition, an expedited external review. The notice to insured individuals must also include a description of the procedures for requesting an external review.

A covered person or person acting on their behalf, including their health care provider, may request an external review of a health insurer’s decision within 60 days of receiving the decision. Requests for external review must be filed with the Department to be considered for review.

The maximum time allowed for the Department and its IRO to complete a standard review is 45 days from the date the Department receives the request. The 45 days is comprised of a maximum of 10 business days’ review time by the Department and up to roughly 30 days’ review time by the IRO. A total of 4 days is allowed for a decision to be issued on a request for expedited external review – with up to 3 days for the Department to determine whether the request is eligible for external review and qualified for expedited handling, and the IRO decision by the 4th day. (Expedited review is to be granted when the time frame for a standard external

review or time frame for completing an expedited internal appeal or second-level grievance review would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.)

NCGS 58-50-80 establishes the manner in which a standard external review shall be handled. Within 10 business days of receipt of the request for standard external review the Department must inform the insurer of the request for review; using information included with the request and additional information provided by the insurer, determine whether the request is eligible for review based on statutory eligibility criteria; inform the covered person, insurer and covered person's provider whether review will be granted; and, if the case is accepted for review, assign the case to an IRO and forward all documentation to the IRO. IRO assignment is to be made using alphabetical rotation.

Requests for expedited review may be made orally or in writing by a covered person or person acting on their behalf, including their health care provider. Requests are first screened by the HCR Program to determine whether they are eligible for external review. If accepted for external review, the request is reviewed by a medical professional under contract with the Department to determine whether the request meets statutory eligibility provisions for review on an expedited basis, or if the review should be conducted on a standard basis. If accepted for expedited handling, the case is assigned to an IRO, all parties are notified, and information and related documents are forwarded to the IRO. Once received, an expedited review follows the same review requirements of a standard review with the exception that the time frame is limited to a total of 4 days total - 3 days for the Department and 1 day for the IRO.

Whether reviewing a case on a standard or expedited basis, the IRO is required to review the case upon receipt of the information forwarded by the Department and the insurer, considering any additional information that may be provided by the covered person within the required time frames, and issue a decision on the case. If the insurer does not comply with the notice to provide information to the IRO within the required time frames, the IRO is authorized to complete the review of the case and issue a decision based on the information provided by the Department and covered person, or terminate the review and issue a decision in favor of the covered person.

Once the external review process is initiated, it may be stopped if the insurer reverses its original noncertification. The insurer must inform the IRO, the covered person, and the Commissioner of Insurance (Commissioner) of its decision to reverse its prior decision, and approve coverage or payment for the requested service or item in order to halt the review.

Assuming the insurer has not reversed itself, once the IRO has completed its review of the case, it is the responsibility of that organization (not the Department) to provide written notice of its decision to the insurer, the covered person, the provider, and the Commissioner. Once issued, the IRO's decision to uphold or reverse the insurer's noncertification decision is binding upon the insurer and upon the covered person, except to the extent that the covered person has other remedies available under applicable state and federal law. The covered person may not file subsequent requests for an external review on the same noncertification once the first external review has been completed and the IRO has issued the decision that upholds the decision of the insurer.

Once the IRO's review is complete, if its decision is to reverse the insurer's denial, the insurer must provide the benefit requested or payment for health care services requested. This coverage or payment must be conveyed within 3 business days of receipt of notice of the IRO's decision for standard review and within 1 business day of receipt of notice from the IRO for expedited review.

III. External Review Program Development Activities

HCR Program staff began work on January 2, 2002, in order to ensure that the Program would be operational by July 1, 2002. This program development work is described below.

A. Contracting for Independent Review Organization Services

Since it is the contracted IRO conducting the review on behalf of the Department that issues a final decision on each case, selection of IROs is key to the program's ability to fulfill its duties.

Request for Proposal

The Department sought to contract with IROs that had extensive experience in providing independent medical review of health plan coverage denials for state agencies and commercial health plans. As required by law, a request for proposal (RFP) meeting the conditions set forth in NCGS 58-50-94 and including an IRO Application as required in 58-50-85(b) was prepared and posted on the State of North Carolina Interactive Purchasing System web site on February 25, 2002. Additionally, IROs that either had contacted the Department previously to express interest in providing independent medical review services or that were known to be nationally accredited were notified of the RFP.

In responding to the RFP, IROs were required to provide in separately sealed envelopes, their technical response to the application and their cost proposal. Per the instructions provided in the RFP, an IRO's technical response envelope contained a completed application signed and notarized by the IRO's chief executive officer or company officer, supporting documentation, and a signed and notarized conflict of interest attestation. The cost proposal envelope contained a completed and signed cost proposal form.

Evaluation & Selection Process

The Department received nine proposals in response to its RFP. In completing the Technical Application Form, IRO's were required to respond, in detail, to the following sections: Qualification and Management of Proposed Independent Review Organization, Qualifications and Experience, Clinical Reviewers, Quality Assurance and Confidentiality, Independent Review Process and Information Systems, and Financial Profile.

In providing a cost proposal, IROs were required to submit a price quote which, if accepted, would remain in force for the entirety of the two-year contract period. IRO cost proposals were required to include the following:

- A total price quote for a standard review

- A total price quote for an expedited review
- A total price quote for a cancellation fee for a standard review
- A total price quote for a cancellation fee for an expedited review

As required under NCGS 58-50-94(b), the IRO proposals were evaluated by an eleven-member Evaluation Committee whose membership included insurers subject to external review, health care providers, and insureds. Proposals were evaluated to determine if an IRO satisfied the minimum qualifications established under NCGS 58-50-87. Using evaluation criteria included in the RFP, each IRO's technical proposal was scored on a "points earned" basis. Only those IROs with an acceptable technical score had their cost proposals opened and evaluated. In evaluating cost proposals, the Evaluation Committee identified those proposals that were within commercially reasonable fees charged for similar services in the industry. Those proposals deemed to provide the best combination of technical and cost values to the State of North Carolina were recommended to the Commissioner.

Pursuant to NCGS 58-50-94(b), the Assistant Commissioner, acting as the representative of the Commissioner, reviewed and accepted the Evaluation Committee's recommendations regarding the cost and quality of the services offered by each IRO, the reputation and capabilities of the IRO submitting the proposals, and the demonstrated or reasonably expected ability to comply with the provision in NCGS 58-50-85 and 58-50-87. Following the recommendation, it was discovered that one IRO was not in compliance with NCGS 58-50-87(c) due to an affiliate relationship with an insurer. Such a relationship imposes an automatic disqualification of an IRO. Those IROs deemed eligible to participate in North Carolina's external review program, and for which a contract was executed are as follows:

- Carolina Center for Clinical Information (Cary, NC)
- Hayes Plus (Lansdale, PA)
- IPRO (Lake Success, NY)
- MAXIMUS CHDR (Pittsford, NY)
- Prest & Associates (Madison, WI)

B. Development of Consumer Request Forms and Other Resources

In order to process a covered person's request for a standard or expedited review, an External Review Request Form was developed in an easy to read and use format. The document requests basic contact information on the covered person (patient), the person requesting the review (if different from the covered person), insurance information, and physician/healthcare provider information. The covered person identifies on the form the type of review they are requesting, provides a description of the disagreement, and signs the medical authorization release portion of

the form. If someone other than the covered person is requesting an external review, then the “Appointment of Authorized Representative” section of the request form must also be signed.

The External Review Request Form is available to consumers on the Department’s web site, and is designed to allow the consumer to complete the form using their computer. However, the form cannot be submitted electronically as it requires the covered person’s signature. The form can also be mailed or faxed to consumers and completed by hand.

Other related documents designed to assist consumers with the external review process include a list of *Frequently Asked Questions*, *Instructions for Completing the External Review Request Form*, and a brochure entitled *A Consumer’s Guide to External Review*. All of these resources are available to the consumer in the HCR Program section of the Department’s web site.

Copies of the External Review Request Form and other consumer materials referenced above are included in Appendix A of this report.

C. Development of HCR Program Operating Procedures

Written procedures for handling requests, along with related operating documents, were developed by HCR Program staff. Additionally, flow diagrams describing the standard and expedited external review process were prepared as a means of clarifying responsibilities and statutory time frame requirements of all parties involved in the external review process. The flow diagrams are presented in Appendix B.

External review requests are submitted to the HCR Program, which is responsible for performing a preliminary review to determine eligibility. To be eligible, the covered person must have received a notice from their insurer denying coverage for services or requested services on the grounds that they are not medically necessary. Additionally, for a request to be found eligible and able to be accepted for review, all of the following criteria must be met:

- The covered person must have been covered by the insurer at the time of the request for the services that are the subject of the external review request.
- The service must reasonably appear to be a covered service under the policy.
- The insurer’s internal appeal process must have been exhausted.
- The request for external review must be complete.
- The request must have been submitted within the statutory time frame, which is within 60 days from the date of the determination that is the subject of the external review - usually this is the insurer’s final determination on its highest level of internal appeal, unless the matter is medically urgent.

Once a request is received and all information necessary to process the request is complete, the case is assigned to a clinical review analyst on staff at the HCR Program who will request

eligibility and benefit information from the insurer. Upon receiving the insurer's response and all required documents, the case is reviewed and a determination is made on the eligibility of the request. If the request is not accepted, the notification to the requesting party will state the reason for non-acceptance. A case may not be accepted for several reasons, including the absence of jurisdiction by the Department either because the plan is a self-funded employer health plan governed solely by ERISA, or because the request involves Medicare or Medicaid programs, etc. Also, in some cases, the insurer elects to provide the services in question upon being notified of the insureds' request for external review, reversing the denial that was the basis for the request and effectively avoiding the need for the case to be assigned to and reviewed by an IRO.

Once accepted, a case is assigned to an IRO using an alphabetical rotation and a conflict of interest screening tool. The case is then forwarded to the assigned IRO. The insurer, covered person (or authorized representative) and the covered person's provider are notified of the case's acceptance and IRO assignment. Additionally, the covered person (or authorized representative) are notified of their right to provide additional information to the IRO. Materials provided to the IRO by the HCR Program include the External Review Request Form, documents provided by the insurer, and medical and supporting documentation provided by the covered person or their authorized representative or provider. The insurer is given a copy of any additional information that the covered person provides to the IRO, and may choose to reverse its own denial based on that information, therefore causing the external review to be discontinued if it has not yet been completed.

The decision issued by the IRO is binding on the insurer and on the covered person except to the extent that the covered person may have other remedies available under applicable federal or state law, including NCGS 90-21.50 through 21.56, Health Care Liability, and Section 502(a) of ERISA. The HCR Program pays the IRO for its services and the insurer is required to reimburse the HCR Program for the cost of the review. If the IRO's determination overturns the insurer's original decision, the health plan must provide for coverage or payment within three days for a standard external review request and within one day for an expedited external review request. If the IRO's decision upholds the insurer's original decision, the covered person may not request another internal appeal or external review on this case.

D. Insurer Education

In April 2002, insurers were notified in writing of the establishment of the HCR Program. Insurers were provided a brief overview of the law and were asked to provide contact information to the HCR Program for use in processing their insureds' requests for external review.

Informational meetings were held with insurers' representatives to discuss the external review process and provide clarification on the statutory provisions governing external review. These meetings also provided the opportunity for health plan representatives to meet HCR Program staff and to begin dialogue in establishing an effective work relationship.

The Department made available to insurers suggested language to satisfy the statutory requirement that their member notice and evidence of coverage include a description of the external review process and procedure for requesting an external review. Additionally, the HCR Program worked with several insurers in the development and refinement of the Insurer Request for Information Form. This document serves to notify the insurer of their covered person's request for an external review and identifies the HCR Program's information requirements to determine the insured's eligibility. Finally, the HCR Program developed Frequently Asked Questions for insurers. All information prepared for the insurance industry's use was posted on the Department's web site. Insurers are notified via e-mail when new and revised information about external review is posted in the HCR Program section of the Department's web site.

E. External Review Data Tracking

In order to accurately capture external review request activity and reportable data, the Department's Information Systems Division developed an electronic database tracking system to support the HCR Program. The goal of this initiative was to develop an automated system to enter external review request information, manage workflow for requests and IRO assignments, create correspondence, and report on Program activities.

Given the limited time frame to accomplish the task, Information Systems staff "fast tracked" the project, using internal resources and existing systems within the Department to meet automation, tracking and reporting requirements of the Program. By June 30, 2002, HCR's data tracking system had been developed, tested, refined, and implemented. The system has the capability of capturing and recording all external review request activity, generating correspondence, recording audit functions, and publishing more than thirty different reports.

F. Medical Professional Consultant

NCGS 58-50-82, which sets forth the procedures for requesting and reviewing a request for an expedited external review, requires the Commissioner to consult with a medical professional to determine whether the request should be reviewed on an expedited basis. Because an expedited request can be made at any time, the HCR Program requires the services of a medical professional who can be available 24 hours-a-day, seven-days-a-week.

The Department advertised for consultants and selected two physicians in order to maintain around-the-clock-availability. These physicians, both of whom are board-certified in internal medicine, are contracted to provide on-call case evaluations of requests for expedited external review. The scope of these evaluations is limited to determining whether a request meets medical criteria for expedited review. Once the case is evaluated, the reviewing physician provides the HCR Program Director their written recommendation on how the case should be handled (i.e., standard or expedited review by the IRO), including the clinical rationale for the recommendation.

G. HCR Program Staffing

The HCR Program was created as a new operating unit of the Department's Technical Services Group. Personnel to support the unit were recruited from outside of the Department, seeking registered nurses with broad clinical and administrative experiences, including experience working with health plans, providers, utilization review programs, appeal and grievance processes, and data tracking systems.

Since September 1, 2002, the Healthcare Review Program staffing is as follows:

- 1 Director
- 1 Senior Clinical Review Analyst
- 1 Clinical Review Analyst
- 1 Administrative Assistant
- 2 Physicians (Consultants)

IV. Continuing Program Activities

A. External Review Community Outreach and Education

In June 2002, prior to the effective date of the HCR Program, the Department's Public Information Officer (PIO) distributed a news release announcing this new consumer program. The announcement was carried by thirty-three newspapers from around the state and one statewide radio news network. Several news reporters contacted the PIO with specific questions about the program, and additional information about external review services was provided. In October 2002, an article about external review services was again released and was published in one magazine and 12 different organizational newsletters. The Department will continue to utilize the news media as a means of informing consumers about the HCR Program and external review rights as opportunities arise.

Since the program began, a variety of activities to inform and educate consumers about external review have been underway. Those activities have included public speaking engagements, writing articles for consumer and health care provider newsletters, and educating health care providers about external review services. Additionally, contacts have been made with consumer advocacy groups, hospitals and professional organizations, to inform them about the Program and to seek opportunities to present information about external review services.

B. Consumer Counseling on UR and Internal Appeal and Grievance Procedures

Beginning April 1, 2002, the Department shifted the bulk of its longstanding responsibility for providing consumer counseling on utilization review and internal appeals and grievance issues from its Consumer Services Division to the HCR Program. This reallocation of responsibility

was made in the belief that consumers who contacted the Department regarding these matters would benefit from speaking with staff who would both be able to specialize in this subject area and possess clinical training and so feel more comfortable with and knowledgeable about medical denials. Furthermore, this arrangement will provide for continuity for those cases that ultimately progress to external review.

The HCR Program can receive a request to assist a consumer in several different ways, including:

- The Consumer Services Division can refer a consumer call to the Program.
- The Consumer contacts the Program directly after being notified via written correspondence from the Consumer Services Division of the availability of clinical staff in the HCR Program to provide suggestions, strategy or information that may be helpful to their case.
- The Consumer Services Division can consult with HCR Program to obtain specific suggestions on a particular aspect of the case, while retaining responsibility for the case.
- The HCR Program can receive calls directly from consumers.

In providing consumer counseling, the HCR Program staff will explain the state laws that govern utilization review and the appeal and grievance processes. If asked, staff will suggest general resources where the consumer may find supporting information regarding their case, suggest collaboration with their physician to identify the most current scientific clinical evidence to support the treatment, and explain how to use the supporting information and law during the appeal process.

In providing consumer counseling, staff will not give an opinion regarding the appropriateness of the requested treatment, suggest alternate modes of treatment, provide specific detailed articles or documents that relate to the requested treatment, give medical advice or prepare the consumer's case for them. Consumers requesting further assistance with the preparation of their appeal or grievance are referred to the Office of Managed Care Patient Assistance located within the Attorney General's Office. Likewise, when consumers request assistance with developing their request for external review (as opposed to seeking information about their rights or about procedural matters), they are referred to the Office of Managed Care Patient Assistance.

C. Oversight of IROs

IROs are subject to many statutory requirements regarding the organizations' structure and operations, the reviewers that they use, and their handling of individual cases. The HCR Program engages in a variety of activities to provide appropriate monitoring. In the event that monitoring reveals that requirements are not being met, the IRO will be informed of the deficiency and, as appropriate, be given an opportunity to correct the matter or face contract termination. Specific types of requirements for IROs and the means by which oversight is provided are described as follows:

Timeliness of Decisions

An IRO must provide notice of its decision on a case to the covered person, the insurer, the covered person's provider who performed or requested the service, and the Commissioner, within the statutory requirement applicable to the type of review performed.

The HCR Program Data Tracking System automatically assigns the statutory decision due date for each case as it is entered. This enables HCR Program staff to monitor IRO assignments and legal deadline dates on an ongoing basis. When an IRO issues its notice of determination, the date of notice is entered into the data tracking system. This enables staff to ensure that the IRO has met the time frame requirements.

Content of Notice

An IRO must include in each written notice of a decision to uphold or reverse the appeal decision, the following requirements as set forth in NCGS 58-50-80(k):

1. A general description of the reason for the request for external review.
2. The date the organization received the assignment to conduct the external review.
3. The date the organization received information and documents submitted by the covered person and by the insurer.
4. The date the external review was conducted.
5. The date of its decision.
6. The principal reason or reasons for its decision.
7. The clinical rationale for its decision.
8. References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.
9. The professional qualifications and licensure of the clinical peer reviewers.
10. Notice to the covered person that he or she is not liable for the cost of the external review.

HCR staff reviews each decision letter issued by an IRO to determine whether its content met statutory requirements. Any deficiencies are discussed with the IRO as they are identified.

Minimum Qualifications for IRO and Individual Reviewers

NCGS 58-50-87 requires IROs to meet minimum qualifications to be eligible to conduct external reviews.

NCGS 58-50-87(a) requires that the IRO have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in NCGS 58-50-80 and 58-50-82 that include, at a minimum:

1. A quality assurance program in place that ensures:
 - a. That external reviews are conducted within the specified time frames and required notices are provided in a timely manner.
 - b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the IRO and suitable matching of reviewers to specific cases.
 - c. The confidentiality of medical and treatment records and clinical review criteria.

- d. That any person employed by or under contract with the IRO adheres to the requirements that apply to the IRO and its reviewers.
- e. The independence and impartiality of the IRO and the external review process and limits the ability of any person to improperly influence the external review decision.
2. A toll-free telephone service to receive information on a 24-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting or recording inquiries or providing appropriate instruction to incoming telephone callers during other than normal business hours.
3. An agreement to maintain and provide to the Commissioner the information set out in NCGS 58-50-90.
4. A program for credentialing clinical peer reviewers.
5. An agreement to contractual terms or written requirements established by the Commissioner regarding the procedures for handling a review.
6. That the IRO consults with a medical doctor licensed to practice in North Carolina to advise the IRO on issues related to the standard of practice, technology, and training of North Carolina physicians with respect to the organization's North Carolina business.

NCGS 58-50-87(b) requires that clinical reviewers assigned by an IRO to conduct external reviews be medical doctors or other appropriate health care providers who meet the following minimum qualifications:

1. Be an expert in the treatment of the covered persons injury, illness, or medical condition that is the subject of the external review.
2. Be knowledgeable about the recommended health care service or treatment through recent or current actual experience treating patients with the same or similar injury, illness, or medical condition of the covered person.
3. If the covered person's treating provider is a medical doctor, hold a nonrestricted license and, if a specialist medical doctor, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.
4. If the covered person's treating provider is not a medical doctor, hold a nonrestricted license, registration or certification in the same allied health occupation as the covered person's treating provider.
5. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

NCGS 58-50-87(c) provides that an IRO may not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, State, or local trade association of health benefit plan, or a national, State, or local trade association of health care providers.

The IRO solicitation and evaluation processes thoroughly address the minimum qualifications for IROs. However, in addition to requiring evidence from an IRO to demonstrate that it meets these standards prior to contracting, HCR staff plans, beginning in 2003, to conduct audits of

each contracted IRO at least once every two years. These audits will provide an opportunity to verify that the policies and procedures presented by the IRO are being implemented.

IRO and Individual Reviewer Conflicts of Interest

NCGS 58-50-87(d) contains detailed provisions aimed at ensuring neither the IRO selected to conduct the external review nor any clinical peer reviewer assigned by the IRO to conduct the review have a professional, familial, or financial conflict of interest with any of the parties involved in the matter that is the subject of review. Prohibitions on conflict of interest include those involving the covered person requesting a review, the health care provider or facility that is recommending or would provide the service for which coverage is requested, or the insurer that is denying coverage.

The HCR Program obtained disclosures of conflicts from each IRO regarding any relationship they may have with an insurer or health care provider or facility and requires each IRO to provide updates to this information. This IRO conflict information is used by HCR staff when a case is assigned to an IRO. In addition, once a case is assigned to the IRO, the IRO must verify that there is no conflict of interest because of connection between its management and the covered person or specific health care providers involved in the case. The IROs are also expected to screen for potential conflicts of interest when assigning a case to its clinical reviewers. IRO policies and procedures relating to IRO and reviewer conflicts were addressed in the IRO solicitation and selection process and future on-site audits of IRO operations will check that these policies and procedures are being utilized.

IRO Reporting Requirements

NCGS 58-50-90 establishes the reporting requirements for contracted IROs. Each IRO is required to maintain written records on all requests for external review, and is required to provide to the Department, on a quarterly basis, a report in the format specified. The report shall include in the aggregate and for each insurer the following:

- The total number of requests for external review by the organization.
- The number of external review requests resolved and, of those resolved, the number of upholding the appeal decision of the insurer and the number reversing the decision of the insurer.
- The average length of time for resolution.
- A summary of the types of coverages or cases for which an external review was sought.
- The number of external reviews that were terminated because of reconsideration by the insurer after receipt of additional information from the covered person.
- Any other information the Commissioner may request or require.

D. Oversight of Insurers

The External Review Law places several requirements on insurers. Insurers are required to provide notice of external review rights to covered persons in their noncertification decisions and notices of decision on appeals and grievances. Insurers are also required to include a description of external review rights and external review process in their summary plan description. When the HCR Program receives a request for external review, the insurer is required to provide certain information to the Department, within statutory time frames, so that an eligibility determination can be made. When a case is accepted for review, the insurer is required to provide information to the IRO assigned to the case (although the law does provide for the review to progress if the insurer does not submit the required information, or for the IRO to close the case and issue a decision in favor of the covered person). When a case is decided in favor of the covered person, the insurer must provide notification that payment or coverage will be provided. This notice must be sent to the covered person and their provider and is required to be sent within 3 business days in the case of a standard review decision and 1 calendar day in the case of an expedited review decision. Finally, insurers are required to reimburse the Department for the cost of each IRO review in which they are involved. The HCR Program sends its invoice to the insurer as soon as it receives one from the IRO, and the insurer is expected to reimburse the Department within 15 days.

The Department reviews for compliance with notice requirements through its form policy review function (conducted by the Life and Health Division). As each request for external review and each accepted case is being handled by the HCR Program, staff is able to monitor on a “real time” basis, company compliance with requirements to provide certain information to HCR and the IRO and within specified time frames. Following each IRO decision to overturn an insurer's denial, HCR staff requires the insurer involved to submit a copy of the required notice of coverage or payment in order to make sure that the insurer is indeed adhering to the IRO determination. Insurers are also directed to provide the HCR Program with evidence of the actual claim payment, and these cases are not closed out by HCR until this evidence is received. Finally, the Department's Managed Care and Health Benefits Division and Market Examinations Division, both of which conduct market conduct audits of health insurers, plan to incorporate review of certain company policies and procedures relating to external review into their examination protocols.

To date, no issues have arisen with respect to insurers' cooperation with Program activities, nor have there been any compliance issues with respect to the processing of individual cases.

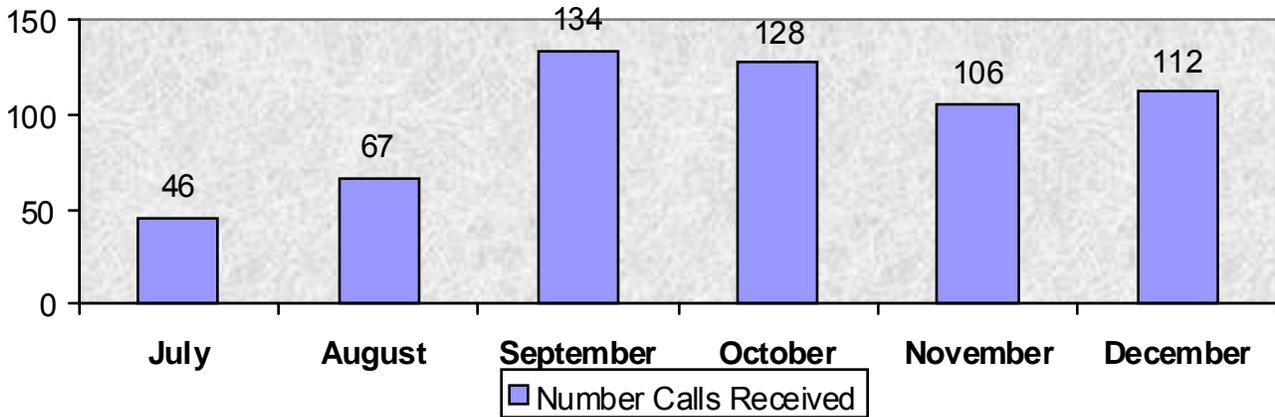
V. Program Activity Data

A. Consumer Contacts

Consumer Telephone Calls

The HCR Program received 593 calls from consumers related to external review and consumer counseling services during the period of July 1, through December 31, 2002. Figure 1 identifies the number of calls received for each month that the Program has been operational. As expected, the number of calls declined in months with holidays.

Figure 1: External Review and Consumer Counseling Calls Received by the Healthcare Review Program



Consumer Web Site Contacts

In an effort to provide consumers who have Internet capability with information about the HCR Program, the staff worked with the Department’s Public Information Office to create an informative and easy to use web site. Information provided on the web site includes: External Review Request Form and Instructions, Frequently Asked Questions, and the Healthcare Review Program Brochure.

Figure 2 identifies the number of times consumers accessed the web site each month. Consumer information about the program and the External Review Request Form was posted by mid-June. Internet records indicate that consumers began searching for information about the Program prior to the July 1st effective date.

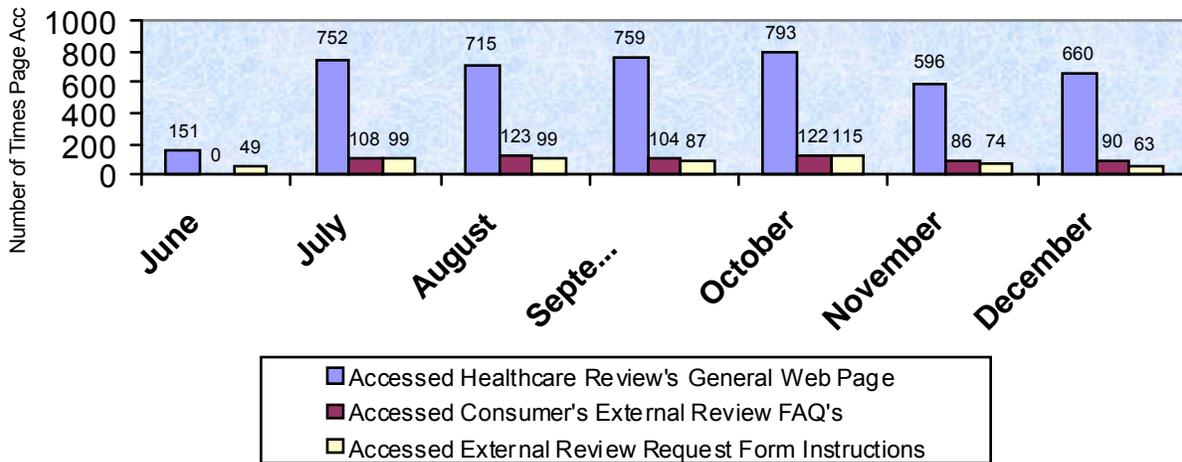
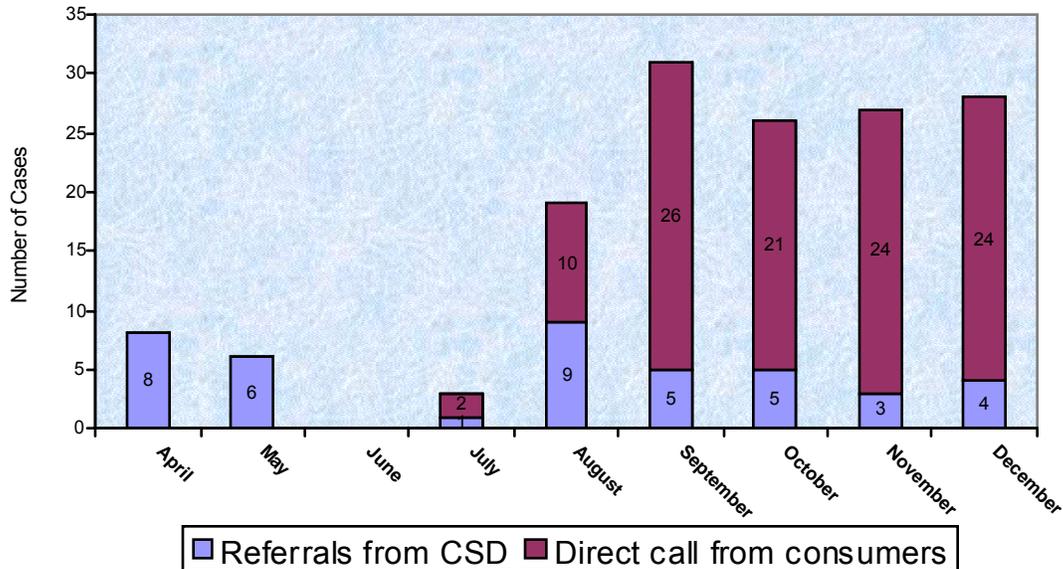


Figure 2: Frequency of External Review Web Site Page Access

B. Consumer Counseling Activity (Utilization Review, Appeals & Grievances)

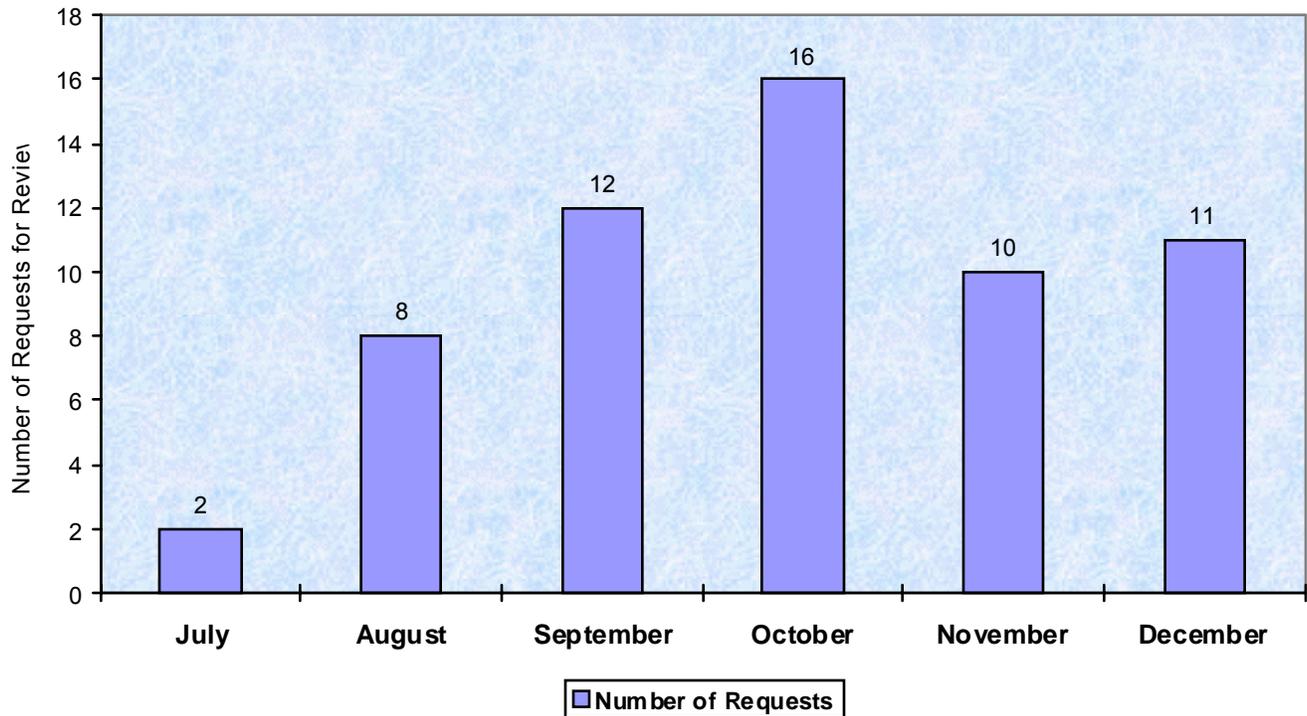
Since April 1, 2002, HCR Program staff provided detailed consumer counseling on utilization review and the internal appeal and grievance process for 148 cases. As shown in Figure 3 below

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C. External Review Requests

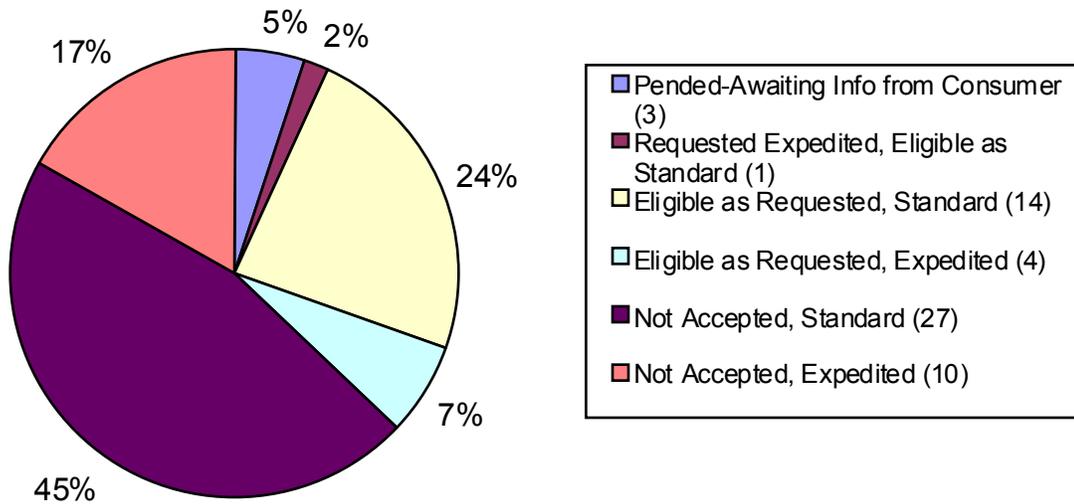
Figure 4 below shows the total number of requests for external review that the HCR Program received each month for the period beginning July 1, 2002 through December 31, 2002. Since the start of the program, the number of requests received each month continued to increase, with the exception of an anticipated decline for the November and December holiday season. A total of 59 requests were received.



D. Disposition of Requests for External Review

Of the 59 requests for external review that the HCR Program received between July 1, and December 31, 2002, 19 (one third) were accepted for review and 3 were pended as of December 31st.

The information illustrated in Figure 5 reflects the year-end status of the 59 requests received. The total number of cases that were accepted for review and handled on a standard basis was 15, including a case that was requested on an expedited basis but was only eligible to be handled on a standard basis. A pending status refers to those cases that required additional information from either the consumer or the insurer before the HCR Program could make a determination regarding eligibility.



A large number of requests for external review were not accepted for review, for a variety of reasons which fall into two main categories. "Ineligible" requests either involved an insurance policy subject to the Department's regulation but not subject to the external review law, or involved an insurance policy subject to the Department's regulation and subject to the external review law but that did not meet the conditions for review specified under the external review law.

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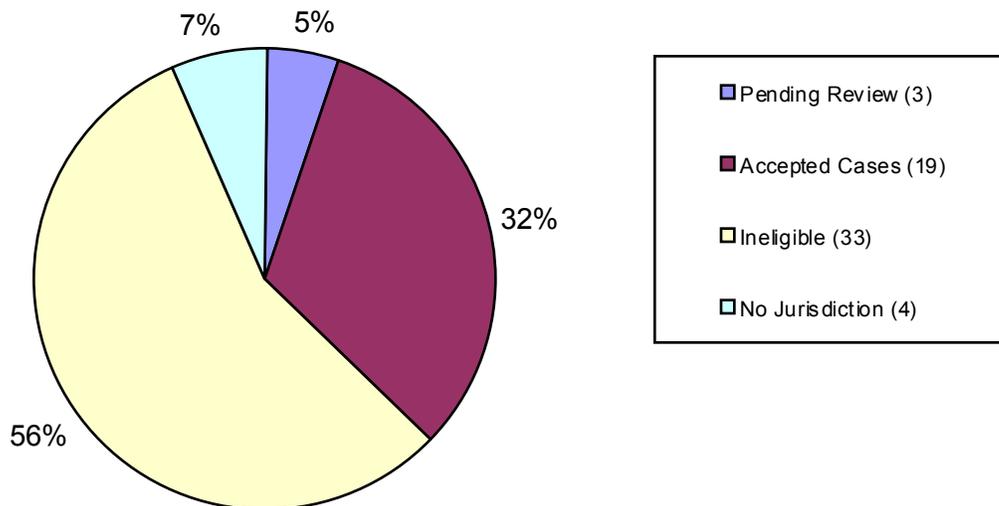


Table 1 shows the specific reasons for each request that was not accepted for review. Requesting external review for an insurer's decision or action other than a medical necessity decision and requesting external review prior to exhausting the internal appeal process are clearly the most common reasons why a request is not accepted for external review.

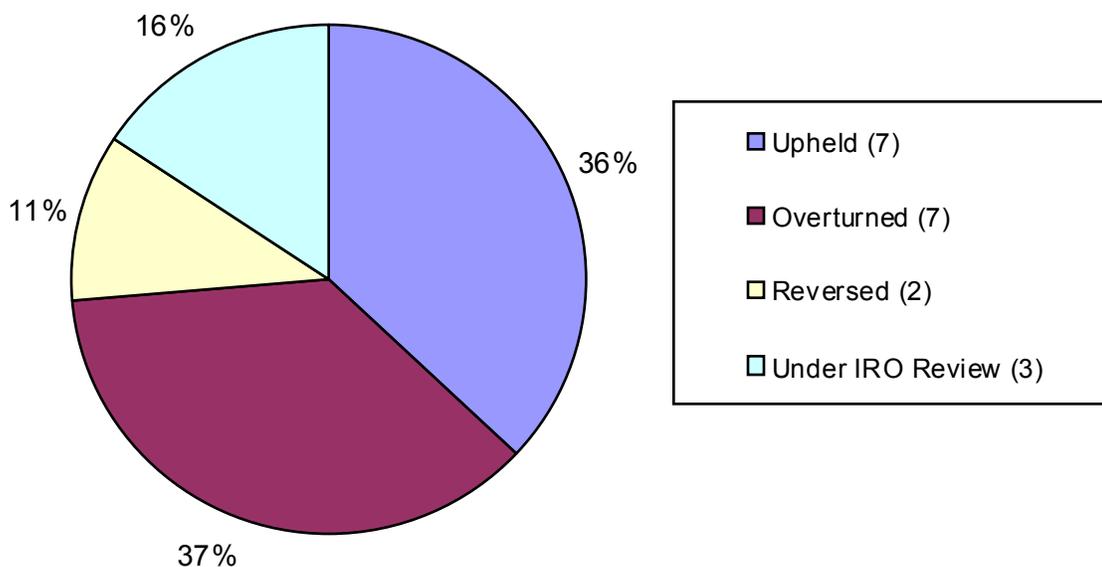
Table 1: Reasons for Non-acceptance by Type of Review Requested

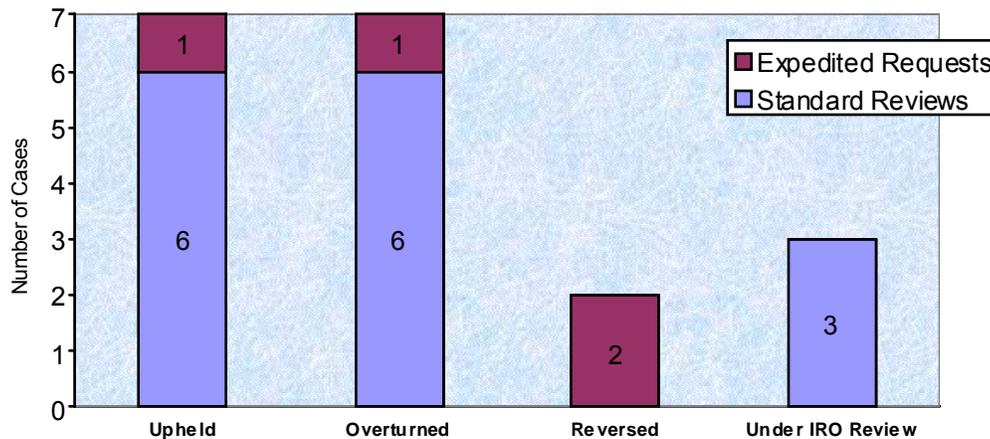
Reason for Non-acceptance	Standard Requests	Expedited Requests	All Requests
Ineligible			
Criteria not Met for Expedited, not eligible as Standard	0	2	2
Expedited External Request, but Standard Appeal Requested with Insurer	0	2	2
No Medical Necessity Determination	8	1	9
No Denial	0	1	1
Request Withdrawn	0	2	2
Retrospective Services on Expedited Request, not Eligible as Standard	0	1	1
Service Excluded	1	1	2
Denial Decision Pre-Dates Law	2	0	2
Ineligible for Coverage	1	0	1
Past 60 Day Request Time Frame	2	0	2
Insurer Appeal Process not Exhausted	7	0	7
Insurance Type not Eligible for External Review	2	0	2
TOTAL INELIGIBLE	23	10	33
NO JURISDICTION			
Contract Situs not in NC	1	0	1
Self-Funded	3	0	3
TOTAL NO JURISDICTION	4	0	4
TOTAL REQUESTS NOT ACCEPTED	27	10	37

E. Outcomes of Accepted Cases

Figure 7 below shows the outcomes of reviews performed on all cases (both standard and expedited) accepted between July 1, and December 31, 2002. Of the 19 cases accepted for review and assigned to an IRO during this period, 16 cases were closed and 3 were pending a decision by the IRO as of December 31, 2002. More than one-half of the cases closed were resolved in the covered person's favor, due either to the IRO having overturned the insurer's noncertification or to the insurer having reversed its own denial. Cases that were "reversed" were decisions made by insurers to reverse their own noncertification and provide coverage for services prior to the case being assigned to an IRO for review or prior to the IRO issuing a decision. Figure 8 shows the outcomes for these accepted cases by type of review granted.

The data presented here merely reports the experience of the cases reviewed between July 1, and December 31, 2002. Because of the small number of cases, it is not appropriate to generalize these outcomes or extrapolate them to predict future review outcomes.





F. Average Time to Process Accepted Cases

When assigned a case, the IRO is responsible for rendering a written decision within time frames mandated by North Carolina law. For a standard review, the IRO has until the 45th calendar day following the HCR Program’s receipt of the request to make and issue a final determination. For an expedited review, the IRO has until the 4th calendar day after the HCR Program’s receipt of the request. The information presented in Tables 2 and 3 shows that there have been no review decisions made outside of the statutorily required time frame. Furthermore, based on the 14 cases for which IRO decisions were issued between July 1, and December 31, 2002, on average, IRO decisions on expedited review were issued within less than 2 days of being received by the HCR Program and IRO decisions on standard review were issued in less than 29 days of receipt by the Program.

Table 2: Average Length of Time to Reach Expedited Review Determination

Case Type	Case Number	Date Received	Date of Determination	Number of Days to Process	Average Number of Days to Reach Decision
Expedited Review	HR030006	08/09/02	08/12/02	3	1.75 Days
	HR030012	09/04/02	09/07/02	3	
	HR030018	09/13/02	09/13/02	0	
	HR030022	09/26/02	09/27/02	1	

Table 3: Average Length of Time to Reach Standard Review Determination

Case Type	Case Number	Date Received	Date of Determination	Number of Days to Process	Average Number of Days to Reach Decision	
Standard Review	HR030005	08/27/02	09/18/02	22		
	HR030007	08/13/02	09/13/02	31		
	HR030008	08/14/02	09/24/02	41		
	HR030013	09/05/02	09/25/02	20		
	HR030025	10/03/02	11/13/02	41		
	HR030027	10/08/02	11/01/02	24		
	HR030028	10/30/02	11/22/02	23		
	HR030031	11/18/02	12/04/02	16		
	HR030033	10/18/02	11/15/02	28		
	HR030035	10/28/02	11/27/02	30		
	HR030039	11/08/02	12/20/02	42		
	HR030044	11/19/02	12/13/02	23		
						28.4 Days

G. Average Costs of Reviewed Cases

The cost associated with a request accepted for external review, which is comprised of the cost of obtaining the review (i.e., the fee charged by the IRO) and, if the IRO overturns the insurer’s noncertification, the cost that the insurer bears in covering the service, can be of use in assessing the cost and benefit of external review.

Cost of IRO Services

IROs submitted per-case pricing for standard and expedited reviews as part of their proposal to contract to perform external review. (Case pricing based on the type of medical service or condition was not permitted.) Currently, contracted fees run from \$300 to \$850 per standard review and \$400 to \$900 for expedited review. Table 4 shows that for the 14 cases for which an IRO decision was issued that are included in this report, the average IRO charge was \$537 per review. Since fees do not vary by case type, the average is simply a function of the distribution of cases across IROs. Cases where an insurer reversed its original denial before a case was assigned to an IRO do not incur any IRO fee. If an insurer reverses its original denial after a case has been assigned to an IRO, the IRO will charge a full or partial fee, depending on the amount of review work performed prior to being informed of the reversal.

Table 4: Average Cost of IRO Review by Diagnostic Category

Diagnostic Category	Upheld	Overturned	Reversed	All
Cancer	\$795	\$ 0	\$ 0	\$795
Chelation Therapy	475	0	0	475
Cranioplasty (2)	475	0	0	950
Gastroenterology	0	0	0	0
Gynecology	0	900	0	900
Infectious Diseases	0	450	0	450
Mammoplasty	0	625	0	625
Mental Health/Substance Abuse	0	300	0	300
Morbid Obesity	575	0	0	575
Neurology	0	300	0	300
Orthopedic/Musculoskeletal	0	625	0	625
Pharmacy Orthopedic	0	0	0	0
Respiratory System	0	625	0	625
Speech Pathology	450	0	0	450
TMJ	450	0	0	450
ALL CASES	\$528	\$546	\$ 0	\$537

Cost of Services Required to be Covered

The average amount of allowed charges for insurers' coverage of services following an IRO's decision in favor of the covered person (7 cases) was \$5,944. Insurers assumed an average of \$1,853 in allowed charges for cases where they reversed their own noncertification prior to an eligible request being assigned to an IRO (2 cases).

The information in Table 5 reflects the average cost, by case type, of services that have been provided after a case has been overturned by the IRO or reversed by the insurer either before or after assignment to an IRO. However, because the number of cases reviewed so far is very small, neither the average allowed charges for all cases nor the average charges per case type should be generalized at this time

Table 5: Average Cost of Allowed Charges Paid by Insurer for Reversed or Overturned Cases

Diagnostic Category	Overturned	Reversed	All
Cancer **	\$ 0.00	\$ 0.00	\$ 0.00
Chelation Therapy **	0.00	0.00	0.00
Cranioplasty (2) **	0.00	0.00	0.00
Gastroenterology	0.00	3,060.46	3,060.46
Gynecology	4,964.52	0.00	4,964.52
Infectious Diseases	1,096.40	0.00	1,096.40
Mammoplasty	9,763.56	0.00	9,763.56
Mental Health/Substance Abuse	3,164.00	0.00	3,164.00
Morbid Obesity **	0.00	0.00	0.00
Neurology	3,144.99	0.00	3,144.99
Orthopedic/Musculoskeletal	2,694.50	0.00	2,694.50
Pharmacy Orthopedic *	0.00	645.03	645.03
Respiratory	16,780.00	0.00	16,780.00
Speech Pathology **	0.00	0.00	0.00
TMJ **	0.00	0.00	0.00
ALL CASES	\$5,943.85	\$1,852.75	\$5,034.82

* Pharmacy costs represent total of monthly costs until policy termination date

** Denial was upheld by IRO. Cost of Service is not known for these cases

VI. Activity by Diagnostic Category

Information indicating which diagnostic categories are the subject of external review, the frequency of expedited review for each diagnostic category, and the outcome of reviews by diagnostic category may be helpful in identifying any trends as they emerge. Such information, on an industry-wide basis, might be of use to insurers, providers, health care researchers and policymakers.

A. Number and Distribution of Eligible Requests and Decisions on Accepted Cases

Table 6 cites the number of eligible requests, the type of review granted, and the outcome of the reviews, by diagnostic category. Table 7 shows the same information on a *percentage share basis* (i.e., each diagnostic category's percentage share of all eligible requests, etc.). Due to the small number of cases per diagnostic category, it is premature to attempt to draw conclusions or identify trends regarding diagnostic categories most frequently the subject of requests for review, most frequently the subject of expedited review, or most frequently upheld or overturned.

B. Review Decisions

Table 8 indicates the number of IRO review decisions rendered for each diagnostic category from which a case was accepted for review, the percentage of insurer decisions that were overturned by the IRO, the percentage of insurer decisions that were upheld by the IRO, and the percentage of decisions that were reversed by the insurer after assignment to an IRO. At this time, there is insufficient data to identify trends or draw conclusions as to the likelihood of a particular outcome for a given diagnostic category.

Table 8: Review Decisions by Diagnostic Category

Diagnostic Category	Number of Decisions	Percent Overturned	Percent Upheld	Percent Reversed
Cancer	1	0	100	0
Chelation Therapy	1	0	100	0
Cranioplasty	2	0	100	0
Gynecology	1	100	0	0
Infectious Diseases	1	100	0	0
Mammoplasty	1	100	0	0
Mental Health/Substance Abuse	1	100	0	0
Morbid Obesity	1	0	100	0
Neurology	1	100	0	0
Orthopedic/ Musculoskeletal	1	100	0	0
Respiratory System	1	100	0	0
Speech Pathology	1	0	100	0
TMJ	1	0	100	0

VII. Activity by Insurer

Over time, it will be useful to identify insurers for whom request activity, case acceptance and case outcomes for accepted cases, both overall or for a particular diagnostic category, is disproportionately high compared to other insurers. Once there is a credible number of reviews performed, consumers will be able use this information to compare insurers, insurers will be able use it to evaluate their own performance, and regulators will be able use it to identify potential “trouble areas”.

A. Summary of Activity by Insurer

Table 9 presents the number of completed reviews performed for each insurer and the outcomes of those reviews. Due to the small number of requests and reviews involved, it is premature to draw conclusions about any insurer’s share of external review cases, about frequency of review decisions that result in the insurer’s denial being overturned or upheld, or about the frequency of any insurer’s decision to reverse its own denial.

Note that the best way to compare the number of external review cases between insurers is to look at the rate of requests relative to number of insureds or total “member months”. Since the number of cases is so small, any attempt to calculate a rate of external reviews per 10,000 insureds or per 10,000 member months would result in miniscule numbers. Therefore, this report shows the number of external reviews, simply as an accounting of activity. Future reports will present this information on a rate basis.

Table 9: External Review Cases and Case Outcomes by Insurer

Insurer	Number Eligible	Upheld		Overturned		Reversed	
		#	%	#	%	#	%
Aetna Health of the Carolinas, Inc.	0	0	0.0	0	0.0	0	0.0
Blue Cross & Blue Shield of North Carolina	3	3	100.0	0	0.0	0	0.0
CIGNA HealthCare of North Carolina, Inc.	3	1	33.3	1	33.3	1	33.3
Celtic Insurance Company	0	0	0.0	0	0.0	0	0.0
Central United Life Insurance Company	0	0	0.0	0	0.0	0	0.0
FirstCarolinaCare, Inc.	0	0	0.0	0	0.0	0	0.0
GE Group Life Assurance Company	0	0	0.0	0	0.0	0	0.0
Guardian Life Insurance Company of America	0	0	0.0	0	0.0	0	0.0
John Alden Life Insurance Company	1	0	0.0	1	100.0	0	0.0
Liberty Life Assurance Company of Boston	0	0	0.0	0	0.0	0	0.0
MA MSI Life and Health Insurance Company	1	0	0.0	1	100.0	0	0.0
NC Healthchoice for Children	1	0	0.0	1	100.0	0	0.0
PARTNERS National Health Plans of North Carolina, Inc.	2	1	50.0	1	50.0	0	0.0
Principal Life Insurance Company	0	0	0.0	0	0.0	0	0.0
Teachers' and State Employees' Comprehensive Plan	1	1	100.0	0	0.0	0	0.0
UnitedHealthCare of North Carolina, Inc.	1	0	0.0	1	100.0	0	0.0
WellPath Select, Inc.	3	1	33.3	1	33.3	1	33.3

B. Insurer and Diagnostic Category

Table 10 contains information about the nature of the external reviews performed for each insurer, expressed in terms of number of cases and distribution of each insurer’s cases by

diagnostic category. Due to the small number of requests and cases reviewed so far, it is premature to draw conclusions or identify trends about any individual insurer.

Table 10: Accepted Cases by Insurer by Diagnostic Category

Insurer and Diagnostic Category	Number of Accepted Cases	Percentage of Insurer's Cases
Blue Cross & Blue Shield of North Carolina	3	
◆ Cranioplasty	2	66.6
◆ Morbid Obesity	1	33.3
CIGNA HealthCare of North Carolina, Inc	3	
◆ Gynecology	1	33.3
◆ Pharmacy Orthopedic	1	33.3
◆ Speech Pathology	1	33.3
John Alden Life Insurance Company	1	
◆ Orthopedic/Musculoskeletal	1	100.0
MAMSI Life and Health Insurance Company	1	
◆ Infectious Disease	1	100.0
NC Healthchoice for Children	1	
◆ Mammoplasty	1	100.0
PARTNERS National Health Plans of North Carolina, Inc.	2	
◆ Respiratory System	1	50.0
◆ TMJ	1	50.0
Teachers' and State Employees' Comprehensive Plan	1	
◆ Chelation Therapy	1	100.0
UnitedHealthcare of NC, Inc.	1	
◆ Mental Health/Substance Abuse	1	100.0
WellPath Select, Inc.	3	
◆ Cancer	1	33.3
◆ Gastroenterology	1	33.3
◆ Neurology	1	33.3

* Cases under Department or IRO review at year-end are not represented in Table.

Table 11 provides detailed data about how IROs decided on diagnostic categories for each insurer. Data is for the 14 cases for which an IRO decision was issued. (Of the 16 cases closed, 2 were closed when the insurer decided to reverse its own noncertification decision.) Due to the small number of IRO decisions issued to date, it is premature to draw any conclusions about how an individual insurer made decisions or how insurers fared in IRO decisions for particular case types compared to others.

Table 11: Review Decisions by Insurer by Diagnostic Case Type

Insurer and Diagnostic Category	Number of IRO Decisions	Outcomes Percentage		
		Overturned	Upheld	Reversed
Blue Cross & Blue Shield of North Carolina				
◆ Cranioplasty	2	0	100	0
◆ Morbid Obesity	1	0	100	0
CIGNA HealthCare of North Carolina, Inc.				
◆ Gynecology	1	100	0	0
◆ Speech Pathology	1	0	100	0
John Alden Life Insurance Company				
◆ Orthopedic/Musculoskeletal	1	100	0	0
MAMSI Life and Health Insurance Company				
◆ Infectious Diseases	1	100	0	0
NC Healthchoice for Children				
◆ Mammoplasty	1	100	0	0
PARTNERS National Health Plans of North Carolina, Inc.				
◆ Respiratory System	1	100	0	0
◆ TMJ	1	0	100	0
Teachers' and State Employees' Comprehensive Plan				
◆ Chelation Therapy	1	0	100	0
UnitedHealthCare of North Carolina, Inc.				
◆ Mental Health/Substance Abuse	1	100	0	0
WellPath Select, Inc.				
◆ Cancer	1	0	100	0
◆ Neurology	1	0	100	0

VIII. Activity by IRO

A. Summary by IRO

Table 12 shows the number of cases assigned to each IRO, along with the number and percentages of types of review decisions for each IRO. The data includes cases assigned to an IRO but not yet decided as of December 31st, so the number of outcomes reported for some IROs do not equal the number of cases assigned, and the percentage of cases upheld and overturned may not equal 100 percent for every IRO. (Hayes Plus, IPRO and Maximus CHDR each had a case pending determination on December 31, 2002.) The number for reversed cases reflects only those cases where an insurer reversed its decision after the IRO assignment. The small number of cases makes it inappropriate to draw any conclusions about any IRO's decisions at this time.

Table 12: IRO Activity Summary

IRO	Number Assigned	Number Reversed	Upheld		Overturned	
			Number	Percent	Number	Percent
Carolina Center for Clinical Information	2	0	0	0.00	2	100.00
Hayes Plus	5	0	4	80.00	0	0.00
IPRO	5	0	1	20.00	3	60.00
Maximus CHDR	5	0	2	40.00	2	40.00
TOTAL	17	0	7	41.18	7	41.18

B. Decisions by Diagnostic Category and Insurer

It is important to consumers and insurers that the external review process provide equitable treatment and outcomes that are as consistent as possible, regardless of which IRO is reviewing a specific case. Due to the unique circumstances that apply in every case, and given that different clinical reviewers review each case, it is impossible to expect the exact same decision to be made for similar cases. However, large disparities between IROs in the outcomes of reviews by diagnostic category or by insurer would warrant investigation by the Department to verify that reviews are performed equitably and according to the review standards set out in law and contract with the IRO.

Table 13 presents case outcomes by diagnostic category for each IRO. Due to the small number of cases, there is not sufficient data to determine trends for decisions among IROs or by diagnostic category.

Table 13: IRO Decision by Diagnostic Category

IRO and Diagnostic Category	Number of Decisions	Outcomes		
		Percent Overturned	Percent Upheld	Percent Reversed
Carolina Center for Clinical Information				
◆ Mental Health/Substance Abuse	1	100	0	0
◆ Neurology	1	100	0	0
Hayes Plus				
◆ Chelation Therapy	1	0	100	0
◆ Cranioplasty	2	0	100	0
◆ Morbid Obesity	1	0	100	0
IPRO				
◆ Cancer	1	0	100	0
◆ Mammoplasty	1	100	0	0
◆ Orthopedic/Musculoskeletal	1	100	0	0
◆ Respiratory	1	100	0	0
Maximus CHDR				
◆ Gynecology	1	100	0	0
◆ Infectious Diseases	1	100	0	0
◆ Speech Pathology	1	0	100	0
◆ TMJ	1	0	100	0

Table 14 shows each IRO's decisions by individual insurer and then for all insurers. The data is not sufficient at this time to make any generalizations about any IRO's treatment of individual insurers.

Table 14: IRO Decisions by Insurer

IRO and Insurer	Number of Decisions	Percent Overturned	Percent Upheld	Percent Reversed
Carolina Center for Clinical Information				
◆ UnitedHealth Care of North Carolina, Inc.	1	100	0	0
◆ WellPath Select, Inc.	1	100	0	0
◆ All Plans	2	100	0	0
Hayes Plus				
◆ Blue Cross & Blue Shield of North Carolina	3	0	100	0
◆ Teachers' and State Employees' Comprehensive Plan	1	0	100	0
◆ All Plans	4	0	100	0
IPRO				
◆ John Alden Life Insurance Company	1	100	0	0
◆ NC Healthchoice for Children	1	100	0	0
◆ PARTNERS National Health Plans of North Carolina, Inc.	1	100	0	0
◆ WellPath Select, Inc.	1	0	100	0
◆ All Plans	4	75	25	0
Maximus CHDR				
◆ CIGNA HealthCare of North Carolina, Inc.	2	50	50	0
◆ PARTNERS National Health Plans of North Carolina, Inc.	1	0	100	0
◆ All Plans	4	50	50	0

IX. HCR Program Evaluation

The HCR Program has implemented a consumer satisfaction survey to understand how satisfied consumers were with the external review process and to determine which, if any, areas needed improvement. A survey is mailed to each person whose case is accepted for review, once a decision is issued and the case is closed.

Surveys were mailed to the 16 individuals whose requests were accepted for review during the period of July 1, 2002 through December 31, 2002. Of the 16 surveys sent, 8 were completed and returned. Respondents included individuals whose noncertification was upheld by the IRO and those whose noncertification was overturned. Respondents generally found the process of requesting an external review satisfactory and compliant with statutory requirements such as time frames, and that the HCR Program staff is accessible and helpful.

Program “clients” continue to be surveyed on an ongoing basis. The results of the survey are as follows:

Healthcare Review Program Consumer Satisfaction Survey

Question	Answers
1. Where did you learn about the Independent External Review Program?	6= Insurer 2= NCDOT Consumer Services Division
2. Was the request form easy to use and understand?	7= Yes 0= No 1= N/A
3. Was your telephone call answered promptly?	7= Yes 0= No 1= N/A
4. Was your call handled in a courteous manner?	7= Yes 0= No 1= N/A
5. Did the Department answer all your questions and help you get the information you were looking for?	7= Yes 1= No 0= N/A
6. Were you able to reach a staff member during non-business hours?	3= Yes 0= No 5= N/A
7. Did the correspondence you received from the Department give you adequate information about the External Review process?	7= Yes 0= No 1= N/A
8. Did you receive information from the Department in the time frames that you were promised?	7= Yes 0= No 1= N/A
9. Did you receive a decision from the IRO in the time frame you were promised?	8= Yes 0= No 0= N/A
10. Did you have any difficulty understanding the reasoning and final decision made by the IRO?	3= Yes 5= No 0= N/A
11. Did the Healthcare Review Program help to resolve your concern?	6= Yes 2= No 0= N/A
12. Would you tell a friend about the External Review Program?	6= Yes 2= No 0= N/A

X. Conclusion

North Carolina's law governing external review provides its citizens with an important consumer protection. Eligible consumers now have the right to request an independent medical review of an insurer denial when the insurer's decision to deny reimbursement was based on medical necessity determinations. External review services provide consumers with a fair, efficient, and cost-effective way to resolve coverage disputes with their insurer.

Through the efforts of the Department's HCR Program, external review services were made available timely and in compliance with all statutory requirements. Reasonable success in informing consumers about external review services and accessibility of the External Review Request Form and related program information is evident by the volume of calls to the HCR Program and web site hits. In comparing the volume of external review requests received by the Program during its first six months of operation (59 requests) to other similar state external review programs during their initial start up phase, the Program has demonstrated that consumers are interested and willing to pursue the external review process. However, despite its success compared to other states, there is a need to increase consumer awareness of this important right. In 2001, health insurers reported conducting 358 second-level grievance reviews, 161 of which were not settled in favor of the insured (i.e., likely eligible for external review). Data for 2002 second-level grievances is not yet available. However, if the number of second-level grievances that upheld the insurer's noncertification was similar to the year before, there is certainly a large number of potential requests for external review that were not made. The HCR Program will focus its efforts on outreach and education in 2003.

Over the last year, the HCR Program has worked closely and in mutual cooperation with insurers, providers, consumer groups and professional organizations in implementing external review services. Improvements to the process have been made based on program experience by the staff and suggestions from insurers. In the end, the Healthcare Review Program operates effectively to provide external review services to the citizens of North Carolina.

APPENDIX A

External Review

Instructions For Completing External Review Request Form

North Carolina law allows consumers to request an external review of denial decisions (known as noncertifications) made by an HMO or insurer when the requested services are denied, reduced, or terminated on any of the following grounds:

- that they are not medically necessary;
- that they cosmetic, experimental or investigational in nature in the case of the specific request, even though the service is covered by the plan in cases when it is not cosmetic, experiment, or investigational; or
- that emergency services were not necessary because prudent layperson acting reasonably would not have believed that an emergency medical condition existed.

The North Carolina Department of Insurance Healthcare Review Program administers this service at no charge to the person whom requests the review. Requests for review are made to the Healthcare Review Program but the actual medical reviews will be conducted by independent review organizations (IROs). An IRO is an organization of physicians and other health professionals with whom the Department of Insurance contracts to review requests when the insured meets the program eligibility requirements.

Two types of external review are available: standard and expedited. Knowing the requirements for each type of request and completing the request form in a clear, legible, thorough manner will allow the Healthcare Review Program to evaluate the request for eligibility without delay. These instructions are provided to explain the terms used within the external review request form, how they relate to the external review process and how the external review process works.

Definition of Terms

Covered Person

This is the patient or person who received or requested the denied service. This person receives correspondence regarding this request for review. It is very important to include all contact and address information when completing the External Review Request Form.

Person Requesting Review

This person fills out or completes the External Review Request Form. This may be the covered person, the covered person's parent or legal guardian, or, if the covered person so chooses, any other person, including the covered person's physician, who he/she would like to represent him/her for purposes of the external review. The Healthcare Review Program requires this contact information, as they may need to ask this person for further information regarding this request. *If the covered person is the one who is requesting the external review, simply write "Same as above" in this section of the request form.*

Insurance Information

This is the information relating to the health insurance under which the patient is covered. The policy and group numbers and other requested information are important because they enable the Healthcare Review Program to access necessary insurance policy information from the insurer.

Patient Relationship

This is the relationship between the covered person and the policyholder. This may be "self," "spouse," "child," or whatever the relationship is between the covered person and the person whose name is on the policy.

Policyholder

This refers to the name of the person that the insurance plan is issued to, whether through an individual policy or employer or other group policy. The policyholder may be a different from the covered person. The Healthcare Review Program requires this information, along with the policyholder's social security number, to access the correct insurance information and determine the eligibility of this request.

Employer/Group Name

The name of the company that employs the policyholder or other group, such as a professional association through which the policyholder receives or purchases health insurance. *If coverage is through an individual policy, write "Individual policy" in this section.*

Coverage Termination Date

The date, if applicable, that the insurance coverage ended. External review can be requested for denied services that were requested or received prior to the time that coverage terminated, but if the decision on the external review is that services should be paid or approved, they will only be approved or covered to the extent that would have been received before the insurance coverage stopped. *If coverage remains in effect, write "N/A" in this section.*

Mental Health Company

The name of the company that provides or administers the mental health benefit portion of the benefit for the insurance policy, if different from the insurer's name. *If the request does not involve mental health care or treatment for substance abuse, write "N/A" in this section. If it does involve mental health or substance abuse, provide the name of the mental health company identified on the covered person's insurance card if one is identified.*

Self-Funded or Self-Insured

Employers that pay for their own health care as opposed to purchasing health care insurance from an insurer. The employer will know if the plan is self-funded, and an insurance card may identify a plan as self-funded or self-insured.

Physician/Health Care Provider

The name of the physician or healthcare provider who has provided, ordered or requested the services that were denied by the insurer.

Final Adverse Determination

The written notification received from the insurer that its denial of a requested service was reviewed at its highest level of appeal and the service remains denied. Some companies offer only one level of appeal and some offer two levels. (The second level is usually referred to as a "second-level grievance.") The final adverse determination may apply to services already provided (retrospective), services requested now because treatment is underway (concurrent), or services requested for the future (prospective), but in any case, the services were denied at the *highest level of appeal*.

All appeals processes offered through the insurer must be completed and a final adverse determination received in order to request a standard external review. A request for external review can be made if the insurer has decided to waive the appeal process and provides notification of this in writing. *A copy of the final adverse determination letter or agreement to waive the appeal process must accompany the request to the Healthcare Review Program for the external review.*

Noncertification

This is the determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and will not be covered because, based upon the information provided, it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. A noncertification includes a decision by an insurer that emergency services received were not necessary because a prudent layperson acting reasonably would not have believed that an emergency medical condition existed. A noncertification also includes a decision by an insurer that a requested service is either cosmetic or experimental or investigational in the case of a specific claim, and is therefore not covered for that person for whom services are requested.

A noncertification is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

Type of Review Requested

Standard Review

This refers to "standard" processing of a request, which is completed within 45 days after the day the Healthcare Review Program receives a request. Standard review is available whether the denied services have already been provided or not, and regardless of whether the denial was made before any services were rendered ("prospective review"), while services were underway ("concurrent review"), or after services were rendered ("retrospective review"). In many cases, standard review is the only type of review that can be requested unless eligibility criteria for expedited review that are outlined below are met.

Expedited Review

This refers to expedited processing of requests, which are completed within four days after the day the Healthcare Review Program receives a request. Expedited review may be approved for requests when services have been requested but not yet provided and when service is underway but needs to be continued or extended. An expedited review is **NOT** available if the requested services have already been received. A request for an expedited external review may be oral or in writing.

Except as noted in item #4 below, to qualify for expedited review the covered person must have a medical condition where the time required to complete the other internal and external review processes available would reasonably be expected to seriously jeopardize his/her life or health or would jeopardize his/her ability to regain maximum function.

To be eligible, one of the following must apply:

1. An initial denial was received; and the covered person has a medical condition where the time frame for completion of an expedited first-level appeal through the insurer would reasonably expect to seriously jeopardize his/her life or health or ability to regain maximum function; and the covered person has filed a request for an expedited review through the insurer.
2. A first level appeal decision upholding an initial denial was received; and the denial decision involves a medical condition of the covered person for which the time frame for completion of an internal expedited second level grievance through the insurer would reasonably expect to seriously jeopardize his/her life or health or ability to regain maximum function; and the covered person has filed a request for an expedited second level review of the first level denial decision.
3. A second-level grievance decision upholding an initial denial was received and the covered person has a medical condition where the time frame for completion of a standard external review through the Healthcare Review Program would reasonable expect to seriously jeopardize his/her life or health or ability to regain maximum function.
4. A second level grievance decision upholding an initial denial was received and the second-level determination concerns a denial of an admission, availability of care, continued stay or health care services for which the covered person received emergency services, but has not been discharged from a facility.

A verbal request for an expedited appeal is allowed; however, a signed Release of Medical Information form will be required for the Healthcare Review Program to complete processing of the request after the case is determined to be eligible for review. In addition, information about the insurer is required in order to begin processing the request. This information should be readily available if the request for an expedited external review is verbal.

Description of Disagreement

This is a description of the service that was denied by the insurer. This is an opportunity to describe to the Healthcare Review Program what the services were and what is the desired outcome of the external review request.

Appointment of Authorized Representative

The person to whom the patient or covered person (or the covered person's legal representative) has given permission to act on his/her behalf in pursuing an external appeal. This authorization may be revoked at any time.

Release of Medical Information

The covered person's signed permission for the Healthcare Review Program and its contracted IRO to access those records from the insurer or health care provider that are required for the reviewer to make a decision about the requested case. This form must be provided to the Healthcare Review Program with the request for external review or the request will be considered incomplete. This is also required for an expedited request, even if a verbal request is made to the Healthcare Review Program.

Overview of External Review Process

For both standard and expedited review, a request for external review must be made within 60 days of the day they receive the highest level adverse determination relating to the denied services.

Standard Review Process

When the Healthcare Review Program receives a request for an external review, the staff will conduct a preliminary review of the request to determine if: 1) the covered person was covered by the insurer at the time of the request for the services that are the subject of this external review request; 2) the services reasonably appear to be a covered service under the policy; 3) the appeals process required through the insurer was exhausted; and 4) the request for external review is complete.

If the request for a standard external review is not complete, the Healthcare Review Program will contact the covered person and/or the covered person's authorized representative within 10 days to inform he/she that the request is incomplete. The notification will ask for the information required to make the request complete to be sent to the Healthcare Review Program within 90 days *of the date the final adverse determination notification was received* that started or prompted the request for an external review. If the information is not submitted to the Healthcare Review Program within this time frame, the request cannot be considered eligible for external review.

Once the information required by the Healthcare Review Program is provided, notification will be sent to the covered person, an authorized representative if appropriate, the provider who requested the services that were denied and the insurer, whether the request is accepted for review. If the request is not accepted, the notification will state the reason why the request was not eligible for an external review.

If the request is accepted for a standard external review, the case will be assigned to an IRO for medical review. The covered person (or the authorized representative) and the treating provider will receive written notification from the Healthcare Review Program within 10 days notifying

them of the name of the IRO assigned to the case. It will also contain a notice of the covered person's right to provide additional information to the IRO for consideration during the review within seven days of the date of the notice informing the covered person of the IRO assignment. Any information that the covered person submits to the assigned IRO must also be sent to the insurer at the same time and by the same means as the information was sent to the IRO. Upon receipt of any additional information from the covered person, the insurer may reconsider its noncertification appeal decision or second-level grievance review decision that was sent to the IRO for consideration. The external review shall be terminated if the insurer decides, upon completion of its reconsideration to reverse its noncertification appeal decision or second-level grievance review decision and provide coverage or payment for the requested health care service that is the subject of the review. Upon making the decision to reverse its noncertification appeal decision, the insurer shall notify the covered person, the organization, and the Healthcare Review Program in writing of the decision. The IRO shall terminate the external review upon receipt of the notice from the insurer of such a reversal.

If the insurer does not reconsideration or reverse its decision, the IRO is required to notify the covered person of the decision about the case within 45 days after the date that the request for review was received by the Healthcare Review Program. If additional information was required to complete the request, the IRO is required to notify the covered person within 45 days of the date the required information was received to complete the request.

Expedited Review Process

When the Healthcare Review Program receives a request for an expedited external review, the staff will first do a preliminary review to determine if:

1. the covered person was eligible for coverage under a health insurance policy at the time of the request for the services that are the subject of this external review request;
2. the services reasonably appear to be a covered service under the policy;
3. that requirements to request an expedited appeal or second-level grievance from the insurer have been met; and
4. the information required to process a request is complete.

Healthcare Review Program staff will assist a person making a request for a review as needed if additional information is required to make the request complete. This includes providing the Release of Medical Records Form and, if applicable, Appointment of Authorized Representative Form.

The Healthcare Review Program will then evaluate the request for an expedited external review to determine if the request meets the eligibility requirements for an expedited review. Eligibility for handling a request on an expedited basis will be determined by consulting with a medical professional. The covered person or his/her representative will be notified within three days whether the request has been accepted. When the request is accepted for review, the covered person will be notified of their right to submit additional information to be considered during the

review. The covered person, or the authorized representative will be instructed to submit this information to the HCR Program for distribution to the IRO and the insurer. There is a time limit for which this information may be submitted, and the covered person or authorized representative will be notified of the deadline for submitting this information by the Program.

If the Healthcare Review Program determines the request does not meet the requirements for an expedited external review, the insurer's internal appeal process may be required to be completed, or if the insurer's internal appeal process has already been completed, the case may be accepted for standard external review.

If a request is accepted to be processed on an expedited basis, the IRO is required to notify the covered person of their decision regarding the case within four days of the date a request was made to the Healthcare Review Program.

The insurer is required to pay for the cost of the review. The decision made by the IRO is binding, both to the covered person whose requested services were denied and to the insurer, except to the extent the covered person has other remedies available under applicable federal or state law. This means that the insurer must pay for or cover previously denied services that the IRO determines should not have been denied. This also means that, when the IRO upholds a denial, any further internal appeals or requests for additional external reviews of the matter cannot be filed. However, the covered person may still have the ability to take other action under state or federal law, including filing suit against the insurer.



North Carolina Department of Insurance
Healthcare Review Program

EXTERNAL REVIEW REQUEST FORM

General Information about Eligibility

North Carolina law provides for review of health insurers' noncertification decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service through its Healthcare Review Program (HCR Program), arranging for an IRO to review your case at no charge to you once the NCDOI establishes that your request is complete and eligible for review.

In order for your request to be eligible for external review, the NCDOI must determine the following:

- That your request is about a medical necessity determination made by your health plan that resulted in a noncertification (denial);
- That you had coverage with your health plan in effect when the noncertification decision was issued;
- That the service for which the noncertification was issued appears to be a covered service under your policy;
- That you have exhausted your health plan's internal review process; and
- That you have provided all the information and completed the required forms.

External review is performed on either a standard or an expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review. A decision is issued within 45 days for standard reviews and 4 days for expedited reviews. An expedited external review of a noncertification decision may be available if you have a medical condition for which the time required to complete either an expedited internal appeal or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

Information Required to Request External Review

For your request to be considered complete, you must submit the following to the HCR Program:

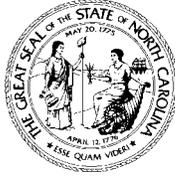
- ✓ This completed External Review Request Form, signed and dated. The Sign the “Appointment of Authorized Representative” part of this form if someone is acting on your behalf.
- ✓ A copy of the letter from your health insurance company that states your requested service was denied at the highest level of their internal appeal process, if you are requesting a standard review. **(Your request must be made within 60 days of receiving the health plan’s notice of final determination that the services in question are not approved.)**

OR

A copy of your health insurance company’s noncertification letter or decision letter on 1st - level appeal, if you are requesting an expedited review. **(Your request must be made within 60 days of receipt of this letter. See page 5 of this form for additional requirements when submitting a request for expedited review.)**

- ✓ A signed copy of the Release of Medical Records Form that allows your insurance company and health care providers to release any relevant medical information and allows NCDOI to share your records with the IRO.
- ✓ A copy of both sides your health insurance card.

<p>To mail a request to the HCR Program:</p> <p>North Carolina Department of Insurance Healthcare Review Program P. O. Box 29387 Raleigh, NC 27611</p>	<p>To submit a request in person:</p> <p>North Carolina Department of Insurance Healthcare Review Program 430 N. Salisbury Street, Room 4105 Raleigh, NC 27603</p>
<p>To call the HCR Program:</p> <p>In-State Toll-free: 1-877-885-0231 Local: 1-919-715-1163</p>	<p>To FAX a request to the HCR Program:</p> <p style="text-align: center;">1-919-715-1175</p> <p>Monday - Friday 8am-5pm <u>ONLY</u>. To fax a request at any other time, you must <u>first</u> contact the Healthcare Review Program.</p>



**North Carolina Department of Insurance
Healthcare Review Program**

EXTERNAL REVIEW REQUEST FORM

Today's Date: _____

Information on Covered Person (Patient)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (H) _____ (W) _____

(Cell) _____ (Fax) _____

Date of Birth: _____ **Social Security #:** _____

Information on Person Requesting Review

(if different from Covered Person)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (H) _____ (W) _____

(Cell) _____ (Fax) _____

Insurance Information

Policyholder's Name: _____
Relationship to Patient: _____
Social Security Number: _____
Policyholder's
Date of Birth: _____
Employer/Group Name: _____
Location of Employer: _____
Phone Number: _____

Is the patient covered under North Carolina Health
Choice for Children (*Health Insurance Program for
Children*)? Yes { } No { }

Is the patient covered under the Teachers' and State
Employee's Comprehensive Major Medical Plan? Yes { } No { }

Insurance Company: _____

Policy Number: _____

Group Number: _____

Coverage Termination Date: _____

Mental Health Company: _____

Is this plan self-funded (self-insured)? Yes { } No { }

Physician/Health Care Provider Information

Name: _____

Practice: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Ext. _____ Fax: _____

Type of Review Requested

Place an "X" to indicate the description that best explains why you are eligible to request external review and type of review you are requesting.

- _____ I have completed my health plan's internal appeal/grievance process and received a notice of final determination denying coverage. I have enclosed a copy of the notice from my health plan with my request.
- _____ **I am requesting a standard external review.**
- _____ **I am requesting an expedited external review** because the time allowed under the standard external review process is reasonably expected to seriously jeopardize my life, health or ability to recover.
- _____ **I am requesting an expedited external review** because the services denied relate to care following an emergency admission and I have not yet been discharged from the hospital.
- _____ **My health plan has agreed to waive its internal appeal and grievance process.** I have enclosed a copy of the notice from my health plan agreeing to the waiver with my request.
- _____ **I am requesting a standard external review.**
- _____ **I am requesting an expedited external review** because the time allowed under the standard external review process is reasonably expected to seriously jeopardize my life, health or ability to recover.
- _____ **I have filed a request for the highest level of internal review available from my health plan more than 60 days ago but have not received a response and have not agreed to allow them more time to respond.** I have enclosed a copy of that request with my request. I am requesting a standard external review.
- _____ I received a notice of noncertification under my health plan's utilization review process and am **requesting expedited external review** because the time required for me to first complete the health plan's internal appeal process is reasonably expected to seriously jeopardize my life, health or ability to recover. I have also filed a request for expedited internal appeal with my health plan. That request was made to the health plan on _____. (To be eligible for expedited external review you must have filed an expedited appeal with your health plan. Enclose a copy of that request if you made it in writing.)
- _____ I received a notice determination under my health plan's internal appeal process and am **requesting expedited external review** because the time required for me to first complete the health plan's internal second-level grievance process is reasonably expected to seriously jeopardize my life, health or ability to recover. I have also filed a request for expedited internal second-level grievance with my health plan. That request was made to the health plan on _____. (To be eligible for expedited external review you must have filed an expedited 2nd-level grievance with your health plan. Enclose a copy of that request if you made it in writing.)

Description of Disagreement

Briefly describe the disagreement with your health plan, and if possible, indicate the services that are the subject of the external review. Please state what your goal is for this external review. You may attach additional pages if necessary. You should also attach any information you received from the health insurance company concerning the denial.

Signature of Person Requesting Review

(must also complete “Appointment of Authorized Representative” if not the Covered Person)

Date

MEDICAL AUTHORIZATION RELEASE

READ CAREFULLY!

The undersigned individual (“covered person”) has requested a Health Benefit Plan External Review pursuant to Part 4 of Article 50 of Chapter 58 of the North Carolina General Statutes. In order to process that review, the undersigned covered person authorizes the North Carolina Department of Insurance to obtain his/her files, including but not limited to medical record information, from the Health Benefit Plan from whose decision the covered person is appealing. The covered person also authorizes the North Carolina Department of Insurance to provide such files to the Independent Review Organization assigned to handle the covered person’s external review. Nothing herein shall be construed to otherwise render inoperative the provisions of NCGS 58-2-105 regarding medical records in the possession of the Department of Insurance.

_____ **Date:** _____
Signature

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

Fill out this section only if someone else is requesting the external review for you

You may request an independent external review yourself, however, you may choose to have another individual, including your healthcare provider, act as your representative. You may revoke this authorization at any time.

I hereby authorize _____ **to pursue this external review on my behalf.**

Relationship to Patient: _____

Signature of Covered Person or Legal Representative

NC DEPARTMENT OF INSURANCE HEALTHCARE REVIEW PROGRAM
(EXTERNAL REVIEW)

FREQUENTLY ASKED QUESTIONS

1. What is external review?

External review refers to an independent medical review of certain decisions made by health insurers. These reviews are arranged for by the North Carolina Department of Insurance Healthcare Review Program (HCR Program). The HCR Program contracts with several companies known as Independent Review Organization (IROs). IROs have large networks of physicians and other types of medical professionals qualified to evaluate a wide range of medical issues. The IRO assigned to your case and its medical reviewers will have no relationship with your health insurer. The IRO makes the final coverage decision on each request that the HCR Program has determined eligible for external review. If the IRO medical reviewer for your case determines that the requested service is medically necessary, your insurer will be required to approve or pay for your previously denied service.

2. What kind of insurer decisions are subject to external review?

External review is available when your health insurer denies coverage for services or requested services on the grounds that they are not medically necessary. This type of denial is often called a “noncertification decision.” A decision by your insurer that services are not covered because they are cosmetic or experimental *in your case* because of *your specific medical circumstances*, rather than because it is absolutely excluded under your insurance policy, is also a noncertification decision subject to external review.

3. Can I request a review for any type of insurance denial?

External review is available for most health insurers that make coverage decisions based on medical necessity. Medical necessity decisions made by the NC Teachers’ and State Employees Comprehensive Major Medical Plan (State Health Plan) and the NC Health Insurance Program for Children (NC Health Choice) are also subject to external review.

External review does not apply to self-funded employer health plans. (These are health plans for which an employer sets aside his own funds to pay for health claims rather than purchasing insurance, and are often “administered” by health insurance companies.) External review also does not apply to Medicare or Medicaid and is not available for certain types of insurance, including: dental, vision, Medicare supplement,

long-term care, specified disease, workers compensation, credit, or disability income, or to medical payments under homeowners or auto insurance.

4. When can I request an external review?

External review is available whether you have already received a service and coverage for it has been denied or you have requested and been denied coverage for a service that you have not yet received.

Most people will qualify for a *standard* external review, which results in a decision within 45 days of submitting a request for review. An *expedited* external review, under which a decision is made within four days of submitting a request, is available in cases where the time involved in obtaining a final decision can have an impact on a person's health. The specific eligibility requirements for expedited review and a detailed description of the standard and expedited review processes are explained in the next several questions and answers.

5. When can I request a standard external review?

You may request a *standard* external review after you have exhausted your health insurer's internal appeal process. Some health insurers offer one level of appeal and some offer two levels. Consult your insurance policy or member handbook to determine how many levels of appeal your insurer offers or requires.

You must make your request to the HCR Program *within 60 days of receiving notice of your insurer's final decision from the highest level of appeal offered*, that your request for coverage remains denied by your insurer. To allow for mailing time and time that you may not have been available to receive your notification from your health insurer, the HCR Program will accept your request up to 70 days after the date on the notice of decision on appeal.

There are two exceptions to the requirement that you complete your health insurer's appeal process. 1.) In some cases, your insurer may choose to waive some or all of its internal appeal process to allow the denial to proceed to external review. If your health insurance company has notified you in writing that it agrees to waive its appeal process, you may request an external review *within 60 days of receiving this notification*. 2.) If you filed a second-level appeal with your insurer more than 60 days ago and have not received a response and have also not agreed to give the insurer additional time to respond, you may request an external review. If your insurer offers just one level of appeal, you may request an external review if you have not received any response from the insurer within 60 days filing the appeal.

Please note: Standard external review is available only for cases where the insurer's appeal decision was made on or after July 1, 2002.

When can I request an expedited external review?

Expedited review is available only when having to first complete your insurer's internal appeal process (even on expedited basis) or receiving a standard external review through the HCR Program would put your life, health, or recovery in serious jeopardy. Therefore, you may request an expedited external review immediately after receiving your initial denial notice (noncertification) or after receiving notice of your insurer's decision to continue its denial after considering your first-level or second-level appeal. We anticipate that most requests for expedited external review will be made very soon after a person receives the insurer's initial notice of denial or denial decision on appeal, but any request to the HCR Program must be made *within 60 days receiving your most recent denial from your insurer*. To allow for mailing time and time that you may not have been available to receive your notification from your health insurer, the HCR Program will accept your request up to 70 days after the date on the notice of decision on appeal.

You are not required to exhaust your insurer's appeals process prior to requesting expedited external review, but you must have already requested an expedited appeal from your insurer prior to requesting external review from the HCR Program. If you have already received a decision on a first-level appeal and now wish to request expedited external review, you must have already requested an expedited second-level appeal from your insurer (if your insurer offers one) prior to requesting the external review.

To determine whether your case qualifies for expedited external review, the HCR Program will 1) verify that you have initiated an expedited appeal with your insurer and 2) consult a medical professional to determine if the time required to first complete the insurer's expedited appeal process before requesting external review is likely to put your life or health or ability to regain maximum function in serious jeopardy. If the HCR Program determines that your request does not qualify for expedited external review, you may be required to first complete your insurer's appeal process.

If you have *already completed your insurer's appeal process* and your insurer has issued its final decision denying the requested service, you may request an expedited external review if the time for a standard external review through the HCR Program would put your life, health or ability to regain maximum function in serious jeopardy. If the HCR Program determines that your case does not qualify for expedited review, it may still qualify for a standard external review.

Please note: Expedited external review is not available if you have already received the services for which coverage has been denied. Expedited external review is available only for cases where the insurer's initial denial (noncertification) or appeal decision was made on or after July 1, 2002. If you believe you need to make a request for an expedited review, you may call the HCR Program for guidance in making your request.

6. What are the eligibility requirements to request an external review?

In order for your request to be eligible for external review, the HCR Program must determine that all of the following criteria have been met:

- (1) Your request was submitted within 60 days of receiving your insurer's final decision on appeal or, for expedited external review, within 60 days of receiving either the initial denial or decision on appeal. (See questions number 5 and 6 for additional discussion of time allowed to request external review.)
- (2) Your request relates to a type of health insurance coverage that is subject to external review. (See question #3 for information on the types of insurance that is subject to external review.)
- (3) Your request is about an insurer's medical necessity determination that resulted in a denial (noncertification) decision. (See question #2 for information on noncertifications.)
- (4) You had coverage in effect with the insurer at the time the services were requested or provided and the denial decision was issued.
- (5) The service for which coverage was denied appears to be a covered benefit under the health insurance policy.
- (6) That you have exhausted your insurer's appeals process as described in #5 above OR, if you are requesting expedited external review, that you meet the medical criteria for expedited review and requested an expedited appeal with your insurer as described in question #6.

7. How do I request an External Review?

For a standard review:

You may call the HCR Program toll-free in North Carolina at **1-877-855-0231** or locally at **919-715-1163** and ask that a request form to be mailed to you. You may also pick up a request form in person at the Healthcare Review Program office. The address is:

**North Carolina Department of Insurance
Healthcare Review Program
430 N. Salisbury Street, Room 4105
Raleigh, North Carolina 27611**

You may access the External Review Request Form from the Department of Insurance web site at www.ncdoi.com. This is an interactive form into which you can enter information. All the fields on the request form must be completed so that the HCR Program can access your information from your insurer or your healthcare provider and determine whether your request is eligible for review. Print and sign the printed copy and send it to the HCR Program. You cannot submit this form to the HCR Program via email or the Internet.

You must provide the following documents to the HCR Program in order for your request to be considered complete:

- the completed and **signed** External Review Request Form;
- a copy of the final denial decision from your health plan;
- the **signed** Release of Medical Record Form;
- the Appointment of Authorized Representative Form, if you plan to have someone else request a review for you.

For expedited review:

You may contact the HCR Program to request an expedited review by phone. If you make a verbal request to the Program for an expedited review, you must still provide the information required on the request form. This is information that is required for the HCR Program to access your insurance information and process your request. Also, you will still be required to submit a signed Medical Records Release Form to the HCR Program, so that we access any medical documents that are required to help make a determination on your request. Contact the Program as follows:

In state Toll-free:	1-877-855-0231
Out of State or local:	1-919-715-1163

You may also request an expedited review by faxing the completed request form to the HCR Program at **919-715-1175**.

8. Must I request an external review myself?

No. You may designate any person you wish, including your health care provider, as your Authorized Representative to act on your behalf in pursuing an external review. The Request for External Review Form includes a section on contact information for an authorized representative. Be sure that this information is included if someone will be acting as your representative.

In the case of a minor or someone deemed incompetent, a request must be made by a parent, conservator, guardian, health care power-of-attorney or any individual who has been designated as the patient's authorized representative.

9. After I request an External Review, when should I expect to hear something?

For standard review:

Within 10 business days after requesting external review, you will receive notification whether the request is complete and whether it has been accepted for review.

If the request is incomplete, the HCR Program will ask you to provide the required information within 90 days of the date you received your final determination from your health plan. If the HCR Program does not receive the information within this time frame, your request will be considered ineligible and you will not be able to request a review for that specific service again.

If your request is complete the HCR Program will advise you of whether your case has been accepted for external review. If accepted, you will be provided with the name of the IRO assigned to the case and given a copy of the information that was provided to the HCR Program by your health insurer. You will also be notified at that time that you have seven days in which to provide the IRO any additional information that you feel would help the IRO make a determination. You may submit this information directly to the IRO or send it to the HCR Program for timely forwarding to the IRO. If you choose to submit additional information directly to the IRO, you must also provide the same information to your health insurer *at the same time and by the same means*. (For example, if you are faxing information to the IRO, you must also fax information to your health insurer.)

If you do submit additional information, your health insurer will have the opportunity to consider the information and, if it chooses, reverse its own denial. If this does occur, the insurer will inform you and the IRO of this decision and the IRO will stop the external review. However, this “reconsideration” process will not slow down the external review and will not affect it if your insurer does not change its decision as a result of the new information.

Upon making its decision, the IRO will notify you in writing of its decision. This will be no more than 45 days after the HCR Program received your request.

For an expedited review:

Within three days after you make your request, the HCR Program will notify you whether your request meets the criteria for an expedited review. This decision will be made in consultation with a medical professional. If your request was accepted, you will be given the name of the IRO assigned to your case.

You will receive verbal or written notification of the IRO’s decision within four days of making your request to the HCR Program. If you receive a verbal notification from the IRO, you will receive a written notification of their decision within two days of their verbal notification.

If your request was not accepted for external review, you will be notified by the HCR Program that:

- you must first complete your health insurer’s appeal process (or expedited appeal process) before the request is eligible for external review; or
- your request is accepted for standard rather than expedited external review; or
- your request is not eligible for external review of any kind.

10. What documents should I provide that will help the IRO make a determination?

You have an opportunity to provide the IRO any additional information that you think helps makes the case that the services that were denied were medically necessary. Examples of these documents might include:

- your doctor's or healthcare provider's recommendation that the services that were denied to you were medically necessary;
- any medical information or justification that your denied service was or is medically necessary, or
- any other information that supports your position that the services denied to you were or are medically necessary.

11. What happens when an external reviewer makes a decision?

The IRO notifies you, your healthcare provider, the HCR Program, and your health insurer when it makes a decision on your request. If the IRO's decision overturns your health insurer's original decision, the health plan must provide for coverage or payment within three days for a standard external review request and within one day for an expedited external review request. This decision is binding on you and your health plan. If the IRO's decision is to agree with your health insurer's original decision, you may not request another review on this case. The decision is binding on you and your insurer except to the extent you may have other remedies available under applicable federal or state law.

12. Will I have to pay for the external review?

There is no cost for the person who requested the external review. The HCR Program pays the IRO for its services and your health insurer will be required to reimburse the Program for the cost of the review.

13. Who conducts the external review?

The external review is conducted by an organization called an Independent Review Organization (IRO). IROs are contracted with the HCR Program to perform impartial reviews of your case to determine the merits of your request and to determine if your request should be covered under your policy. The doctors or medical professionals who review your request are Board Certified Specialists and have the same or similar background as the doctors or medical professionals who provided or requested your care. They will review your insurance coverage policy, as well as the medical documents and other information supplied to them by you and your insurer for review. Your request will be considered against the standard of practice in the medical community. IRO decisions will be made based upon supporting clinical evidence, standards of practice and personal experience of the specialty reviewer.

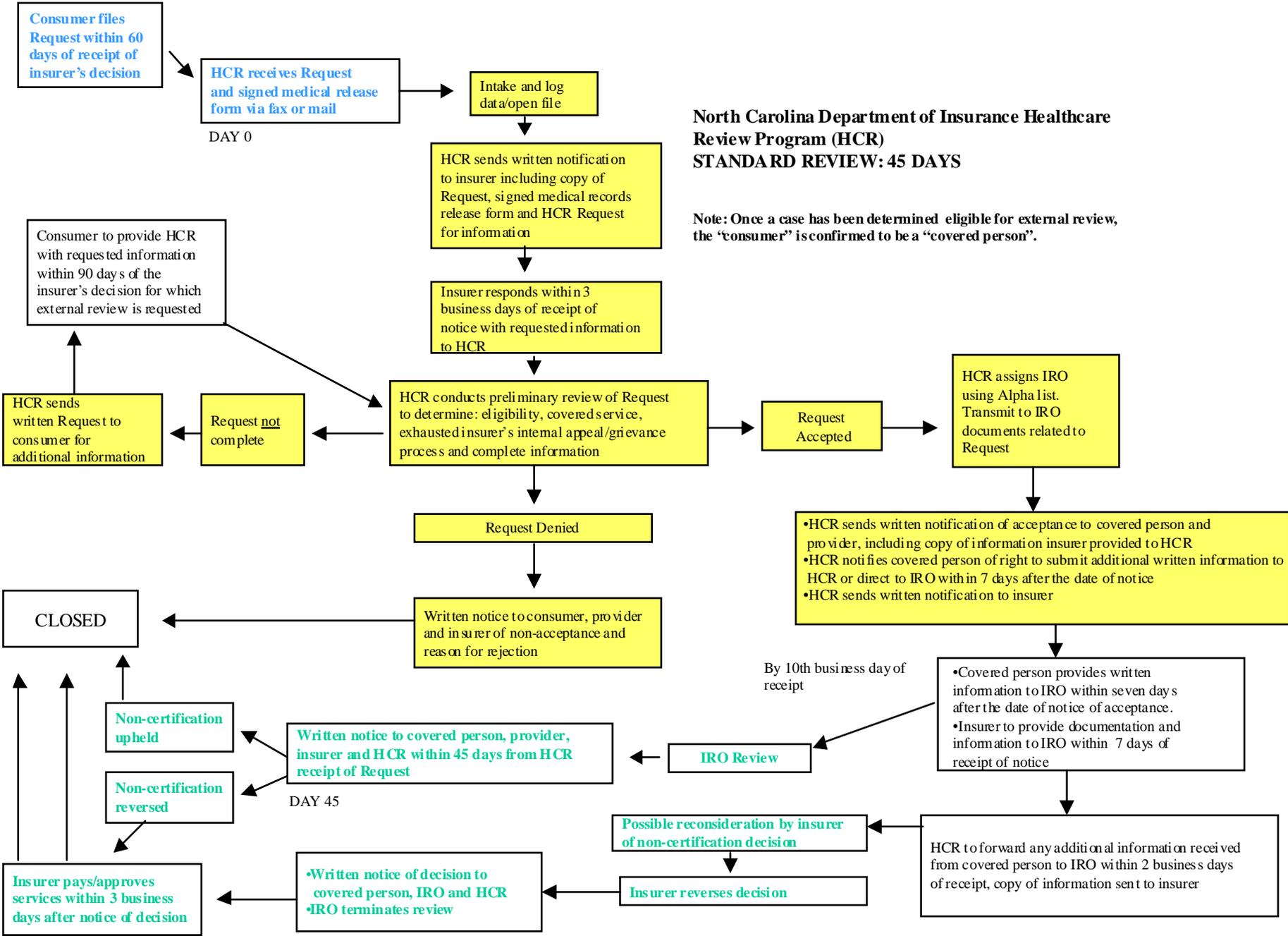
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APPENDIX B

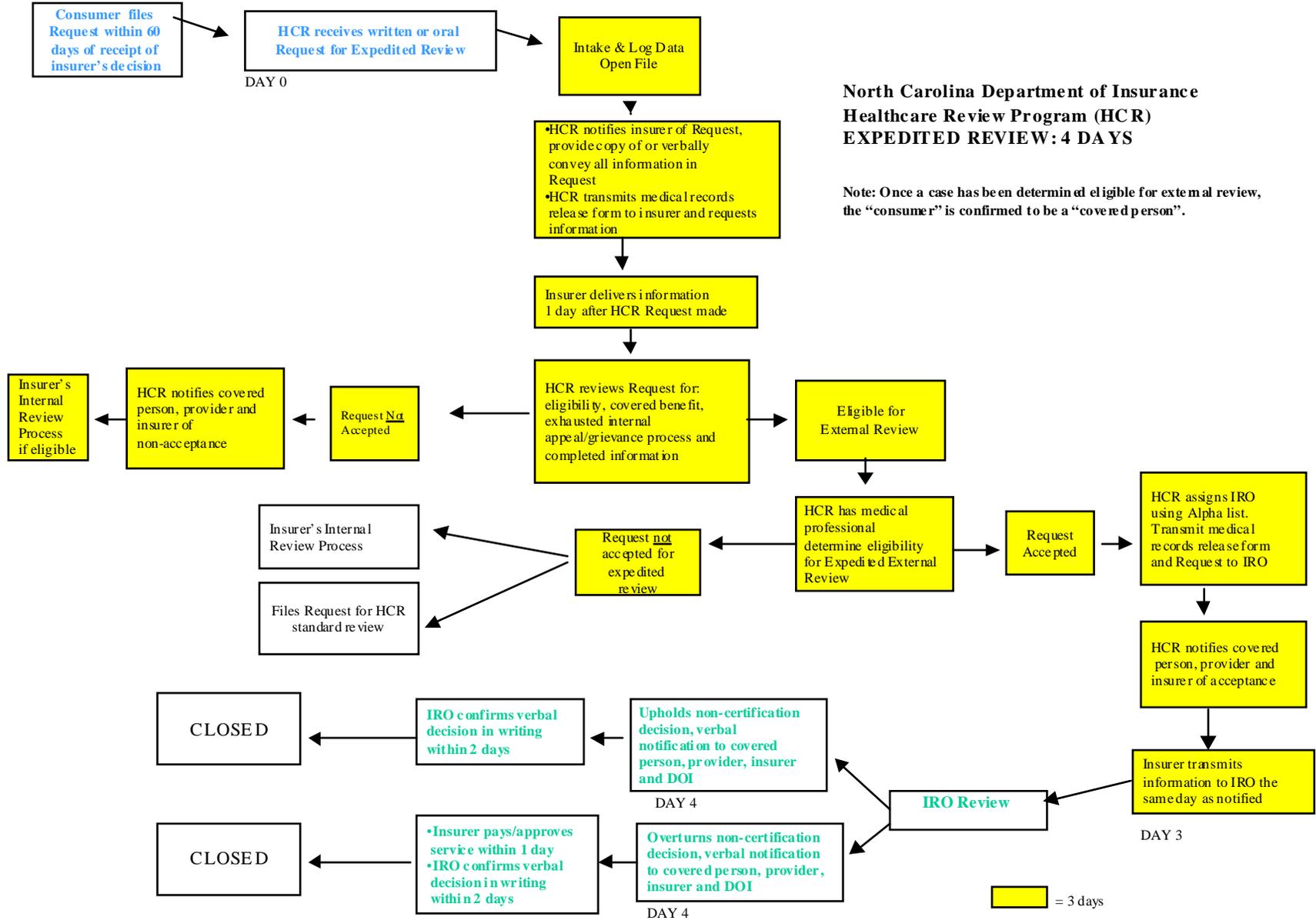
North Carolina Department of Insurance Healthcare Review Program (HCR)
STANDARD REVIEW: 45 DAYS

Note: Once a case has been determined eligible for external review, the “consumer” is confirmed to be a “covered person”.



*If insurer fails to provide information to the IRO within the required amount of time frame, the IRO may decide to terminate review and reverse the non-certification; advise HCR, covered person and insurer within 1 business day of deciding.

= Completed within 10 business days of receipt of Request



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