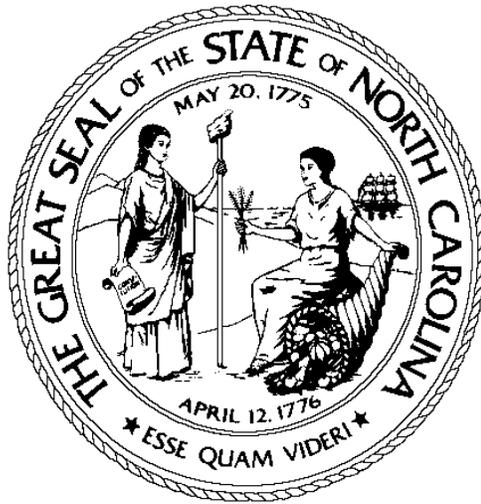


North Carolina Department of Insurance



Healthcare Review Program Annual Report

for the period of January 1, 2007 – December 31, 2007

James E. Long
Commissioner of Insurance

A REPORT ON EXTERNAL REVIEW REQUESTS IN NORTH CAROLINA

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Healthcare Review Program Semiannual Reports

Release I	July 1, 2002 – December 31, 2002
Release II	July 1, 2002 – June 30, 2003
Release III	July 1, 2002 – December 31, 2003
Release IV	July 1, 2002 - June 30, 2004
Release V	January 1, 2003 – December 31, 2004
Release VI	January 1, 2005 – June 30, 2005
Release VII	January 1, 2004 – December 31, 2005
Release VIII	January 1, 2006 – June 30, 2006
Release IX	January 1, 2003 – December 31, 2006
Release X	January 1, 2007 – December 31, 2007

All Healthcare Review Program Reports are available on the N. C. Department of Insurance web site at: www.ncdoi.com

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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. Denials for cosmetic or investigational/experimental services may be eligible for external review depending on the nature of the case. North Carolina's External Review law applies to persons covered under a fully insured health plan, the North Carolina State Health Plans which includes an indemnity plan, Teachers' and State Employees' Comprehensive Major Medical Plan (State Health Plan Indemnity Plan or SHP Indemnity Plan) and a Preferred Provider Organization plan, NC *SmartChoice* (State Health Plan PPO Plan or SHP PPO Plan); and the Health Insurance Program for Children (known as CHIP). There is no charge to the consumer for requesting an external review.

To be eligible for external review, the covered person generally must have exhausted their health plan's internal appeals and grievance processes. (Specific laws 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 Healthcare Review Program (HCR Program or Program). HCR Program staff screen requests for eligibility, and assign accepted cases to contracted independent review organizations (IROs) that perform the review.

The HCR Program contracted with four IROs in 2007, all multi-specialty organizations. 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 four business days is allowed for a decision to be issued on a request for expedited external review. All IROs issued their determinations within the statutory required time frame.

For the reporting period of January 1, 2007 – December 31, 2007, 264 requests for external review were received from 226 individuals. The percentage of accepted cases is measured against the number of individuals who make a request for external review. Of the 226 individuals requesting a review in 2007, 133 (58.8%) requests were accepted. Data collected between January 1, 2003 – December 31, 2007 shows that since 2004, the number and percentage of cases accepted for external review has steadily increased. In 2004, 46.1 percent of requests were accepted; in 2007, 58.8 percent of requests were accepted.

In 2007, of the 133 cases that were accepted, 36.8 percent of cases were decided in favor of the consumer, either due to the insurer reversing its own denial (two cases) prior to an IRO decision being rendered, or the IRO overturning the insurer's noncertification (47 cases). During the last five calendar years, of the 520 accepted cases for external review, the ratio of cases upheld compared to cases overturned or reversed by the insurer has remained relatively constant. Overall, outcomes of accepted cases has been in favor of the consumer 41.1 percent of the time due to either the IRO overturning the insurer's noncertification decision or the insurer reversing its own noncertification decision.

The HCR Program continues to receive and accept significantly more cases to be processed on a standard basis versus an expedited basis. In 2007, of the 133 requests accepted, three (2.2%) requests were accepted and processed on an expedited basis. During the Program's five calendar years of operation, 520 cases were accepted for external review, and 41 cases (7.88%) were processed on an expedited basis. Since 2005, the volume of accepted expedited requests has declined.

For 2007, "Lab, Imaging, Testing" represented the largest majority of accepted cases by service type with 52 (39%) of 133 accepted cases. In previous reports, "Surgical Services" represented the largest share of accepted cases. The growth in "Lab, Imaging, Testing" service type was due in large part to the patient advocacy services of Genomic Health who provides Oncotype DX breast cancer genetic assay test to predict the risk of recurrence of breast cancer in women with certain types of breast cancers. "Surgical Services" had the second largest share of requests with 23 cases (17.3%) with orthognothic surgery representing the largest number of surgical cases. "Pharmacy" had the third largest share of requests with 20 accepted cases (15%).

The HCR Program captures the cost of allowed charges for overturned or reversed services each year, as well as the cumulative charges for these services. In 2007, the average cost of allowed charges from all cases that have been reversed by the insurer or overturned by an IRO was \$7,155.83 with a total cumulative cost for the year of \$300,544.92. **Since July 1, 2002, the cumulative total of services provided to consumers as a result of external review is \$2,597,019.08. Due to the prospective nature of nine (9) cases overturned by the IRO, the cost of the allowed charges for these services has not yet been reported.** The IRO charges for reviewing cases are per case fees which range from \$450 to \$900, depending on the IRO assigned and whether the review was conducted under a standard or expedited time frame. The average cost to insurers for the 131 reviews performed by an IRO during 2007 was \$579.30.

For the period of January 1, 2007, to December 31, 2007, 11 different health benefit plans, plus the SHP Indemnity Plan and SHP PPO Plan had a total of 133 cases that were eligible for external review (*13 plans total – includes SHP Indemnity and SHP PPO*). Case origination from State Health Plan's Indemnity Plan, State Health Plan's PPO and Blue Cross & Blue Shield of North Carolina, comprised 81.8 percent of the external review activities. Ten other insurers, including two Multiple Employer Welfare Arrangements (MEWAs) made up the remaining 18.2 percent of cases. With 59 (44.3%) accepted cases in 2007, the State Health Plan's Indemnity Plan remains the health plan with the largest number of requests for external review. Blue Cross & Blue Shield of North Carolina, the state's largest insurer, had the second largest number with 36 (27%) accepted cases. State Health Plan's PPO Plan had the third largest number of accepted cases in 2007 with 14 (10.5%). While this reporting provides an accounting of the cases accepted for review, the case volume is too small to draw conclusions about insurers or how they compare to one another. The data does show that the percentage share of insurer activity of accepted external review requests for 2007 remains relatively unchanged to insurer activity reported over the last five years.

The HCR Program also provides counseling to consumers who have questions or need assistance with issues involving their insurer's utilization review or internal appeal and grievance process. Consumers receive counseling from a staff of professional nurses who understand the clinical

aspects of cases as well. In 2007, the HCR Program received 1,344 requests for assistance from consumers calling the HCR Program. A comparison of consumer counseling case volume by year for the period of January 1, 2003 through December 31, 2007 shows an overall steady volume of call activity, with a total of 6,895 calls related to external review and consumer counseling services. During this five-year reporting period, consumer calls included questions pertaining to external review services as well as those from consumers and providers seeking guidance on utilization review and insurers internal appeals and grievance procedures and other insurance related issues. Data collected since 2004 documents the growth in the percentage of callers who contacted the HCR Program specifically on appeals and grievance issues.

The HCR Program continues to promote consumer and provider awareness of external review services through a variety of community outreach and education initiatives. In 2007, a letter from the Commissioner of Insurance was sent to home health agencies, cardiac rehabilitation centers and skilled nursing facilities which explained the importance of external review services and included a Program brochure and external review services contact card. Other community outreach initiatives have included radio interviews, presentations to hospital case manager groups, and collaborating with the Department's Consumer Services Division in rewriting the Appeals/Grievance brochure used by consumers. All of these outreach activities have contributed to informing and educating the provider community and public, of the availability of external review services.

The HCR Program continues to utilize a consumer satisfaction survey with all accepted cases in order to obtain feedback from consumers regarding their external review experience. In 2007, 132 surveys were sent at the completion of an external review. Overall, responders are generally pleased with the customer service they receive while contacting the HCR Program. More responders are identifying "Word of Mouth" as the method by which they learned about external review; but most still identify "Insurer" as the method by which they hear about the Program.

Introduction

The Department of Insurance (the Department) established the HCR Program to administer North Carolina's External Review Law. The External Review Law (N. C. Gen. Stat. §§ 58-50-75 through 95) provides for the independent review of a health plan's medical necessity denial (known as a noncertification). The HCR Program also counsels consumers who seek guidance and information on utilization review and internal appeals and grievance issues.

North Carolina's External Review law applies to persons covered under a fully insured health plan, the North Carolina State Health Plan which includes an indemnity plan, the Teachers' and State Employees' Comprehensive Major Medical Plan (State Health Plan Indemnity Plan or SHP Indemnity Plan) and NC *SmartChoice*, a Preferred Provider Organization Plan (State Health Plan PPO Plan or SHP PPO Plan); and the Health Insurance Program for Children (known as CHIP).

This report, which is required under N. C. Gen. Stat. § 58-50-95, is intended to provide a comparative summary of the Program's performance for the past five years and an analysis of external reviews received during 2007. Detailed information is 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. Previous HCR Program reports provide a detailed summary and analysis of Program activities since July 1, 2002.

While the year-to-year number of requests for review and accepted cases remains relatively small for statistical purposes, the cumulative data for this five-year reporting period does provide the opportunity to comment on some trending seen in types of requests, case acceptance, eligibility determinations and general type of service requested. Data relative to specific services requested, case outcomes and insurers remains small for statistical purposes; therefore, the validity of using the data for purposes of drawing conclusions remains limited. The data is presented for review, both in the name of disclosure and because its validity will increase over time as the number of requests for review and cases accepted continues to grow.

Background of the Healthcare Review Program

The HCR Program became effective July 1, 2002, as part of the North Carolina Patients' Bill of Rights legislation. N. C. Gen. Stat. §§ 58-50-75 through 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.

Requests for external review are made directly to the Department and screened for eligibility by HCR Program staff, but the actual medical reviews are conducted by IROs that are contracted with the Department. In addition to arranging for external review, staff also counsels consumers on matters relating to utilization review and the internal appeal and grievance processes required to be offered by insurers.

The HCR Program is staffed by a Director, two (2) Clinical Analysts and an Administrative Assistant. The Program utilizes registered nurses with broad clinical, health plan utilization review experiences to process external review requests and to enhance the Program's Consumer Counseling services.

The HCR Program contracts with two (2) board-certified physicians to provide on-call case evaluations of expedited external review requests. The scope of these evaluations is limited to determining whether a request meets medical criteria for expedited review. The consulting physician is available to consult with Program staff and review consumer requests for expedited review at all times.

The HCR Program contracts with four (4) IROs to provide clinical review of cases. 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, ensuring compliance with statutory and contract requirements.

Program Activities

A. External Review

The HCR Program staff is responsible for receiving requests for external review. In most cases, external review is available only after appeals made directly to a health plan have failed to secure coverage. A covered person or person acting on their behalf, including their health care provider, may request an external review of a health plan's decision within 60 days of receiving a decision. Upon receipt, requests are reviewed to determine eligibility and completeness. Cases accepted for review are assigned to an IRO. The IROs assign clinical experts to review each case, issuing a determination as to whether an insurer's denial should be upheld or overturned. Decisions are required to be made within 45 days of the request for a standard review. Cases accepted for expedited review require a decision to be rendered within four (4) business days of the request.

B. Oversight of IROs

The IROs utilized by the Program are those companies that were determined via the solicitation process, to meet the minimum qualifications set forth in N. C. Gen. Stat. § 58-50-87 and have agreed to contractual terms and written requirements regarding the procedures for handling a review.

IROs are requested to perform a clinical evaluation of contested insurer decisions upholding the initial denial of coverage based on lack of medical necessity. Specifically, the scope of service for the IRO is to:

- Accept assignment of cases from a wide variety of insurers without the presence of conflict of interest.
- Identify the relevant clinical issues of the case and the question to be asked of the expert clinical peer reviewer.

- Identify and assign an appropriate expert clinical peer reviewer who is free from conflict and who meets the minimum qualifications of a clinical peer reviewer, to review the disputed case and render a decision regarding the appropriateness of the denial for the requested treatment of service.
- Issue determinations that are timely and complete, as defined in the statutory requirements for standard and expedited review.
- Notify all required parties of the decision made by the expert clinical reviewer.
- Provide timely and accurate reports to the Commissioner, as requested by the Department.

The HCR Program is responsible for monitoring IRO compliance with statutory requirements on an ongoing basis. HCR Program staff screen each IRO case assignment to assure that no material conflict of interest exists between any person or organization associated with the IRO and any person or organization associated with the case. The HCR Program audits 100 percent of all IRO decisions for compliance with requirements pertaining to the time frame for issuing a decision and for the content of written notice of determinations. The HCR Program also conducts on-site compliance audits of contacted IROs to determine if the IRO continues to satisfy requirements regarding its handling of individual cases and policies and procedures, as well as fulfill its obligation to provide an adequate network of disinterested reviewers to review cases assigned.

C. Oversight of Insurers (External Review)

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 certificate of coverage or summary plan description. When the HCR Program receives a request for external review, the insurer is required to provide certain information to the Program, 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 and a copy of that same information to the covered person or the covered person's representative. The insurer is required to send the information to the covered person or the covered person's representative by the same time and same means as was sent to the IRO.

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 three (3) business days in the case of a standard review decision and one (1) calendar day in the case of an expedited review decision. Insurers are required to send a copy of this notice to the HCR Program, as well as evidence of payment once the claim is paid.

The Department's HCR Program contracts with IROs to provide independent medical review of insurer's denial of coverage. As set forth in N. C. Gen. Stat. § 58-50-92, the insurer against which a request for a standard or expedited external review is filed shall reimburse the Department for the fees charged by the organization in conducting the external review, including work actually performed by the organization for a case that was terminated due to an insurer's decision to reconsider a request and reverse its noncertification decision, prior to the

insurer notifying the organization of the reversal, or when a review is terminated because the insurer failed to provide information to the review organization.

The HCR Program acts as the liaison between insurers and IROs for invoicing and payment of IRO services. As the contracting entity with the IROs, it is the responsibility of the Department to insure that IROs are paid in a timely manner for their services. Compliance with payment timeframes by all insurers is monitored and reported on a weekly basis by the HCR Program Administrative Assistant and reported to the HCR Program Director.

Overall, the Program's experience to date has been that insurers are cooperative during the handling of external review cases and are meeting their statutory obligations with respect to deadlines and payment notifications.

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

The HCR Program provides consumer counseling on utilization review and internal appeals and grievance issues. Consumers speak with professional registered nurses who are clinically experienced and knowledgeable regarding medical denials.

In providing consumer counseling, the HCR Program staff explain state laws that govern utilization review and the appeal and grievance process. 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 their treatment, and explain how to use supporting information 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, and 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, or of their external review request, are referred to the Office of Managed Care Patient Assistance located within the Attorney General's Office. Providing these counseling services offers consumer's continuity in those cases where the appeal process does not conclude the matter and an external review is requested.

E. Community Outreach and Education on External Review and HCR Program Services

The HCR Program actively promotes consumer and provider awareness of external review services through a comprehensive community outreach and education program. Strategies used to inform and educate consumers and providers have included, group presentations, radio interviews and direct mailings to provider offices. In 2007, the HCR Program mailed out to home health agencies, cardiac rehabilitation centers and skilled nursing facilities, an HCR Program external review services contact card, designed to be included in an address/telephone file. This card, along with a Program brochure and letter from the Commission of Insurance highlighting the importance of the Program, was well received as evidenced by calls the Program staff received from the recipients requesting additional printed materials.

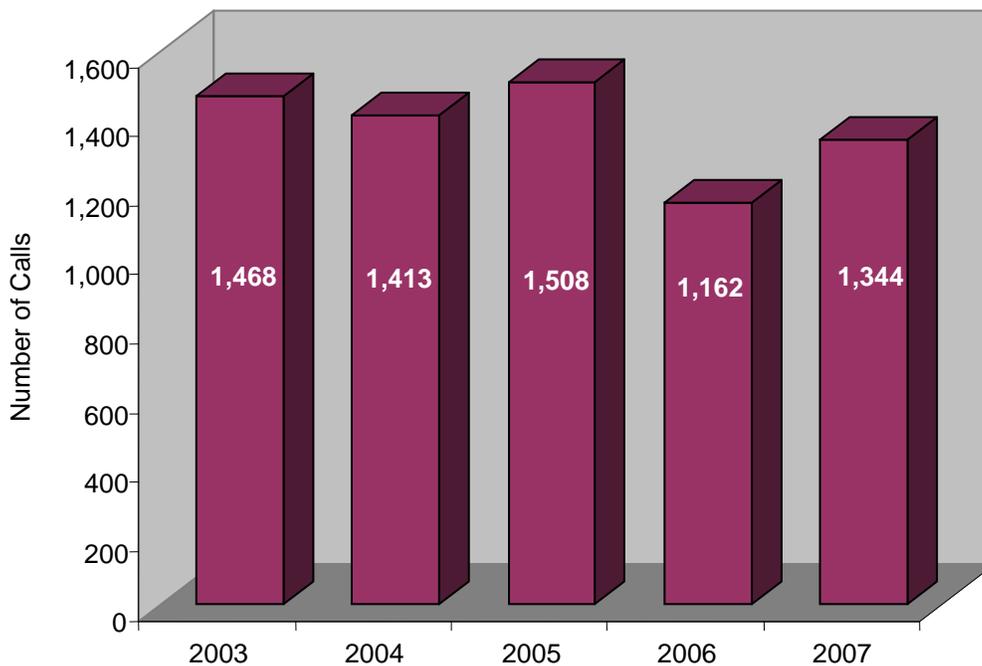
Other HCR Program outreach resources available to consumers include the HCR Program web page and the Consumer Counseling page to facilitate ease of use and provide additional information about services available through the Program.

IV. Comparative HCR Program Performance Data

A. Consumer Telephone Calls

The HCR Program received 6,895 calls from consumers related to external review and consumer counseling services during the period of January 1, 2003 – December 31, 2007. Figure 1 shows the volume of calls received by year. In June 2006, the HCR Program experienced an equipment failure relating to the automated phone data collection system. While consumers never lost the ability to contact the HCR Program staff, the ability to capture the call data was lost. In September 2006, a new PBX phone system was installed, including web-based software to collect phone activity data. Therefore, the volume of phone activity reported in 2006 only reflects eight months of data collection. During the reporting period, consumer telephone calls include questions pertaining to external review service, as well as those from consumers and providers seeking assistance, information and counseling relating to utilization review, an insurer’s appeals and grievance process or external review. Overall, the number of calls remains constant, identifying a continued need for consumer information.

Figure 1: Comparison of External Review and Consumer Counseling Call Volume Received by the HCR Program by Calendar Year, January 1, 2003 – December 31, 2007



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

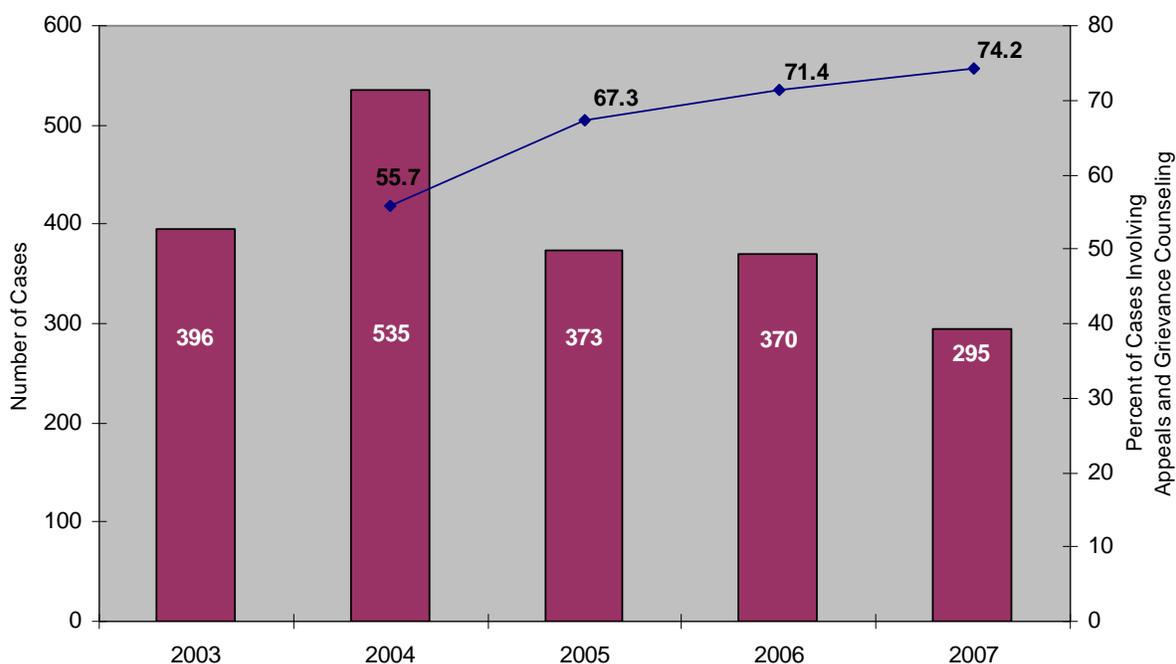
The HCR Program counseled 1,969 consumers during the period of January 1, 2003 – December 31, 2007. As shown in Figure 2, the volume of consumer counseling cases has remained steady during the past five years. The graph also shows the percentage of consumer counseling calls that were related to appeals and grievances issues. Each year, the percentage of those callers who contacted the HCR Program specifically for counseling on appeals and grievance issues grows.

Over the last five years, consumer counseling cases have involved the following issues:

- Insurer's claim payment.
- Insurance coverage.
- Issues relating to insurance coverage other than health benefit plan.
- Denials made by self-funded employer plans regulated under Employee Retirement Income Security Act (ERISA).
- Network Access.
- Insurers not regulated under North Carolina law.
- Insurance coverage issues.
- Pre-existing condition issues.
- Coordination of Benefits issues.
- Specific disease insurance issues.
- Information regarding external review services.

HCR Program staff continues to refer consumers to appropriate resources if their concern cannot be addressed by Program staff. During the past five years, consumers have been referred to the Department's Consumer Services Division, the Department's Seniors' Health Insurance Information Program (SHIIP), the United States Department of Labor, the Managed Care Patient Assistance Program, other state insurance regulatory agencies, and Federal agencies (i.e., Centers for Medicare & Medicaid Services, Office of Personnel Management and Department of Defense).

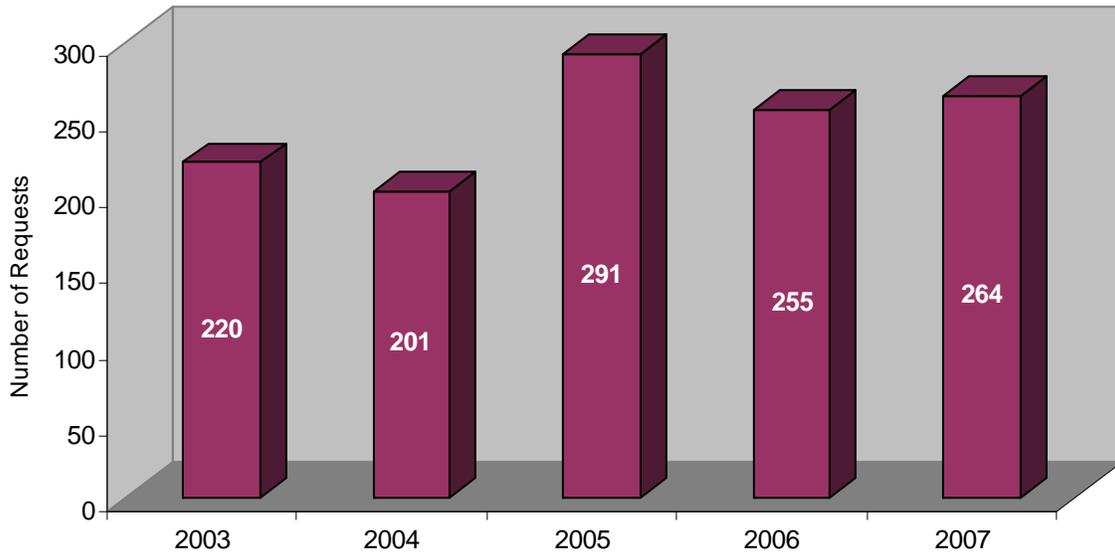
Figure 2: Comparison of Consumer Counseling Case Volume Received by the HCR Program by Calendar Year, January 1, 2003 – December 31, 2007



C. External Review Requests

During the period of January 1, 2003 - December 31, 2007, the HCR Program received 1,231 requests for external review. Figure 3 compares the volume of requests for each year. The data indicates that the volume of requests received during this reporting period has remained stable. The HCR Program attributes the sustained level of activity to the ongoing community outreach efforts to educate consumers and providers about the Program, as well as the counseling given to consumers early in the appeal process.

Figure 3: Comparison of External Review Requests Received by the HCR Program by Calendar Year, January 1, 2003 – December 31, 2007

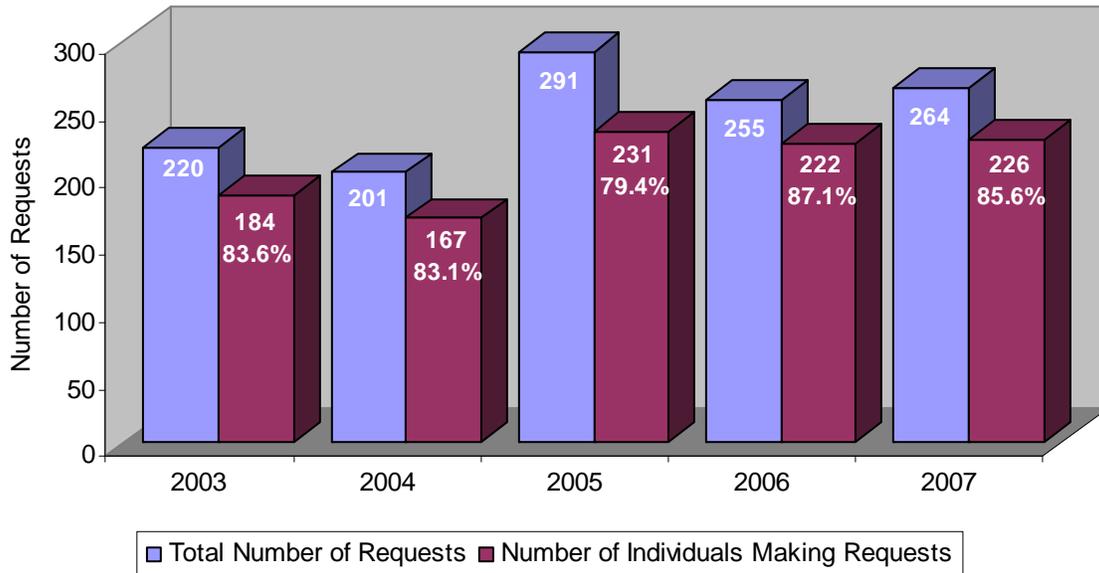


D. Eligibility Determinations on Requests for External Review

A request for external review is made directly to the HCR Program. The HCR Program staff reviews each request for completeness and eligibility. Upon receipt of an incomplete request, the consumer is notified, sent a Request Form and/or notified of the missing information, and given a date to submit the missing information in order for the request to be complete and received by HCR staff as set forth in statute.

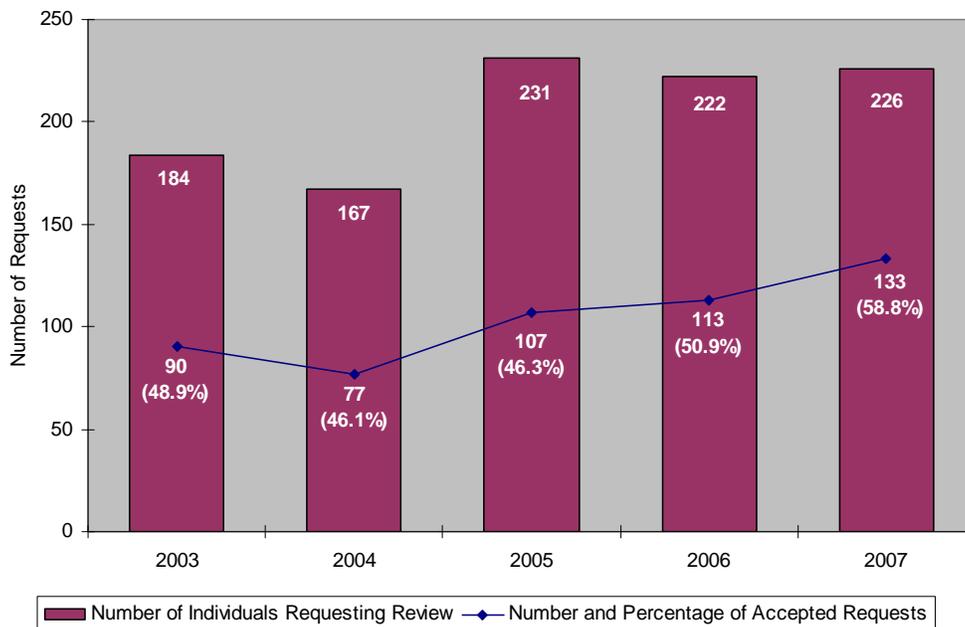
Eligibility of requests received is considered on the basis of individuals who requested an external review rather than each separate request. Because consumers may submit an incomplete request for external review and subsequently submit a completed request, counting all incomplete requests as ineligible inappropriately reflects the number of requesters who were denied an external review to be higher than the actual number. To be accurate in reporting the percentage of cases accepted by the Program, it is important to account for only those individuals making a request for review, not all requests received. This also entails those individuals who had previously submitted an ineligible request due to the fact that the insurer's appeal process had not been completed. Figure 4 reflects the total number of requests received versus the number of individual requests made.

Figure 4: Comparison and Percentage of Total Requests Received to the Individuals Making Requests by Calendar Year, January 1, 2003 – December 31, 2007



The percentage of accepted cases is measured against the number of individuals who make a request for external review. Figure 5 shows that since 2005, the percentage of accepted cases has steadily increased compared to the number of individuals making a request. From January 1, 2003 to December 31, 2007, the HCR Program accepted 520 requests for external review.

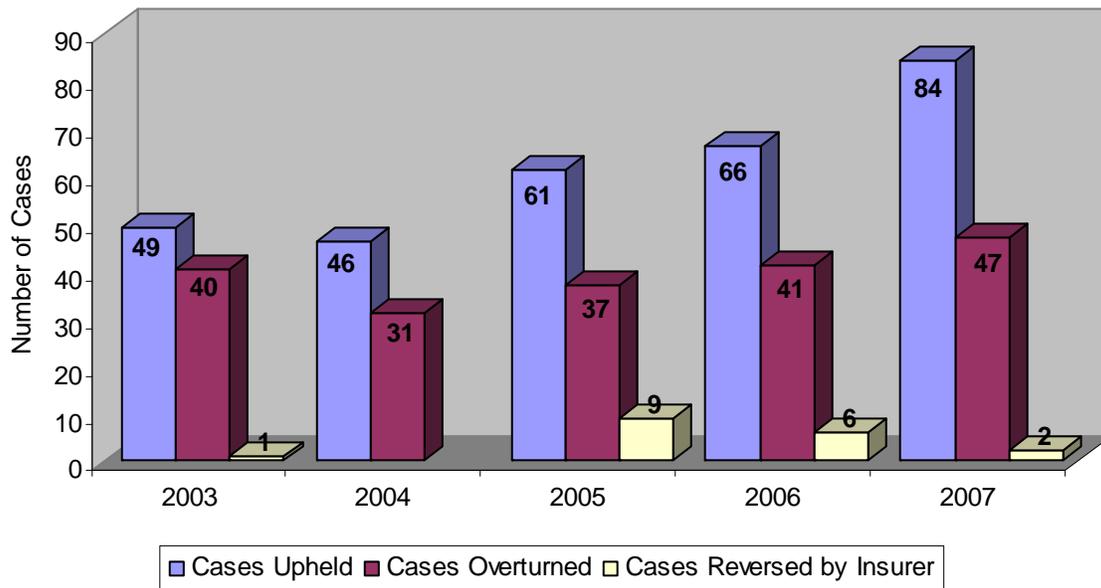
Figure 5: Number and Percentage of Cases Accepted for External Review Compared to the Number of Individuals Making Requests, January 1, 2003 – December 31, 2007



E. Comparison of Outcomes of Accepted Cases

During the past five calendar years, of the 520 accepted cases for external review the ratio of cases upheld compared to cases overturned or reversed by the insurer has remained relatively constant. Outcomes of accepted cases have been decided in favor of the consumer 41.1 percent of the time due to either the IRO overturning the insurer's noncertification decision or the insurer reversing its own noncertification decision.

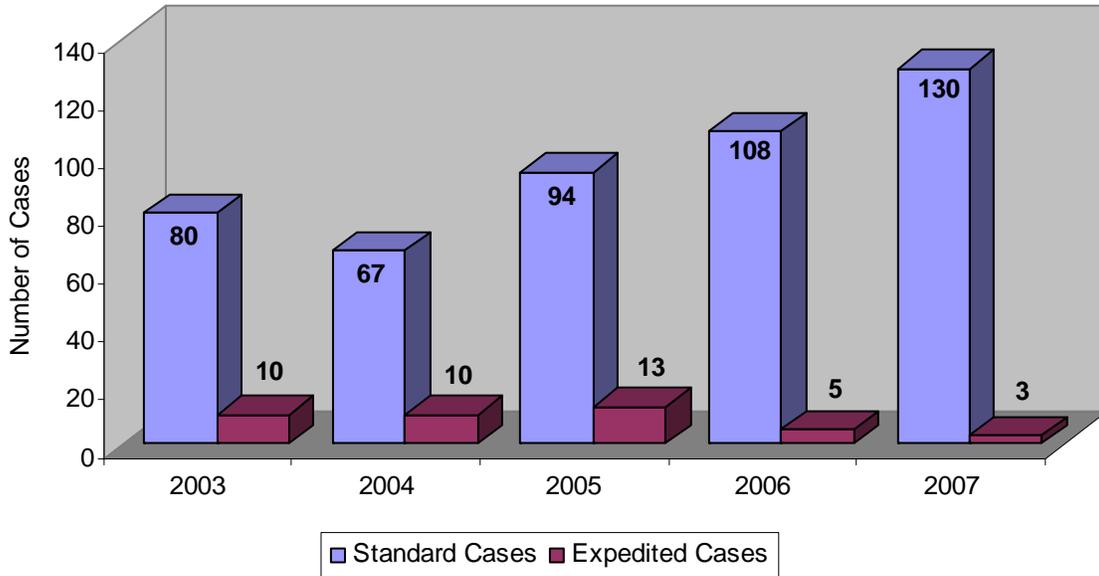
Figure 6: Comparison of Case Outcomes by Calendar Year, January 1, 2003 – December 31, 2007



F. Types of External Review Requested

The HCR Program continues to receive and accept significantly more cases to be processed on a standard basis versus an expedited basis. In order to be eligible for expedited processing, a contracted medical consultant, having no association with the insurer, must advise that the time frame required to complete the insurer's internal appeal or a standard external review is likely to seriously jeopardize the patient's life, health or ability to regain maximum function. Figure 7 shows a comparison of cases accepted by type of review by calendar year.

Figure 7: Comparison of External Review Cases Accepted by Type of Review by Calendar Year, January 1, 2003 – December 31, 2007



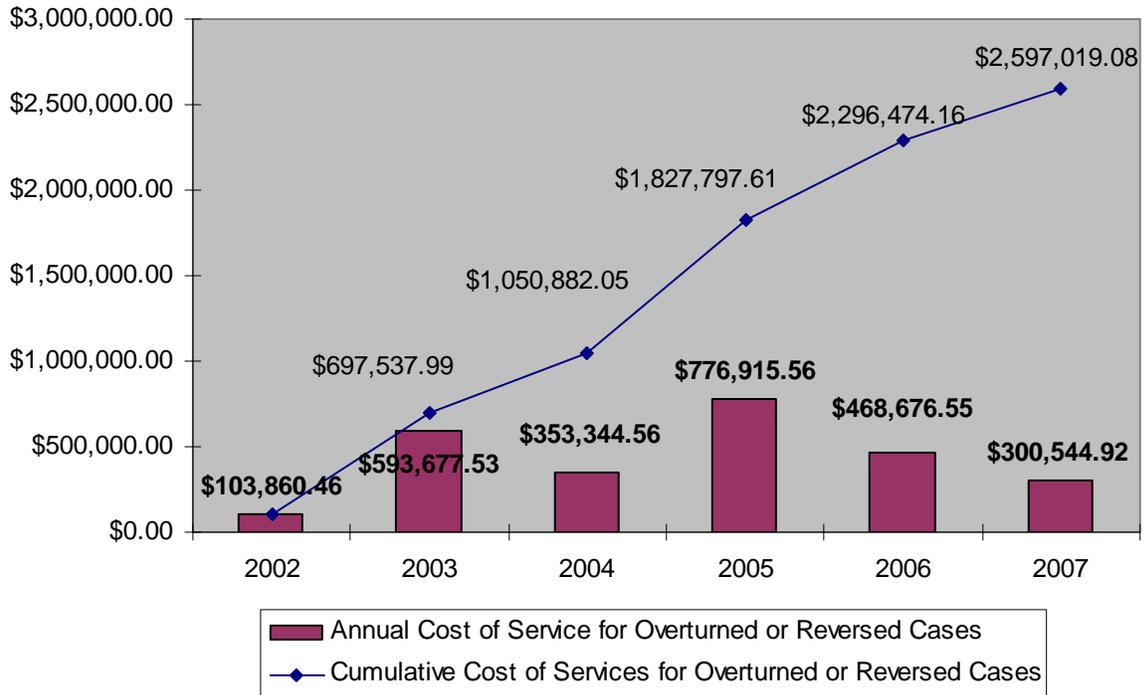
G. Average Time to Process Accepted Cases

When a case is assigned to an IRO for a determination, the IRO must render a decision within the time frames mandated under North Carolina law. For a standard review, the decision must be rendered by the 45th calendar day following the date of the HCR Program’s receipt of the request. For an expedited request, the IRO has until the 4th business day following the HCR Program’s receipt of the request. Most cases accepted on a standard basis are completed between the 40th and 45th day. Most cases accepted on an expedited basis are completed between the 3rd and 4th business day. In no case was the mandated deadline for a decision not met during this five year comparison period.

H. Cumulative Cost of Services

Figure 8 shows the cost of the allowed charges for overturned or reversed services that the HCR Program captured each year, as well as the cumulative total of allowed charges for these services. The total cost of services for each year may have changed with this report as a result of capturing the cost of previously overturned services that were completed during this past year.

Figure 8: Yearly and Cumulative Value of Allowed Charges for Overturned or Reversed Services, July 1, 2002 – December 31, 2007



The average cost of allowed charges from all cases that have been reversed by the insurer or overturned by an IRO since the Program began is \$12,135.60. The total cost of allowed charges for all cases reversed by the insurer or overturned by the IRO for each year are:

2002-	\$103,712.46
2003-	\$593,677.53
2004-	\$353,344.06
2005-	\$776,915.56
2006-	\$468,676.55
2007-	\$300,544.92

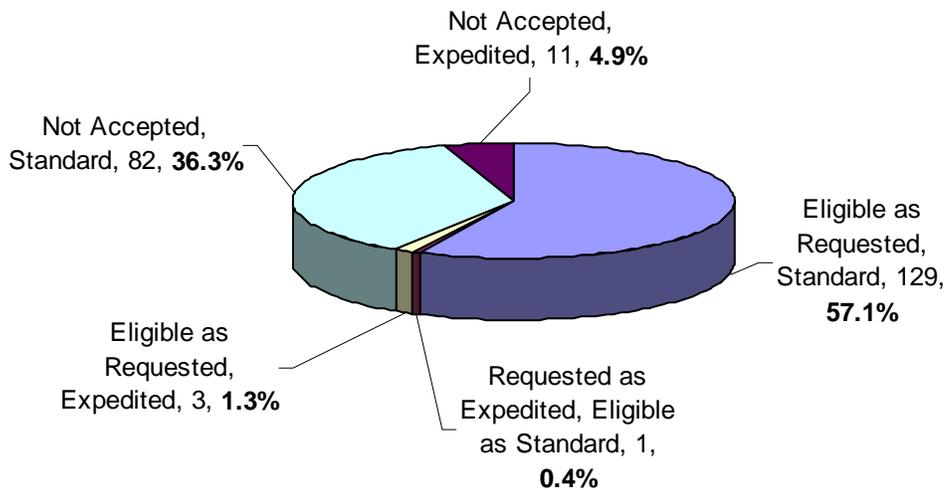
To date, the cumulative total of services provided to consumers as a result of external review since the Program commenced is \$2,597,019.08. Because of the prospective nature of nine (9) cases that were overturned by the IRO, the cost of the allowed charges for those cases are not available for reporting at this time.

V. 2007 External Review Activity

A. Eligibility of External Review Requests

Figure 9 shows the disposition of requests for external review for the period of January 1, 2007 – December 31, 2007. During 2007, the HCR Program experienced the highest percentage of eligible requests since the Program began. Of the 226 individuals who requested review in 2007, 58.8 percent were determined to be eligible.

Figure 9: Disposition of External Review Requests Received, January 1, 2007 – December 31, 2007



The reason why a case would not be accepted falls into two (2) major categories: “no jurisdiction” or “ineligible”. “No jurisdiction” refers to those cases whose insurer did not fall under the jurisdiction of the Department, such as self-funded employer health plans, Medicare or those policies whose contract is situated in a state other than North Carolina. “Ineligibility” refers to those cases that did not fulfill the statutory requirements for eligibility for an external review.

Table 1 shows the number of cases that were not accepted for review and the reasons for which they were not accepted for the year 2007. During this time, non-accepted requests due to “ineligible” reasons rather than “no jurisdiction” reasons continue to make up the largest numbers for external review requests to be deemed ineligible. However, consumers who were not eligible for external review because they were covered under a self-funded employer plan made up the single largest group of ineligible requests. Consumers who received a denial from their insurance company that did not involve a noncertification were the second largest group and those who had not exhausted their insurer’s appeal process prior to requesting an external review represented the third largest number of requests that were not accepted.

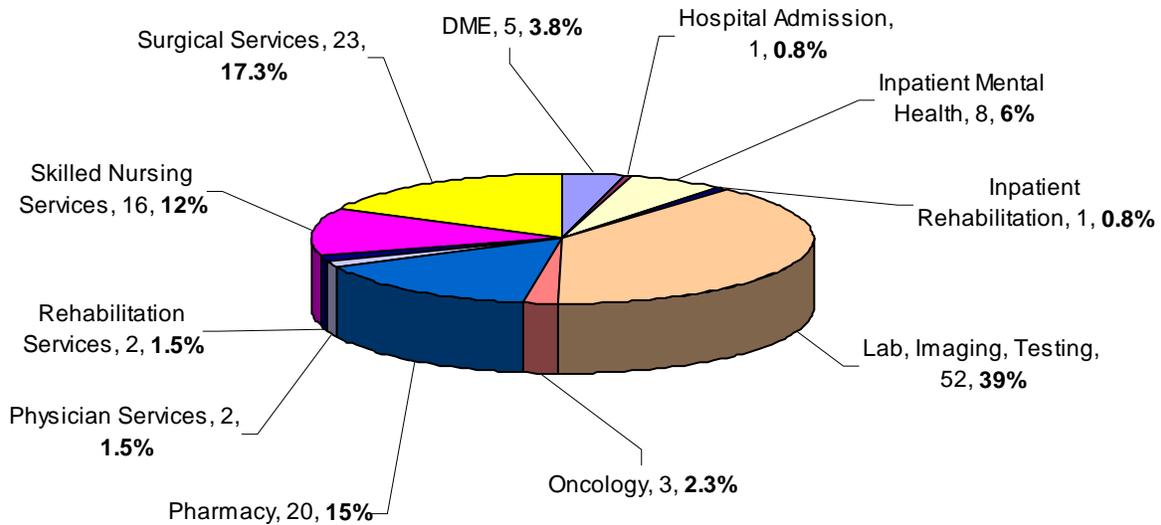
Table 1: Reasons for Non-Acceptance of an External Review Request, January 1, 2007 – December 31, 2007

Reason for Non-acceptance	Number of Requests
INELIGIBLE	
Missed Insurer's Timeframe to Complete Appeals	3
Health Criteria Not Met For Expedited, Not Eligible as Standard	1
Not a Medical Necessity Determination	19
Request Withdrawn	1
Already Underwent External Review	2
No Denial Issued	2
Retrospective Services-- Not Eligible For Expedited	1
Past 60 Day Request Time Frame	7
Insurer Appeal Process Not Exhausted	18
Request is Incomplete, No Resubmission of Request	12
Total Ineligible	66
NO JURISDICTION	
Contract Situs Not In NC	4
Self-Funded Employer Plan	21
Medicare HMO	2
Total No Jurisdiction	27
Total Requests Not Accepted	93

B. Activity by Type of Service Requested

The HCR Program classifies accepted cases into “general” service categories. Figure 10 shows the number of accepted cases by type of service for 2007. For the first time since the Program began, “Surgical Service” is not the largest share of accepted cases. With 52 accepted cases, representing 39 percent of the 133 accepted cases for external review, “Lab, Imaging, Testing” had the most accepted cases. “Surgical Services” had the second largest share of requests (17.3%) and “Pharmacy” had the third largest share of requests (15%). The increase in “Lab, Imaging, Testing” was due in large part to the patient advocacy services of Genomic Health who provides the Oncotype DX breast cancer genetic assay test to predict the risk of recurrence of breast cancer in women with certain types of breast cancers.

**Figure 10: Accepted Cases by Type of Service Requested
January 1, 2007 – December 31, 2007**



Although the HCR Program reports primarily on the basis of the general types of services under dispute, information on specific service types is also kept by the Program to analyze activity and identify trends. Table 2 gives the reader a listing of the specific services, along with the number of accepted cases for that service, that made up the general type of service category used for reporting for the period of January 1, 2007 – December 31, 2007.

Table 2: Type of General Service and Specific Services Requested for All Accepted Cases for External Review, January 1, 2007 – December 31, 2007

Type of General Services and Specific Services Requested			
DME (5)	Lab, Imaging, Testing (52)	Pharmacy (20)	Skilled Nursing Facility (16)
CPM Machine (1) DOC Band (1) ECTT Device (1) JAS Elbow Brace (1) Motorized Scooter (1)	Bone Density Test (1) Coronary Angiogram (1) Fibrosure (1) General Labwork (3) MRI (4) PET Scan (4) Oncotype DX (38)	Botox (4) Chelation (3) Eufflexa (1) Genotropin (4) IV for Lyme's (4) Provigil (1) Synvisc (1) Valtrex (1) Xenical (1)	Surgical Services (23) Alloderm Procedure (1) Asst. Surgeon (1) Carotid Stent (1) Intrastomal Corneal Ring (1) Panniculectomy (4) Orthognathic Surgery (12) Osteochondral Knee Allograft (1) UPPP (1) VNS (1)
Hospital Admission (1)			
Pneumonia (1)			
Inpatient Mental Health (8)	Oncology (3)		
Inpatient Residential (5)	Mammosite (3)		
Inpatient Acute (3)	Physician Service (2)	Rehabilitation (2)	
Inpatient Rehabilitation (1)	Office visit /services (1) Anesthesiology (1)	Cardiac Rehab (1) Physical Therapy (1)	
Orthopedic (1)			

Table 3 shows a comparison of the percentage share that each service type held for all accepted cases as well as the percentage of total outcomes for 2007. For the first time since the Program's start, "Surgical Services" did not comprise the majority of the types of service under review. In 2007, 'Lab, Imaging, Testing' was the category which made up the greatest percentage share of reviews with 39 percent of the review activity. This category also made up the majority of the overturned decisions with 38.3 percent as well as the upheld decisions with 39.2 percent. "Surgical Services" made up 25.5 percent of the overturned decisions and "Pharmacy" made up the second largest percentage of upheld decisions with 17.8 percent.

Table 3: Percentage Share of Review Activity by Type of Service Requested, January 1, 2007 – December 31, 2007

Types of Service	2007				
	Number of Accepted Cases	Percentage of Accepted Cases	Outcomes		
			% Overturned	% Reversed	% Upheld
DME	5	3.8%	2.1%	0.0%	4.8%
Hospital Admission	1	0.8	0.0	0.0	1.2
Inpatient Mental Health	8	6.0	8.5	0.0	4.8
Inpatient Rehabilitation	1	0.8	0.0	0.0	1.2
Lab, Imaging, Testing	52	39.0	38.3	50.0	39.2
Oncology	3	2.3	2.1	0.0	2.4
Pharmacy	20	15.0	10.7	0.0	17.8
Physician Services	2	1.5	2.1	50.0	0.0
Rehabilitation Services	2	1.5	0.0	0.0	2.4
Skilled Nursing Facility	16	12.0	10.7	0.0	13.1
Surgical Services	23	17.3	25.5	0.0	13.1
Total	133	100%	100%	100%	100%

Because of the increasing types of services that are denied and the basis upon which the noncertification is issued, it is important for the reader to differentiate between a medical necessity denial and other types of noncertifications (i.e., experimental/investigational or cosmetic). Decisions made by IROs are considered by the nature of the noncertification as well as the service requested. For example, an insurer may base its denial decision solely on the medical necessity of the procedure, evaluating whether the procedure meets its guidelines for appropriateness for the covered person's condition. However, noncertifications are also any situation where the insurer makes a decision about the covered person's condition to determine whether a requested treatment is experimental, investigational or cosmetic, and the extent of coverage is affected by that decision. A further breakdown of case outcomes, from decisions rendered by IROs, as they relate to the service type and the nature of the noncertification for the year 2007 is shown in Table 4.

Table 4: Outcomes of Accepted External Review Requests by Service Type and Denial Type, January 1, 2007 – December 31, 2007

Service Type	2007					
	Medical Necessity		Experimental / Investigational		Cosmetic	
	Overtured	Upheld	Overtured	Upheld	Overtured	Upheld
DME	0	2	0	2	1	0
Hospital Admission	0	1	0	0	0	0
Inpatient Mental Health	4	4	0	0	0	0
Inpatient Rehabilitation	0	1	0	0	0	0
Lab, Imaging, Testing	2	3	16	30	0	0
Oncology	0	0	1	2	0	0
Pharmacy	3	8	2	7	0	0
Physician Services	1	0	0	0	0	0
Rehabilitation Services	0	2	0	0	0	0
Skilled Nursing Facility	5	11	0	0	0	0
Surgical Services	9	7	3	1	0	3
Total	24	39	22	42	1	3
Percentage of Case Volume	48.1%		48.9		3.0%	

In 2007, the distribution between medically necessary cases and experimental / investigational cases was almost equal. Medical necessity external review cases made up 48.1 percent of the total number of cases where IROs rendered decisions. These cases involved a variety of general service types, but primarily involved “Inpatient Mental Health”, “Skilled Nursing Facility” and “Surgical Services”. By contrast, almost all of the cases involving experimental / investigational denials involved “Lab, Imaging Testing”. Of the 46 cases where IROs decided on “Lab, Imaging, Testing” cases, 38 involved the Oncotype DX Breast Cancer Genetic assay testing for the risk of breast cancer recurrence in women with certain types of breast cancers. One provider, Genomic Health, acting on behalf of their patients, made 34 of those 38 requests for external review.

Figure 11 and 12 show in graph form the outcomes of all external review cases received in 2007. Of the 15 requests received requesting expedited external review, only three expedited cases were accepted during 2007. One case involving a PET scan was reversed by the insurer prior to the IRO reviewing the case. One expedited case involving pharmacy was upheld by the IRO and one surgical case involving carotid artery stenting was overturned by the IRO. The abundance of standard cases for 2007 involved “Lab, Imaging, Testing”.

Figure 11: Outcomes of all Expedited External Review Requests by General Service Type, January 1, 2007 – December 31, 2007

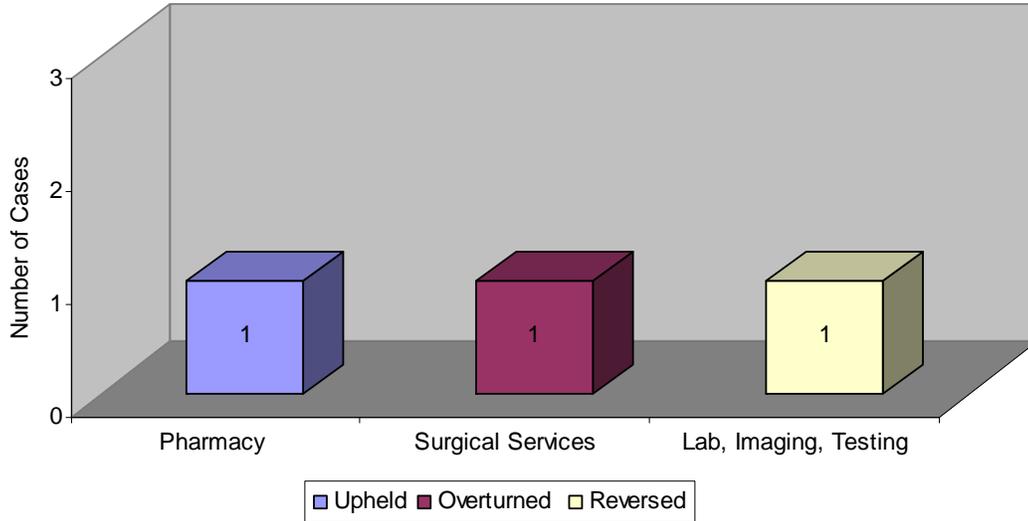
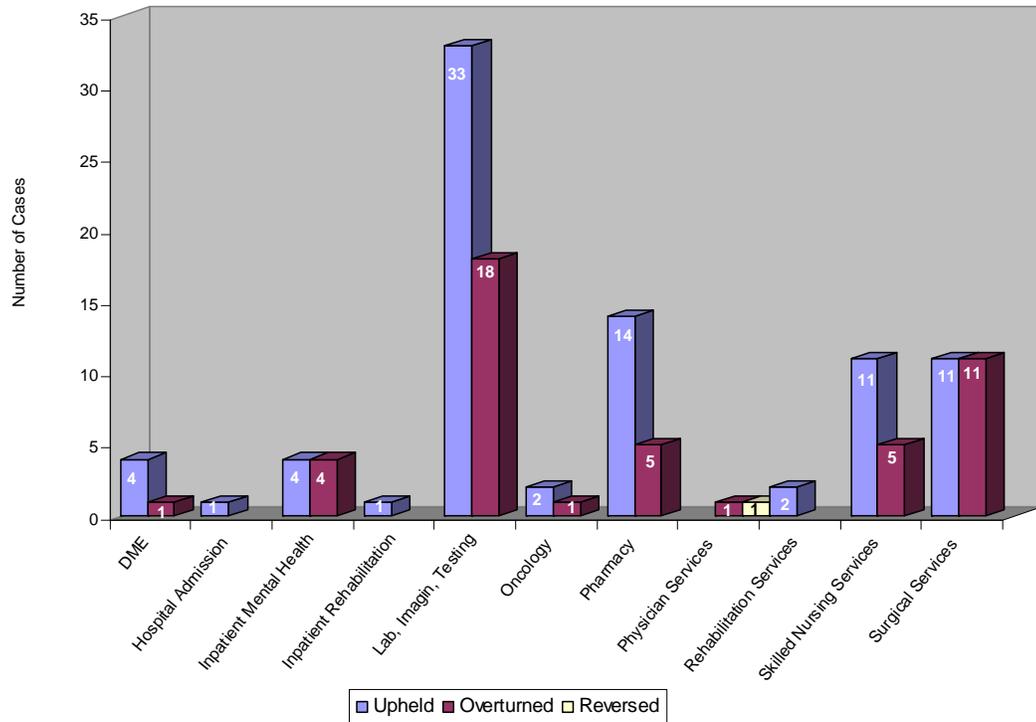


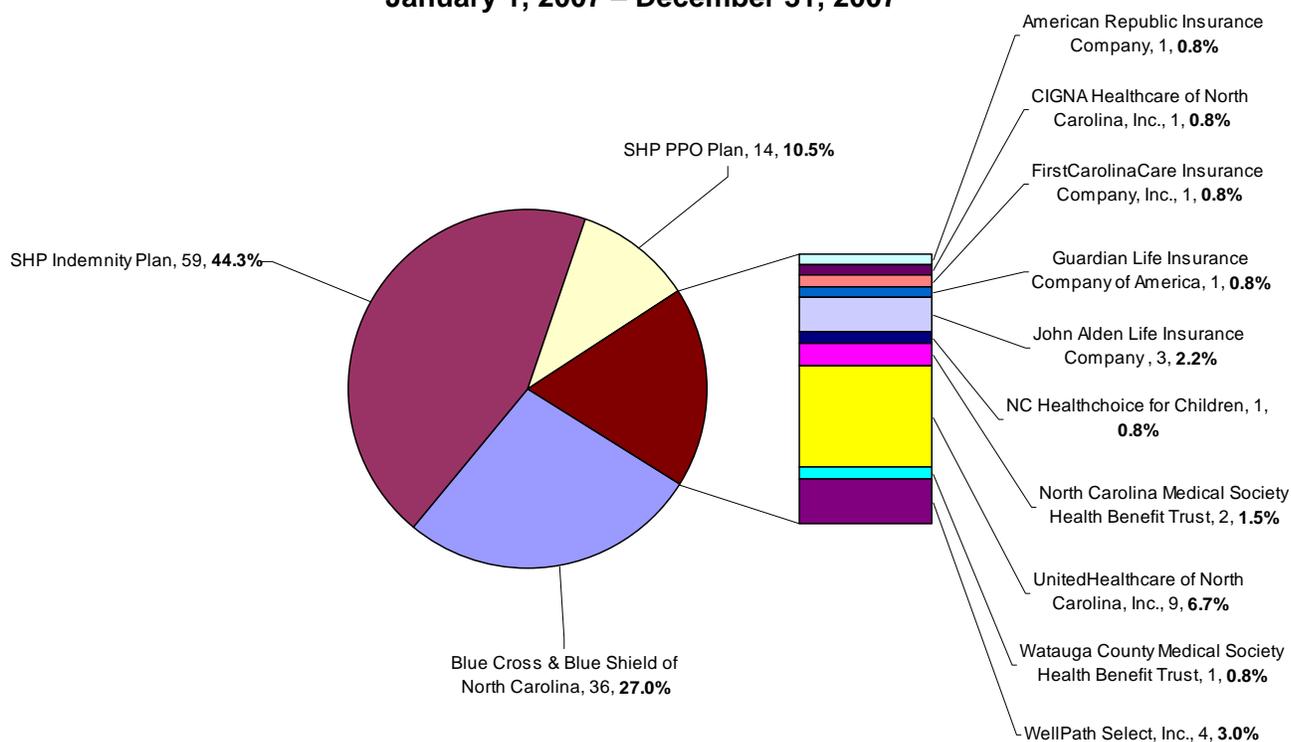
Figure 12: Outcomes of all Standard External Review Requests by General Service Type, January 1, 2007 – December 31, 2007



C. External Review Activity by Insurer and Type of Service

In 2007, cases originating from State Health Plan’s Indemnity Plan, State Health Plan PPO Plan, and Blue Cross & Blue Shield of North Carolina comprised 81.8 percent of the external review activity. Ten other insurers, including two Multiple Employer Welfare Arrangements (MEWAs), made up the remaining 18.2 percent of cases. Six of the insurers had only one case, UnitedHealthcare of North Carolina, Inc. had nine cases, WellPath Select, Inc. had four cases, John Alden Life Insurance Company had three cases, and the North Carolina Medical Society Health Benefit Trust had two cases. With 59 cases accepted during 2007, the State Health Plan’s Indemnity Plan remains the health plan with the largest number of requests for external review. Blue Cross & Blue Shield of North Carolina, the state’s largest insurer, had the second largest number with 36 accepted cases. The percentage share of insurer activity for 2007 is depicted in Figure 13.

Figure 13: Insurers’ Share of Accepted External Review Requests, January 1, 2007 – December 31, 2007



The rate of cases accepted for external review involving any specific insurer must be compared to the number of covered members per month in order to have meaning for prevalence of activity. HMOs are required to report “member month” data to the Department on an annual basis. Insurers offering indemnity and PPO plans are not required to report member months. Member month data for both the State Health Plan’s Indemnity and PPO plans, and for CHIP is reported to the Program upon request. Historically, the rate of external review activity for all HMOs, the State Health Plan’s Indemnity plan and PPO plan (2006) has been a case rate of less than one (1) case per 100,000 members. In 2007, insurer activity of accepted external review requests remained relatively unchanged.

Table 5 reports information about the nature of services that were the subject of each insurer's external review cases and the outcome of these cases for 2007. This information is expressed in terms of the numeric distribution of insurer's cases, by type of service, and the outcomes for each type of service, expressed as a percentage of total cases for the type of service.

Table 5: Accepted Case Activity by Insurer and Type of Service Requested, January 1, 2007 – December 31, 2007

Insurer and Type of Service	2007			
	Number of Accepted Cases	Outcomes		
		Percent Overturned	Percent Reversed	Percent Upheld
American Republic Insurance Company	1			
• Rehabilitation Services	1	--	--	100.0
Total Percentage for Insurer		--	--	100.0
Blue Cross & Blue Shield of North Carolina	36			
• DME	1	100.0	--	--
• Inpatient Mental Health	1	100.0	--	--
• Inpatient Rehabilitation	1	--	--	100.0
• Lab, Imaging, Testing	16	43.7	--	56.3
• Pharmacy	8	25.0	--	75.0
• Physician Services	1	100.0	--	--
• Skilled Nursing Facility	1	100.0	--	--
• Surgical Services	7	42.9	--	57.1
Total Percentage for Insurer		44.4	--	55.6
CIGNA Healthcare of North Carolina, Inc.	1			
• Pharmacy	1	100.0	--	--
Total Percentage for Insurer		100.0	--	--
FirstCarolinaCare Insurance Company	1			
• DME	1	--	--	100.0
Total Percentage for Insurer		--	--	100.0
Guardian Life Insurance Company of America	1			
• Lab, Imaging, Testing	1	--	--	100.0
Total Percentage for Insurer		--	--	100.0
John Alden Life Insurance Company	3			
• DME	1	--	--	100.0
• Inpatient Mental Health	1	100.0	--	--
• Physician Services	1	--	100.0	--
Total Percentage for Insurer		33.3	33.3	33.4
NC Healthchoice for Children	1			
• DME	1	--	--	100.0
Total Percentage for Insurer		--	--	100.0
North Carolina Medical Society Health Benefit Trust	2			
• Lab, Imaging, Testing	2	50.0	--	50.0
Total Percentage for Insurer		50.0	--	50.0
SHP Indemnity Plan	59			
• Inpatient Mental Health	3	--	--	100.0
• Lab, Imaging, Testing	23	21.7	--	78.3
• Oncology	1	--	--	100.0
• Pharmacy	6	33.3	--	66.7
• Rehabilitative Services	1	--	--	100.0
• Skilled Nursing Facility	15	26.7	--	73.3
• Surgical Services	10	60.0	--	40.0
Total Percentage for Insurer		28.8	--	71.2

Table 5: Accepted Case Activity by Insurer and Type of Service Requested, January 1, 2007 – December 31, 2007 (Cont.)

Insurer and Type of Service	2007			
	Number of Accepted Cases	Outcomes		
		Percent Overturned	Percent Reversed	Percent Upheld
SHP PPO Plan	14			
• Hospital Admission	1	--	--	100.0
• Lab, Imaging, Testing	5	40.0	20.0	40.0
• Oncology	2	50.0	--	50.0
• Pharmacy	2	--	--	100.0
• Surgical Services	4	50.0	--	50.0
Total Percentage for Insurer		35.8	7.1	57.1
UnitedHealthcare of North Carolina, Inc.	9			
• Inpatient Mental Health	2	50.0	--	50.0
• Lab, Imaging, Testing	4	50.0	--	50.0
• Pharmacy	1	--	--	100.0
• Surgical Services	2	50.0	--	50.0
Total Percentage for Insurer		44.4	--	55.6
Watauga County Medical Society Health Benefit Trust	1			
• Inpatient Mental Health	1	100.0	--	--
Total Percentage for Insurer		100.0	--	--
WellPath Select, Inc.	4			
• DME	1	--	--	100.0
• Lab, Imaging, Testing	1	100.0	--	--
• Pharmacy	2	--	--	100.0
Total Percentage for Insurer		25.0	--	75.0

D. External Review Activity by IRO

During the period of January 1, 2007 – December 31, 2007, IROs rendered 131 external review decisions for consumers. Although 133 cases were accepted for external review during this period, two cases were reversed by the insurer prior to an IRO decision being rendered. The cases sent to IROs for independent review encompass a variety of insurers, noncertification reasons and specific types of services. Table 6 compares the number of cases assigned to each IRO with the number and percentage of their review decisions for the year 2007. The number of cases assigned to an IRO under the alphabetical rotation system is dependent upon whether a conflict of interest was determined to exist, the ability of the IRO to review the service type and the availability of a qualified expert reviewer. Overall, IROs decided in favor of the consumer 35.9 percent of the time during 2007.

**Table 6: IRO Activity Summary,
January 1, 2007 – December 31, 2007**

IRO	2007				
	Number Assigned	Overturned		Upheld	
		Number	Percentage	Number	Percentage
I PRO	36	10	27.8	26	72.2
Maximus CHDR	34	20	58.8	14	41.2
MCMC*	0	0	0.0	0	0.0
NMR, Inc.	36	13	36.1	23	63.9
Permedion	25	4	16.0	21	84.0
All Cases	131	47	35.9	84	64.1

* MCMC contract expired on 6/30/07

MCMC did not receive any case assignments in 2007 due to the presence of conflict of interest if the case were to be assigned to this IRO. The Program's contract with MCMC expired on June 30, 2007.

E. IRO Decisions by Type of Service Requested and Insurer

Table 7 breaks down the number of cases involving the general service type that each IRO reviewed for the calendar year 2007. This table only gives an accounting of the cases assigned and does not analyze outcomes by virtue of the type of noncertification issued. The overall number of cases does not allow for trends to be identified or assumptions to be made.

Table 7: Accepted Case Activity by IRO and Type of Service Requested, January 1, 2007 – December 31, 2007

IRO and Type of Service	2007		
	Number of Accepted Cases	Outcomes	
		Percent Overturned	Percent Upheld
I PRO	36		
• DME	1	--	100.0
• Inpatient Mental Health	2	50.0	50.0
• Lab, Imaging, Testing	18	11.1	88.9
• Pharmacy	4	50.0	50.0
• Skilled Nursing	5	20.0	80.0
• Surgical Services	6	66.7	33.3
Maximus CHDR	34		
• Inpatient Mental Health	3	100.0	--
• Inpatient Rehabilitation	1	--	100.0
• Lab, Imaging, Testing	16	68.8	31.2
• Pharmacy	7	28.6	71.4
• Skilled Nursing Facility	3	67.7	33.3
• Surgical Services	4	50.0	50.0
MCMC*	0		
NMR, Inc.	36		
• DME	1	100.0	--
• Hospital Admission	1	--	100.0
• Inpatient Mental Health	2	--	100.0
• Lab, Imaging, Testing	10	50.0	50.0
• Oncology	3	33.3	66.7
• Pharmacy	5	--	100.0
• Physician Services	1	100.0	--
• Rehabilitation Services	1	--	100.0
• Skilled Nursing	4	50.0	50.0
• Surgical Services	8	37.5	62.5
Permedion	25		
• DME	3	--	100.0
• Inpatient Mental Health	1	--	100.0
• Lab, Imaging, Testing	7	--	100.0
• Pharmacy	4	25.0	75.0
• Rehabilitation Services	1	--	100.0
• Skilled Nursing	4	--	100.0
• Surgical Services	5	60.0	40.0

* MCMC contract expired on 6/30/07

Table 8 shows each IRO's decisions by individual insurer for January 1, 2007 – December 31, 2007. An IRO is assigned a case on the basis of: a) an alphabetical rotation that is required by law, b) that the IRO has a qualified clinical expert to review the case, and c) that there is no conflict of interest. The nature of the denial has no bearing on the assignment to an IRO.

**Table 8: IRO Decisions by Insurer,
January 1, 2007 – December 31, 2007**

IRO and Insurer	2007		
	Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld
I PRO	36		
• Blue Cross & Blue Shield of North Carolina	9	44.4	55.6
• John Alden Life Insurance Company	1	--	100.0
• SHP Indemnity Plan	18	11.1	89.9
• SHP PPO Plan	2	50.0	50.0
• UnitedHealthcare of North Carolina, Inc.	6	50.0	50.0
Maximus CHDR	34		
• Blue Cross & Blue Shield of North Carolina	10	50.0	50.0
• CIGNA HealthCare of North Carolina, Inc.	1	100.0	--
• Guardian Life Insurance Company of America	1	--	100.0
• John Alden Life Insurance Company of America	1	100.0	--
• North Carolina Medical Society Employee s Health Benefit Trust	2	50.0	50.0
• SHP Indemnity Plan	13	61.5	38.5
• SHP PPO Plan	3	66.7	33.3
• UnitedHealthcare of North Carolina, Inc.	2	50.0	50.0
• Watauga County Medical Society Health Benefit Trust	1	100.0	--
MCMC*	0		
NMR	36		
• Blue Cross & Blue Shield of North Carolina	12	50.0	50.0
• SHP Indemnity Plan	15	26.7	73.3
• SHP PPO Plan	7	28.6	71.4
• WellPath Select, Inc.	2	50.0	50.0
Permedion	25		
• American Republic Insurance Company	1	--	100.0
• Blue Cross & Blue Shield of North Carolina	5	20.0	80.0
• FirstCarolinaCare Insurance Company, Inc.	1	--	100.0
• NC Healthchoice for Children	1	--	100.0
• SHP Indemnity Plan	13	23.1	76.9
• SHP PPO Plan	1	--	100.0
• UnitedHealthcare of North Carolina, Inc.	1	--	100.0
• WellPath Select, Inc.	2	--	100.0

* MCMC contract expired on 6/30/07

The total number of cases for any IRO, and the number of assigned cases by insurer that were reviewed by an IRO is still too small to identify trends or make any evaluative statements.

F. Cost of External Review Cases for 2007

The cost of an external review for a specific case can be comprised of one (1) or two (2) components. All cases incur administrative cost – the fee charged by the IRO to perform the review. For those cases where the IRO overturns the insurer denial or where the insurer reverses itself, there is also the cost of covering the service. Depending upon the benefit plan and where the covered person stands in terms of meeting their deductibles and annual out-of-pocket maximums, the insurer’s out-of-pocket cost associated with covering a service will vary.

Table 9 shows the average cost of the IRO review and cost of allowed charges for cases that were reversed by the insurer or overturned (average and cumulative) and the average cost of IRO review for cases upheld in 2007, by type of service requested.

Table 9: Cost of IRO Review, Average and Cumulative Allowed Charges by Type of Service Requested, January 1, 2007 – December 31, 2007

Type of Service Requested	Average Costs of IRO Review for Requests Upheld	Average Costs for Requests Reversed or Overturned		Cumulative Total Allowed Charges for Overturned or Reversed Service
		Cost of IRO Review	Cost of Allowed Charges	
DME	\$565.00	\$575.00	\$3,020.71	\$3021.71
Hospital Admission	575.00	0.00	0.00	0.00
Inpatient Mental Health*	643.75	518.75	20,865.96	62,597.87
Inpatient Rehabilitation	450.00	0.00	0.00	0.00
Lab, Imaging, Testing	636.03	515.28	2,852.27	54,193.20
Oncology	575.00	575.00	789.52	789.52
Pharmacy	590.00	610.	13,872.28	69,361.38
Physician Services	0.00	575.00	918.34	1,836.68
Rehabilitation Services	637.50	0.00	0.00	0.00
Skilled Nursing Facility	663.64	555.00	4,467.72	22,338.62
Surgical Services*	509.62	649.58	14,401.16	86,406.94
All Cases	\$596.88	\$571.25	\$7,155.83	\$300,544.92

* Outstanding cost of allowed charges remains for service.

Currently, contracted fees for IRO services are between \$450 and \$725 for a standard review, and \$750 and \$900 for an expedited review. These fees are fixed per-case fees bid by each IRO; they do not vary by the type of service that is covered. The average cost to insurers for the 131 reviews performed during 2007 was \$579.30.

An IRO may charge an insurer a cancellation fee if the insurer reverses its own decision after the IRO has proceeded with the review. One insurer was charged a cancellation fee of \$95.00 for a request that was reversed by the insurer after the case had been assigned to a reviewer by the IRO. The average cost of service for cases reversed by the insurer was \$248.03.

VI. HCR Program Evaluation

The HCR Program continues to utilize its consumer satisfaction survey with all accepted cases in order to obtain feedback from consumers regarding the external review experience. A consumer satisfaction survey is mailed to the consumer or authorized representative at the completion of each accepted case. From January 1, 2007 – December 31, 2007, 132 surveys were sent at the completion of an external review. Only 50 consumers or authorized representatives (37.9%) completed the survey and returned it to the HCR Program. Of those cases that were overturned by the IRO, 22 of 46 persons responded (47.8%) and of those cases that were upheld by the IRO, 26 of 84 persons responded (30.9%). In cases where the insurer reversed its own decision, both persons responded.

Overall, responders are generally pleased with the customer service they receive while contacting the Healthcare Review Program. More responders are identifying “Word of Mouth” as the method by which they learned about external review but most still identify “Insurer” as the method by which they hear about the HCR Program. Most responders report satisfaction with the HCR Program staff and information about the external review process.

In addition to questions regarding the service the HCR Program staff provided and the IRO decision, the survey asks for consumer comments and “Would you tell a friend about external review?” Of the responders whose decision was overturned, 100 percent stated they would tell a friend about external review. As the Program has seen in years past, a large percentage of those whose decision was upheld (84.6%), would also tell a friend about external review. As shown in Table 14, 92 percent of individuals who went through the external review process stated they would tell a friend about external review, suggesting that external review is viewed to be a valued and important consumer protection.

**Table 14: Consumer Satisfaction Survey Analysis,
January 1, 2007 – December 31, 2007**

Outcome of External Review	Number of Surveys Sent	Number of Surveys Received	Percentage of Respondents	Number of Respondents “would tell a friend”	Percentage of Respondents “would tell a friend”
Overtured	46	22	47.8	22	100.0
Upheld	84	26	30.9	22	84.6
Reversed	2	2	100.0	2	100.0
Total:	132	50	37.9	46	92.0

VII. Conclusion

Since the Program’s inception five and one-half years ago, consumers and providers on behalf of consumers have accessed the HCR Program seeking information about external review services

or counseling on utilization review and internal appeal and grievance procedures. North Carolina's external review law provides consumers with another option for resolving coverage disputes with their insurer using this efficient, cost-effective process. In North Carolina, there is no cost to the consumer for requesting an external review. From July 1, 2002 to December 31, 2007, the HCR Program received 1,290 requests for external review, and accepted 542 cases. To date, the cumulative total of services provided to consumers as a result of external review is \$2,597,019.08.

This HCR Program's Annual Report presents external review and consumer counseling activity data which documents the growth of the Program, usage of services by consumers, and external review case outcomes for calendar year 2007. Comparative data for the last five calendar years demonstrates a sustained need for services by consumers. The report also provides information 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. While the quantity of data is still relatively small, and general conclusions cannot be made, some overall observations can be reported based upon the data we have available.

Program highlights as reported in the data includes steady growth in consumer counseling calls that were related to utilization review and insurers internal appeals and grievance procedures and the growth in the number and percentage of cases accepted for external review compared to the number of individuals making the request over the last five calendar years. In 2007, "Lab, Imaging, Testing" was the predominant case type for all accepted external review requests, due in large part to the patient advocacy services of Genomic Health who provides the Oncotype DX breast cancer genetic assay test to predict the recurrence of breast cancer in women with certain breast cancers. Of the 133 cases accepted for external review in 2007, 84 cases were upheld, 47 cases overturned and two (2) cases reversed by the insurer.

The HCR Program continues to seek out new and different opportunities to promote consumer and provider awareness of external review services through a variety of community outreach and education initiatives. Activities in 2007 have included speaking engagements, publications, and radio interviews. During this reporting period, the Commissioner of Insurance sent letters to home health agencies, cardiac rehab centers and skilled nursing facilities, informing them of the importance and availability of external review services. The mailing to these provider groups included an external review services contact card and a Program brochure. Following the mailing, the Program staff received calls from provider offices requesting additional brochures, and over 1,000 additional brochures were mailed out.

North Carolina's external review service continues to be an effective vehicle for consumers to resolve coverage disputes with their insurer in a fair, efficient, and cost-effective manner. In this state, consumers can easily request an external review as there are no monetary claims threshold requirements, and no cost to the consumer to request an external review. In the end, the Healthcare Review Program operates effectively to provide external review services to the citizens of North Carolina.