

HEALTHCARE REVIEW PROGRAM

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North Carolina Department of Insurance
Wayne Goodwin, Commissioner

A REPORT ON EXTERNAL REVIEW REQUESTS IN NORTH CAROLINA

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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

The Healthcare Review Program (HCR Program or Program) became effective on July 1, 2002 as a result of the enactment of the Health Benefit Plan External Review law. The law provides for the establishment and maintenance of external review procedures by the Department of Insurance (Department) to assure that insureds have the opportunity for an independent medical review of denials (noncertifications) made by their health plan. The Program also counsels consumers who seek guidance and information on utilization review and internal insurer appeals and grievance issues.

In providing consumer counseling, staff explain to the consumer about their health insurers appeal process and suggest approaches to accessing the process specific to their case. Staff will also explain state laws that govern utilization review and the appeals and grievance process. Consumers speak with professional registered nurses who are clinically experienced and knowledgeable regarding medical denials and consumer rights under North Carolina law. HCR Program staff counseled 296 consumers during 2008.

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 health plan. 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 independent review organizations (IROs) that are contracted with the Department. There is no charge to the consumer for requesting an external review.

In 2008, 168 individuals requested an external review and 89 cases were accepted. Of those accepted, 83 cases were processed on a standard basis and six cases were processed on an expedited basis. Overall, outcomes of accepted cases were decided in favor of the consumer 39 percent of the time.

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 2008, the average cost of allowed charges from all cases that were reversed by the health plan or overturned by an IRO was \$12,392.68 with a cumulative total for the year of \$384,172.94. Since July 1, 2002, the cumulative total of services provided to consumers as a result of external review is \$2,998,157.75.

The HCR Program continues to promote consumer and provider awareness of external review services through a variety of community outreach and education initiatives. In 2008, HCR Program staff conducted onsite educational presentations to skilled nursing facilities. Other HCR Program outreach resources available to consumers include the HCR Program web page, the Program brochure entitled *A Consumer's Guide to External Review* and the Consumer Counseling web page to facilitate ease of use and provide additional information about services available through the Program. Recognizing the importance of new technologies in

connecting with the public, the HCR Program is in development of a web video and Facebook page which will expand our outreach and education to the public.

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 2008, 89 surveys were sent at the completion of an external review, of which 43.8 percent were completed and returned. Overall, responders were generally pleased with the customer service they receive while contacting the HCR Program. Consumers reported satisfaction with the HCR Program staff and information about the external review process. Survey results also showed that 97.4 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.

Introduction

Entering its seventh year of operation, North Carolina's Healthcare Review Program (HCR Program or Program) continues to provide North Carolinians with 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 Program also provides consumer counseling to those who seek guidance and information on utilization review and the health plan's internal appeals and grievance processes.

North Carolina's External Review law (N. C. Gen. Stat. §§ 58-50-75 through 95) provides for the independent medical review of a health plan noncertification, and offers another option for resolving coverage disputes between the covered person and their insurer. In North Carolina, external review is available when an insurer denies coverage for services on the grounds that they are not medically necessary (a noncertification decision), or that they are cosmetic or experimental for the covered person's specific medical condition. The law applies to persons covered under a fully insured health plan, the Teachers' and State Employees' Comprehensive Major Medical Plan (State Health Plan Indemnity Plan or SHP Indemnity Plan) which terminated on June 30, 2008, NC *SmartChoice*, the North Carolina State Health Plan Preferred Provider Organization Plan (State Health Plan PPO Plan or SHP PPO Plan), and the North Carolina Health Insurance Program for Children (CHIP).

For a request to be accepted for external review, the covered person must meet eligibility requirements. Requests for external review are made directly to the HCR Program and each case is reviewed for completeness and eligibility. If accepted for external review, the case is assigned to an IRO for clinical review and final decision.

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

The HCR Program contracts with two 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 warrants an expedited handling of the review. The consulting physician is available to consult with Program staff and review consumer requests for expedited review at all times.

The Program contracts with IROs to perform the independent medical review of external review cases. IROs are subject to many statutory requirements regarding the organization's 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.

This report, which is required under N. C. Gen. Stat. § 58-50-95, is intended to provide a summary of the Program's activities and performance for the calendar year of 2008, as it relates to the nature and outcomes of the requests accepted for review, the health plans whose decisions are subject to review, and the IROs whose performance of the reviews are essential to the Program's successful operations. Cumulative analysis is provided for the captured costs relating to the services that have been overturned or reversed as a result of the HCR Program to demonstrate the value that is provided to North Carolina citizens.

Program Services

Consumer Counseling

The HCR Program staff provide counseling to consumers who have received a denial and have questions about the appeal process and may not be sure how to proceed with the appeal process. In providing counseling, Program staff explain to consumers their rights under North Carolina law, suggest resources or strategies that may be helpful to them, and explain how to use this information during the appeal process with their health insurance company.

In providing consumer counseling, staff do not give any opinions regarding the appropriateness of the requested treatment, suggest alternate modes of treatment, or provide specific detailed articles or documents that relate to the requested treatment. HCR staff will not give medical advice or prepare the consumer's case for them. Consumers requesting further assistance with the compilation or 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 North Carolina Attorney General's Office. Providing these counseling services offers consumers continuity in those cases where the appeal process does not conclude the matter and an external review is requested.

The Department operates an external review hotline (1-877-885-0231), to assist consumers in answering any questions they may have regarding the appeal process or external review services. The hotline calls are answered by the Program's clinical review analysts who are extremely knowledgeable about issues involving utilization review or insurer internal appeal and grievance processes. Consumers receive this counseling from a staff of professional nurses who understand the clinical aspects of cases as well. In 2008, the HCR Program received 1,083 calls from consumers asking questions about external review service, as well as those from consumers and providers seeking assistance, information and counseling relating to utilization review or a health plan's appeals and grievance process. The number of calls received by the Program each year remains constant identifying a continued need for consumer information.

The Program counseled 296 consumers during 2008. Of those individuals, 75.6 percent involved direct or indirect consumer counseling on appeals and grievance issues. The remainder of the calls involved:

- Health plan's claim payment
- Issues relating to insurance other than a health benefit plan.
- Denials made by self-funded employer plans regulated under the Employee Retirement Income Security Act (ERISA).
- Network access.
- Health plans 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. Consumers may be referred to the Department's Consumer Services Division, the Department's Seniors' Health Insurance Information Program (SHIIP), the United States Department of Labor, other state insurance regulatory agencies, and Federal agencies (i.e., Centers for Medicare & Medicaid Services, Office of Personnel Management and Department of Defense).

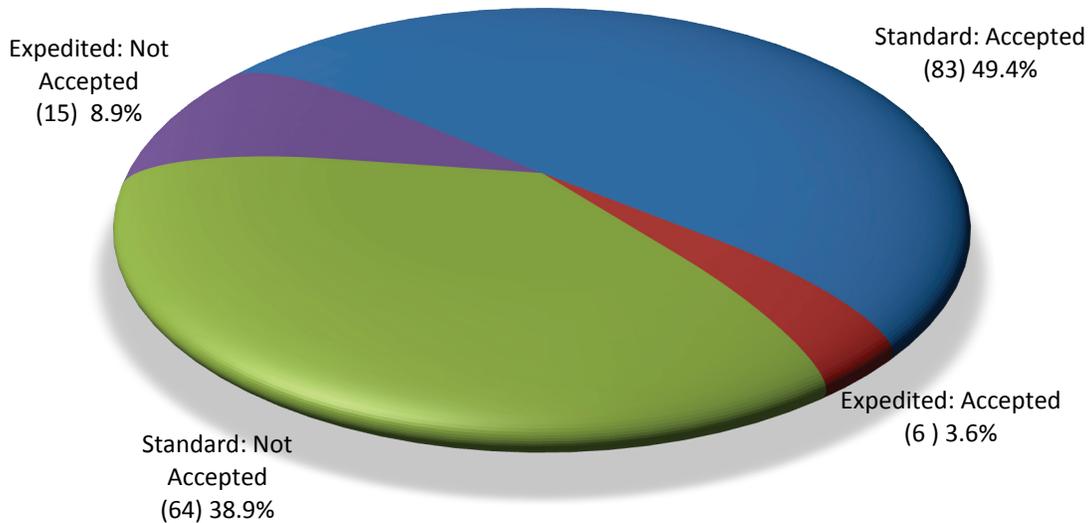
External Review

The HCR Program staff receives requests for external review from consumers or their authorized representative. In most cases, external review is available only after all appeals made directly to a health plan have failed to secure coverage. Requests for an external review of a health plan's decision must be made to the Program within 60 days of receiving a denial decision from the health plan. 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 a health plan'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 business days of the request.

Eligibility

During 2008, the HCR Program received 188 requests for external review. Twenty of these requests involved a re-submission of a previously incomplete request by the same individual. Therefore, 168 individuals requested external review. Figure 1 shows the disposition of requests for external review made to the Program during 2008. During this time, 53 percent of the requests received by the HCR Program were determined to be eligible and were comprised of both standard and expedited requests.

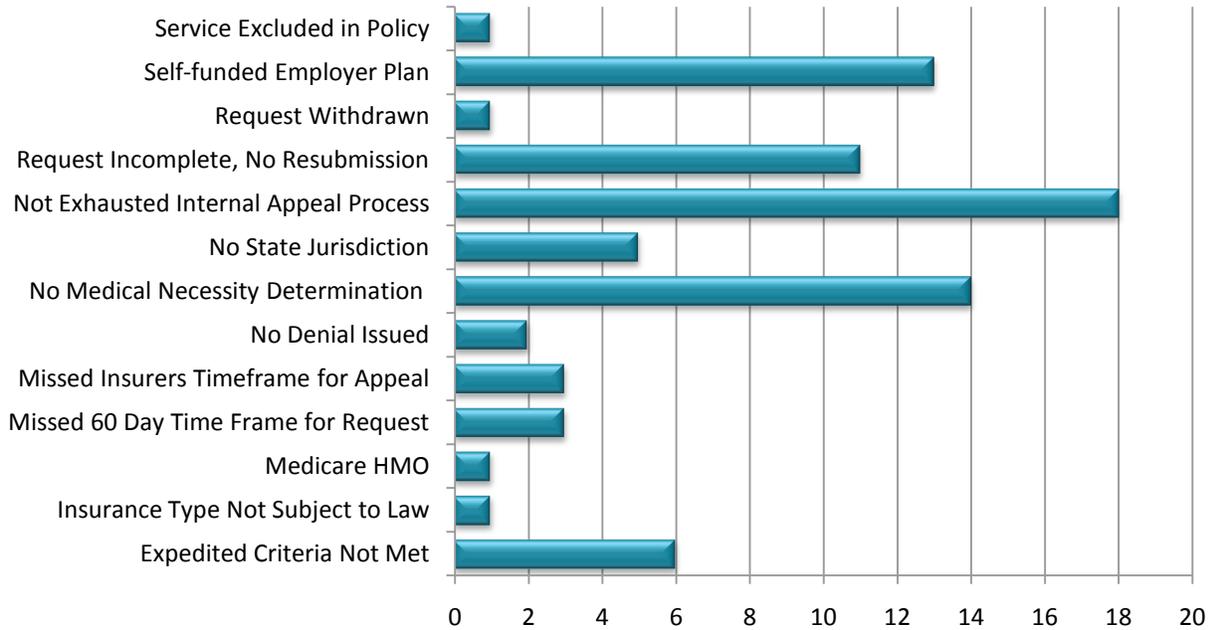
Figure 1: Disposition of External Review Requests Received in 2008



The reason why a case would not be accepted falls into any number of specific categories. Generally, however, a request may be deemed ineligible if the request does not meet the statutory requirements for eligibility or if the plan itself does not fall under North Carolina regulatory authority.

Figure 2 shows the number of cases that were not accepted for review and the reasons for which they were not accepted for the year 2008. During this time, of the 79 requests that were deemed to be not eligible, requests from consumers who had not fully exhausted the health plan's internal appeals process prior to requesting external review were the largest group with 18 cases not accepted. Requests that involved a denial for reasons other than a noncertification, such as an administrative denial, made up the second greatest number of ineligible requests with 14 cases. Consumers who were not eligible for external review because they were covered under a self-funded employer plan made up the third largest group of ineligible requests with 13 cases not accepted. These three reasons made up almost 60 percent of the cases not accepted for review.

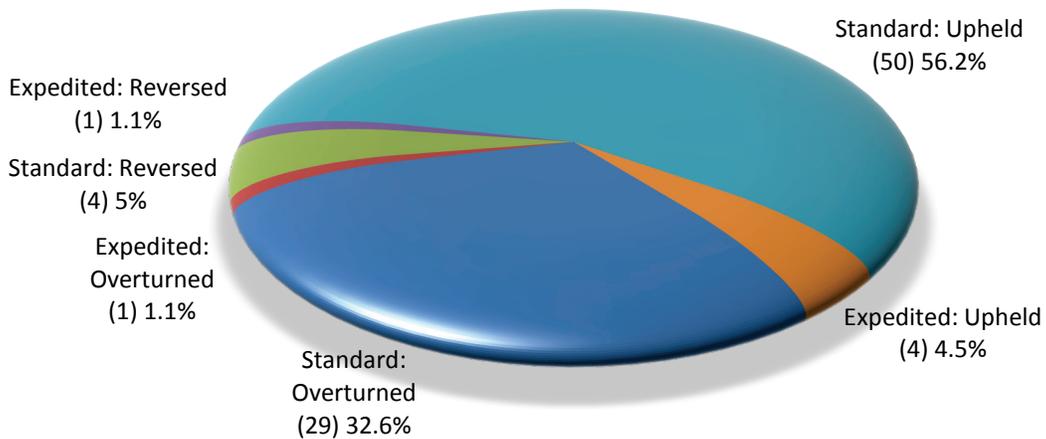
Figure 2: Reasons for Non-Acceptance of an External Review Request in 2008



Outcomes

In 2008, 89 cases were accepted for external review. Of those accepted, 83 were accepted to be processed on a standard basis. Only six cases throughout the year were processed on an expedited basis. Figure 3 shows the outcomes of all cases that were accepted for review during the year 2008. Overall, in 2008 cases that were accepted for external review were decided in favor of the consumer 39 percent of the time.

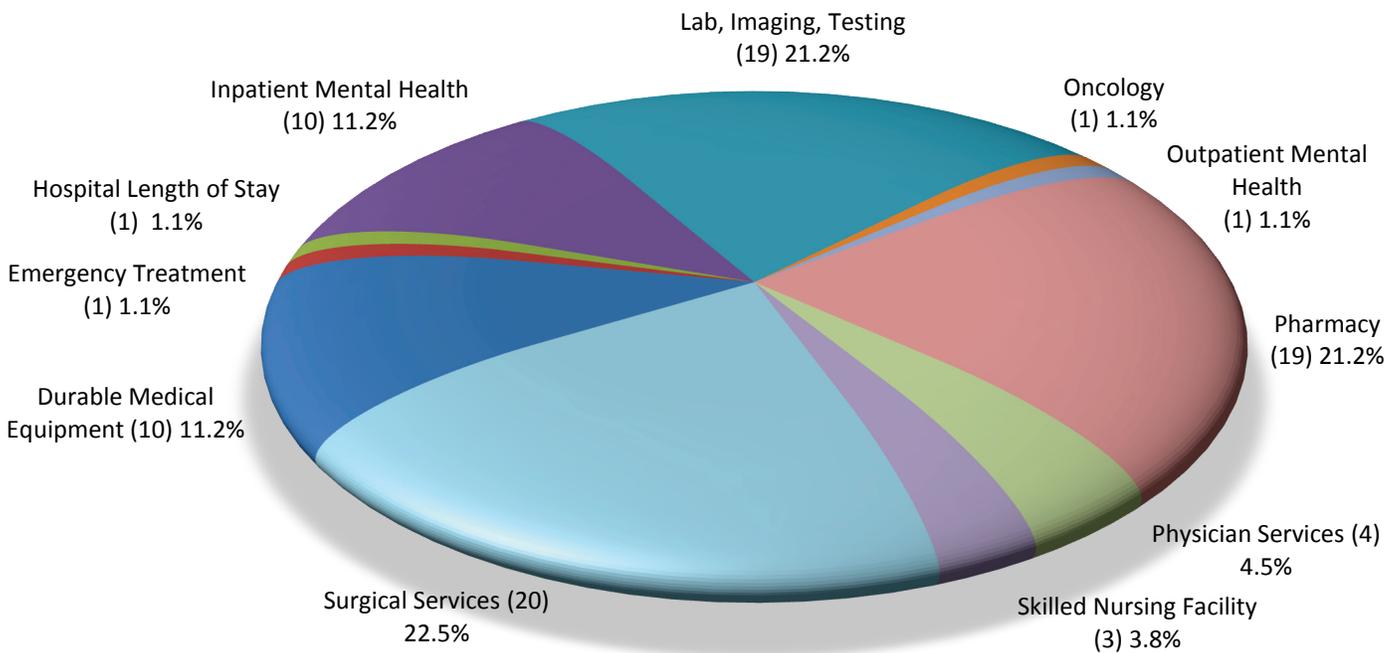
Figure 3: Outcomes of Cases Accepted for External Review by Request Type in 2008



Activity by Type of Service Requested

The HCR Program classifies accepted cases into “general” service categories. Figure 4 shows the number and percentage of accepted cases for each general service category for 2008. With 20 accepted cases, representing a variety of procedures, *Surgical Services* comprised 22.5 percent of the requests made in 2008. *Lab, Imaging, Testing* and *Pharmacy* both had 19 accepted cases. *Durable Medical Equipment* and *Inpatient Mental Health* were the categories with the third largest number of requests with 10 requests each under this general category.

Figure 4: Accepted Cases by Type of Service Requested in 2008



Although the HCR Program reports primarily on the basis of the general types of services under dispute, data on specific service types relating to the request is also kept by the Program to analyze activity and identify trends. Information regarding the specific service types is available upon request to the HCR Program.

Table 1 shows the percentage of outcomes for all accepted cases by general service type as well as the percentage share of total outcomes for all services for 2008. *Surgical Services*, the largest category of requests, was decided in favor of the consumer 50 percent of the time, due to either the IRO overturning the health plan’s denial or to the health plan reversing their own denial. Requests involving *Lab, Imaging, Testing* were upheld in favor of the health plan 68.4 percent of the time. Requests made for *Pharmacy* services revealed similar outcome percentages in favor of

the health plan with 63.2 percent. Requests involving *Durable Medical Equipment* had a higher percentage of cases upheld in favor of the health plan with 80 percent. *Inpatient Mental Health* services were decided in favor of the consumer 30 percent of the time.

Table 1: Percentage of Outcomes by Type of Service Requested in 2008

Type of Service	Percentage Overturned	Percentage Reversed	Percentage Upheld
Durable Medical Equipment	20.0	0.0	80.0
Emergency Treatment	0.0	0.0	100.0
Hospital Length of Stay	100.0	0.0	0.0
Inpatient Mental Health	30.0	10.0	60.0
Lab, Imaging, Testing	31.6	0.0	68.4
Oncology	0.0	0.0	100.0
Outpatient Mental Health	100.0	0.0	0.0
Pharmacy	31.6	5.5	63.2
Physician Services	40.0	0.0	60.0
Skilled Nursing Facility	66.7	0.0	33.3
Surgical Services	35.0	15.0	50.0
Percentage of Outcome for All Cases	33.7%	5.6%	60.7%

Because of the types of services that are denied and the basis upon which the noncertification is issued, it is important to differentiate between a denial based solely on medical necessity and other types of noncertification decisions (i.e., experimental/investigational or cosmetic). For example, a health plan may base its denial decision only on the medical necessity of the procedure, evaluating whether the procedure meets its guidelines for appropriateness for the covered person’s condition. However, noncertifications may also include any situation where the health plan 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. Table 2 further analyzes the 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 2008.

Table 2: Outcomes of Accepted External Review Requests by Service Type and Nature of Denial in 2008

Service Type	Medical Necessity		Experimental / Investigational		Cosmetic Services	
	Overtured/ Reversed	Upheld	Overtured/ Reversed	Upheld	Overtured/ Reversed	Upheld
DME	1	4	1	4	0	0
Emergency Treatment	0	1	0	0	0	0
Hospital Length of Stay	1	0	0	0	0	0
Inpatient Mental Health	4	6	0	0	0	0
Lab, Imaging, Testing	0	1	6	12	0	0
Oncology	0	0	0	1	0	0
Outpatient Mental Health	1	0	0	0	0	0
Pharmacy	4	9	3	3	0	0
Physician Services	1	2	1	0	0	0
Skilled Nursing Facility	2	1	0	0	0	0
Surgical Services	6	3	4	6	0	1
Percentage of Outcomes	22.5%	30.3%	16.9%	29.2%	0.0%	1.1%
Percentage of All Cases:	52.8%		46.1%		1.1%	

In 2008, the distribution between medically necessary cases and experimental / investigational cases was similar, with 52.8 percent of the cases decided on the medical necessity of the procedure and 46.1 percent of the cases decided on the experimental or investigational nature of the treatment as it related to the consumer’s medical condition. Only one case throughout the year was decided on whether the services were considered to be cosmetic.

Medical necessity cases involved almost all of the general service types, except *Oncology*. Cases involving *Pharmacy* (13), *Inpatient Mental Health* (10) and *Surgical Services* (9) represented the categories with the most number decided on the merits of medical necessity alone. Almost all of the cases involving experimental / investigational denials involved *Lab, Imaging Testing* with 18 cases and *Surgical Services* with 10 cases.

In 2008, the majority of cases that were accepted for review were those that were requested on a standard basis, with 93.3% of all cases falling into this 45 day time frame for processing cases. Table 3 shows the outcomes of cases by the general type of service by type of review requested. Expedited cases fell into only three of the general services type categories: *Pharmacy*, *Skilled Nursing Facility*, and *Surgical Services*. Standard cases involved all general service category types.

Table 3: Outcomes of all Requests by General Service Type and Review Type in 2008

Service Type	Standard Review		Expedited Review	
	Overtured/ Reversed	Upheld	Overtured/ Reversed	Upheld
DME	2	8	0	0
Emergency Treatment	0	1	0	0
Hospital Length of Stay	1	0	0	0
Inpatient Mental Health	4	6	0	0
Lab, Imaging, Testing	6	13	0	0
Oncology	0	1	0	0
Outpatient Mental Health	1	0	0	0
Pharmacy	7	10	0	2
Physician Services	2	2	0	0
Skilled Nursing Facility	1	1	1	0
Surgical Services	9	8	1	2
Percentage of Case Volume	93.3%		6.7%	

Health Plan Oversight

The External Review law places several requirements on health plans. Health plans are required to provide notice of external review rights to covered persons in their noncertification decisions and notices of decision on appeals and grievances. Health plans are also required to include a description of external review rights and external review process in their certificate of coverage or policy language. When the HCR Program receives a request for external review, the health plan is required to provide requested information to the Program within statutory time frames, so that an eligibility determination can be made. When a case is accepted for review, the health plan 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 health plan 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 health plan must provide notification that payment or coverage will be provided. This notice must be sent to the covered person and their provider, as well as the Program, and is required to be sent within three business days in the case of a standard review decision and one calendar day in the case of an expedited review decision. The Program then monitors the payment status of the claims.

Additionally, the HCR Program acts as the liaison between health plans and IROs for invoicing and payment of IRO services. As set forth in N. C. Gen. Stat. § 58-50-92, the health plan whose denial decision is the subject of the review provides payment to the IRO for conducting the external review to the Department. This may include a cancellation fee for work performed by the IRO for a case that was terminated prior to the health plan notifying the organization of the reversal of its own noncertification decision, or when a review is terminated because the health plan failed to provide information to the review organization. As the entity that is contracted with the IROs, it is the responsibility of the Department to insure that IROs are paid in a timely manner for their services. Weekly auditing of health plan compliance with payment for IRO services is conducted by the Program.

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

External Review Activity by Health Plan and Type of Service

To measure the prevalence of external review activity compared to the membership of a health plan, the rate of cases accepted for external review involving any specific health plan would have to be measured against the number of covered members per month. HMOs are required to report "member month" data to the Department on an annual basis. Health plans 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 has been a case rate of less than one case per 100,000 members.

In 2008, cases originating from Blue Cross Blue Shield of North Carolina, the North Carolina State Health Plan Indemnity Plan, and the North Carolina State Health Plan PPO Plan, comprised 61.8 percent of the external review activity. Ten other health plans made up the remaining 38.2 percent of cases. Of these remaining health plans, WellPath Select, Inc. had 10 cases; United Healthcare Insurance Company had seven cases. With 32 cases accepted between the two State Health Plan entities during 2008, the Indemnity and PPO Plans represent the largest number of requests for external review. Blue Cross & Blue Shield of North Carolina, the state's largest health plan, had the second largest number with 23 accepted cases. The percentage share of health plan activity for 2008 is depicted in Figure 5.

Figure 5: Health Plans Share of Accepted External Review Requests in 2008

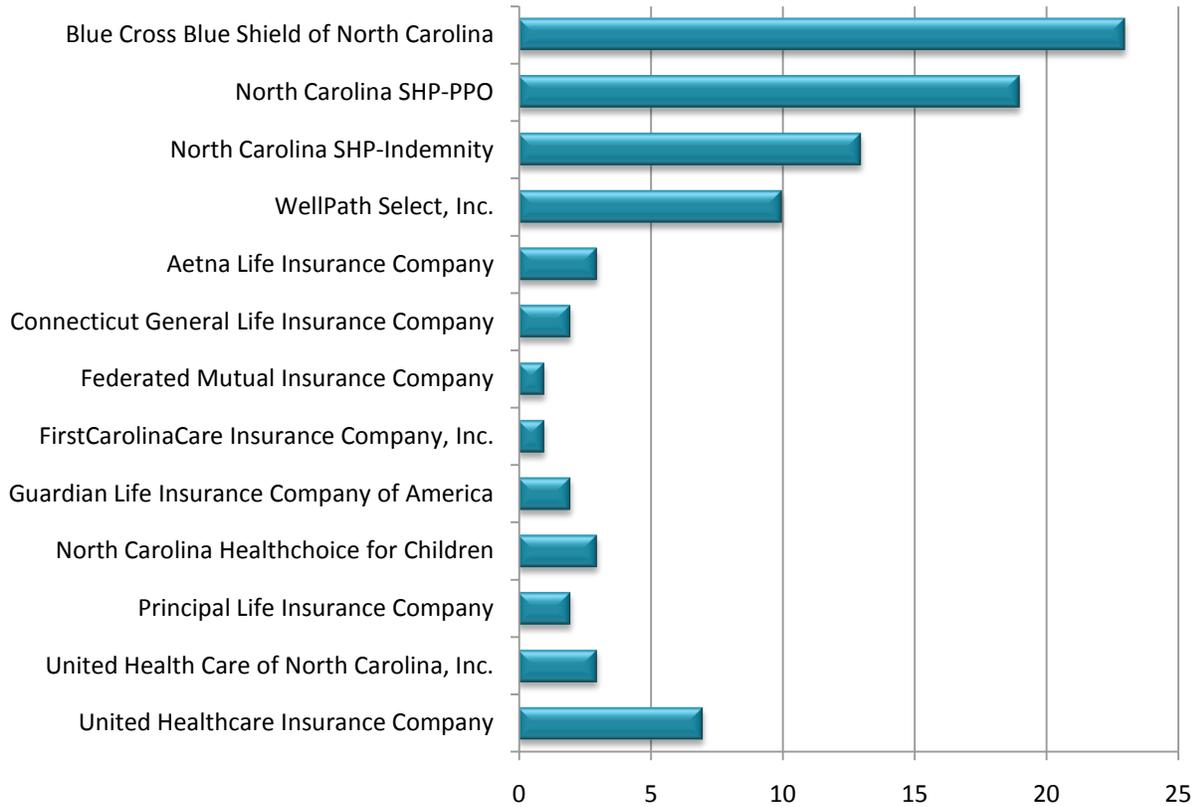


Table 4 demonstrates the outcomes of external review activity by the health plan whose decision is subject to review and the general type of service that the denial involved. This data is presented for informational purposes only. The number of requests per health plan is too small to draw any conclusions or identify trends as it relates to the health plan and the type of service that was denied. For the health plans with larger numbers of requests, outcomes in favor of the consumer for all service types averages 35.8 percent. Blue Cross Blue Shield of North Carolina’s decisions were decided in favor of the consumer by IROs 34.8 percent of the time. The North Carolina SHP Indemnity Plan’s decisions were decided in favor of the consumer by IROs 46.2 percent of the time and the North Carolina SHP PPO Plan was decided in favor of the consumer 26.3 percent of the time. Because an IRO is not involved in the outcome decision when a health plan reverses their own denial, this table only includes those 84 cases that were decided by an IRO.

Table 4: Accepted Case Activity by Health Plan and Type of Service Requested in 2008

Health Plan and Type of Service	Number of Requests	Percentage Overturned	Percentage Upheld
Aetna Life Insurance Company	3		
• Inpatient Mental Health	1	100.0	--
• Pharmacy	1	100.0	--
• Surgical Services	1	--	100.0
Total Percentage for Health plan		66.7	33.3
Blue Cross Blue Shield of North Carolina	22		
• Durable Medical Equipment	4	25.0	75.00
• Inpatient Mental Health	3	66.7	33.3
• Lab, Imaging, Testing	4	25.0	75.0
• Pharmacy	2	--	100.0
• Physician Services	1	100.0	--
• Skilled Nursing Facility	1	100.0	--
• Surgical Services	7	28.6	71.4
Total Percentage for Health plan		36.4	63.6
Connecticut General Life Insurance Company	2		
• Hospital Length of Stay	1	100.0	--
• Surgical Services	1	100.0	--
Total Percentage for Health plan		100.0	--
Federated Mutual Insurance Company	1		
• Lab, Imaging, Testing	1	--	100.0
Total Percentage for Health plan		--	100.0
FirstCarolinaCare Insurance Company	1		
• Pharmacy	1	--	100.0
Total Percentage for Health plan		--	100.0
Guardian Life Insurance Company of America	2		
• Inpatient Mental Health	1	--	100.0
• Physician Services	1	--	100.0
Total Percentage for Health plan		--	100.0
NC Healthchoice for Children	3		
• Durable Medical Equipment	2	--	100.0
• Pharmacy	1	100.0	--
Total Percentage for Health plan		33.3	66.7
North Carolina SHP-Indemnity	13		
• Durable Medical Equipment	3	33.3	66.7
• Lab, Imaging, Testing	4	50.0	50.0
• Pharmacy	2	50.0	50.0
• Physician Services	2	50.0	50.0
• Skilled Nursing Facility	1	--	100.0
• Surgical Services	1	100.0	--
Total Percentage for Health plan		46.2	53.8

**Table 4: Accepted Case Activity by Health plan and Type of Service Requested in 2008
(Cont.)**

Health plan and Type of Service	Number of Requests	Percentage Overturned	Percentage Upheld
North Carolina SHP-PPO	18		
• Durable Medical Equipment	1	--	100.0
• Inpatient Mental Health	2	--	100.0
• Lab, Imaging, Testing	5	20.0	80.0
• Outpatient Mental Health	1	100.0	--
• Pharmacy	2	--	100.0
• Skilled Nursing Facility	1	100.0	--
• Surgical Services	6	33.3	66.7
Total Percentage for Health plan		27.8	72.2
Principal Life Insurance Company	2		
• Lab, Imaging, Testing	2	100.0	--
Total Percentage for Health plan		100.0	--
United Healthcare Insurance Company	6		
• Lab, Imaging, Testing	1	--	100.0
• Pharmacy	5	40.0	60.0
Total Percentage for Health plan		33.3	66.7
United Health Care of North Carolina, Inc.	3		
• Inpatient Mental Health	1	--	100.0
• Lab, Imaging, Testing	1	--	100.0
• Surgical Services	1	100.0	--
Total Percentage for Health plan		33.3	66.7
WellPath Select, Inc.	8		
• Emergency Treatment	1	--	100.0
• Inpatient Mental Health	1	--	100.0
• Lab, Imaging, Testing	1	--	100.0
• Oncology	1	--	100.0
• Pharmacy	4	25.0	75.0
Total Percentage for Health plan		12.5	87.5

IRO Oversight

The Program currently contracts with three IROs-- Maximus CHDR, Medwork of Wisconsin, Inc, and National Medical Review, Inc. (NMR)-- although two other IROs held contracts with the Program during this reporting period as well. The IROs whose contracts terminated in 2008 are IPRO and Permedion, Inc. All IROs that are contracted with the Program to provide independent external reviews 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 an external review.

IROs are contracted to perform a clinical evaluation of contested health plan 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 health plans 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 a continual 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.

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. The HCR Program audits 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. All decisions have been rendered within the required time frames.

The HCR Program also conducts on-site compliance audits of contracted 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.

External Review Activity by IRO

During 2008, five IROs rendered 84 external review decisions for consumers: IPRO, Maximus CHDR, Medwork or Wisonsin, Inc., NMR, and Permedion, Inc. The contract for IPRO terminated on June 30, 2008 and the contract for Permedion, Inc. terminated on February 22, 2008. Medwork of Wisonsin, Inc. became effective on July 1, 2008. Because the IROs were not all effective for the same 12 month period, the number of cases assigned to each IRO is dissimilar. Although 89 cases were accepted for external review during this period, five cases were reversed by the health plan prior to an IRO decision being rendered, so reporting on IRO activity will

represent only 84 cases. The cases sent to all IROs for independent review in 2008 encompass a variety of health plans, denial reasons and types of services. Table 5 compares the number of cases assigned to each IRO that held a contract with the Program throughout the year, with the percentage of their review decisions for the year 2008. 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 35.7 percent of the time during 2008, which is consistent with outcomes measured in previous years.

Table 5: IRO Activity Summary for 2008

IRO	Number Assigned	Percentage Overturned	Percentage Upheld
I PRO ¹	17	29.4	70.6
Maximus CHDR	31	45.2	54.8
Medwork of Wisconsin, Inc. ²	9	33.3	66.7
NMR, Inc.	26	30.8	69.2
Permedion ³	1	0.0	100.0
Total and Percentage of Outcomes for All Cases	84	35.7	64.3

IRO Decisions by Type of Service Requested and Health Plan

Table 6 breaks down the number of cases involving the general service type that each IRO reviewed for the calendar year 2008. This table only gives an accounting of the cases assigned and does not analyze outcomes by virtue of the type of noncertification issued. This information is presented as informational. The overall number of cases does not allow for trends to be identified or assumptions to be made.

An IRO is assigned a case on the basis of: a) an alphabetical rotation that is required by law, b) the IRO having a qualified clinical expert to review the case, and c) no existing conflict of interest. The nature of the denial has no bearing on the assignment to an IRO.

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¹ I PRO's contract terminated on June 30, 2008.

² Medwork of Wisconsin, Inc. became effective with the HCR Program on July 1, 2008.

³ Permedion's contract terminated on February 22, 2008.

Table 6: Accepted Case Activity by IRO and Type of Service Requested in 2008

IRO and Type of Service	Number of Accepted Cases	Percentage Overturned	Percentage Upheld
IPRO	17		
• DME	3	--	100.0
• Inpatient Mental Health	1	--	100.0
• Lab, Imaging, Testing	4	50.0	50.0
• Pharmacy	6	16.7	83.3
• Physician Services	1	100.0	--
• Skilled Nursing Facility	1	100.0	--
• Surgical Services	1	--	100.0
All Services:		29.4	70.6
Maximus CHDR	31		
• Durable Medical Equipment	5	40.0	60.0
• Hospital Length of Stay	1	100.0	--
• Inpatient Mental Health	4	25.0	75.0
• Lab, Imaging, Testing	6	33.3	66.7
• Pharmacy	6	66.7	33.3
• Skilled Nursing Facility	1	100.0	--
• Surgical Services	8	37.5	62.5
All Services:		45.2	54.8
Medwork of Wisconsin, Inc.	9		
• Lab, Imaging, Testing	1	--	100.0
• Pharmacy	3	33.3	66.7
• Physician Services	1	--	100.0
• Surgical Services	4	50.0	50.0
All Services:		33.3	66.7
NMR	26		
• Durable Medical Equipment	2	--	100.0
• Emergency Treatment	1	--	100.0
• Inpatient Mental Health	4	50.0	50.0
• Lab, Imaging, Testing	8	25.0	75.0
• Oncology	1	--	100.0
• Outpatient Mental Health	1	100.0	--
• Pharmacy	2	--	100.0
• Physician Services	2	50.0	50.0
• Skilled Nursing Facility	1	--	100.0
• Surgical Services	4	50.0	50.0
All Services:		30.8	69.2
Permedion	1		
• Pharmacy	1	--	100.0
All Services:		--	100.0

Table 7 shows each IRO's decision by health plan for the year 2008. The total number of cases for any IRO, and the number of assigned cases by health plan that were reviewed by an IRO is still too small to identify trends or make any evaluative statements.

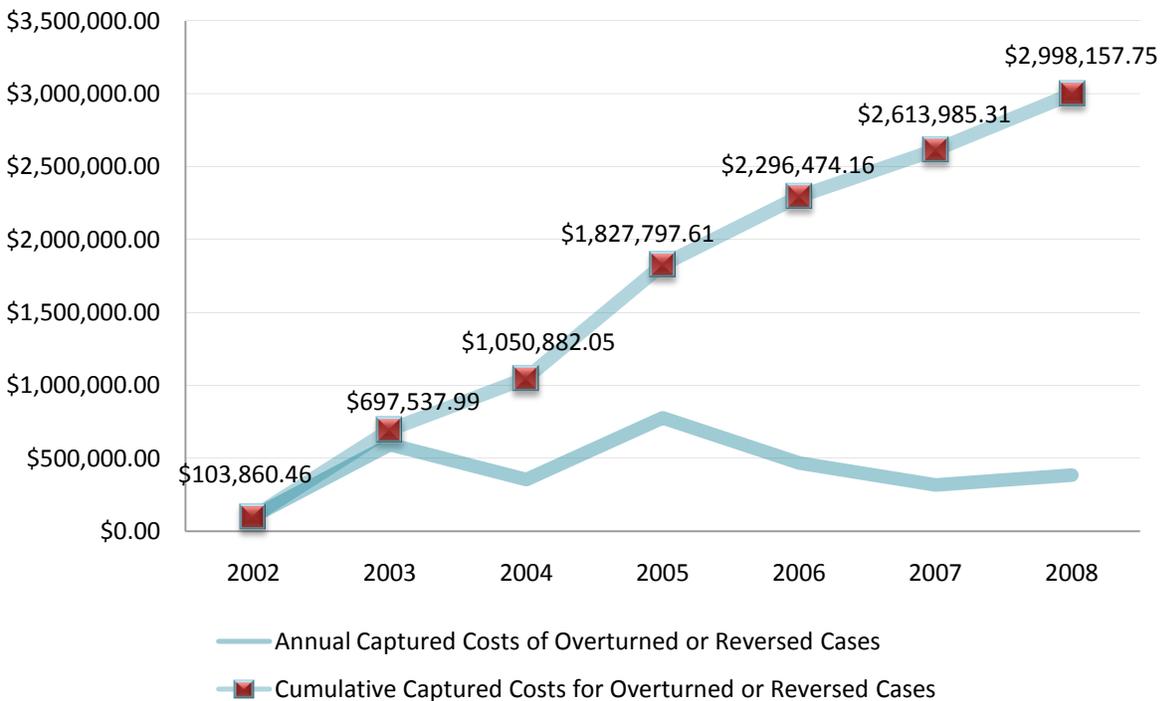
Table 7: IRO Decisions by Health plan in 2008

IRO and Health plan	Number of Decisions	Percentage Overturned	Percentage Upheld
IPRO	17		
• Blue Cross & Blue Shield of North Carolina	4	25.0	75.0
• North Carolina SHP-Indemnity	3	33.3	66.7
• North Carolina SHP-PPO	4	25.0	75.0
• Principal Life Insurance Company	1	100.0	--
• United HealthCare Insurance Company	2	50.0	50.0
• WellPath Select, Inc.	3	--	100.0
All Health plans:		29.4	70.6
Maximus CHDR	31		
• Aetna Life Insurance Company	1	100.0	--
• Blue Cross & Blue Shield of North Carolina	10	40.0	60.0
• Connecticut General Life Insurance Company	1	100.0	--
• NC Healthchoice for Children	2	50.0	50.0
• NC SHP-Indemnity	6	66.7	33.3
• NC SHP-PPO	4	--	100.0
• Principal Life Insurance Company	1	100.0	--
• United HealthCare Insurance Company	1	--	100.0
• UnitedHealthcare of North Carolina, Inc.	3	33.3	66.7
• WellPath Select, Inc.	2	50.0	50.0
All Health plans:		45.2	54.8
Medwork of Wisconsin, Inc.	9		
• Aetna Life Insurance Company	1	--	100.0
• Blue Cross & Blue Shield of North Carolina	1	--	100.0
• Guardian Life Insurance Company of America	1	--	100.0
• NC SHP-PPO	3	66.7	33.3
• United HealthCare Insurance Company	3	33.3	66.7
All Health plans:		33.3	66.7
NMR	26		
• Aetna Life Insurance Company	1	100.0	--
• Blue Cross & Blue Shield of North Carolina	7	42.9	57.1
• Connecticut General Life Insurance Company	1	100.0	--
• Federated Mutual Insurance Company	1	--	100.0
• Guardian Life Insurance Company of America	1	--	100.0
• NC Healthchoice for Children	1	--	100.0
• NC SHP-Indemnity	7	25.0	75.0
• NC SHP-PPO	4	28.6	71.4
• WellPath Select, Inc.	3	--	100.0
All Health plans:		30.8	69.2
Permedion	1		
• FirstCarolinaCare Insurance Company, Inc.	1	--	100.0
All Health plans:		--	100.0

Captured Costs on Overturned or Reversed Services

Figure 6 shows the total 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. In 2008, consumers received \$384,173 worth of services that otherwise would have been denied but for the Program’s assistance. While this amount alone may reflect the value that the HCR Program brings to consumers, the data presented in its cumulative form shows that North Carolina consumers have been provided with nearly \$3 million worth of services since the Program began and demonstrates the ongoing value that the Program provides. This chart is reflective of the concurrent and retrospective costs for services that were denied. It does not account for 10 cases that have been overturned but the services have not yet been provided due to the prospective nature of the services.

Figure 6: Yearly and Cumulative Value of Allowed Charges for Overturned or Reversed 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.

The total cost of allowed charges for all cases reversed by the health plan 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-	\$317,510.65
2008-	\$384,172.94

The average cost of allowed charges per year from all cases that have been reversed by the health plan or overturned by an IRO since the Program began is \$428,308.

Cost of External Review Cases for 2008

Table 8 shows the average cost of the IRO review for the cases that were decided by an IRO and cost of allowed charges for the 31 cases that were reversed by the health plan or overturned (average and cumulative) in 2008, by type of service requested. Four cases that were decided in 2008 do not have captured costs at this time due to the prospective nature of the services.

**Table 8: Cost of IRO Review, Average and Cumulative Allowed Charges
By Type of Service Requested in 2008**

Type of Service	Average Cost of IRO Review	Average Cost of Service	Cumulative Cost of Service
Durable Medical Equipment	\$583.00	\$3,081.16	\$6,162.32
Emergency Services	690.00	0.00	0.00
Hospital Length of Stay	450.00	1,616.52	1,616.52
Inpatient Mental Health	487.00	26,357.58	105,430.33
Lab, Imaging, Testing	579.00	2,650.08	15,900.46
Oncology	690.00	0.00	0.00
Outpatient Mental Health	690.00	302.62	302.62
Pharmacy	659.00	11,200.66	67,203.96
Physician Services	638.00	11,616.99	23,233.97
Skilled Nursing Facility	640.00	5,560.00	11,120.00
Surgical Services	626.00	21,866.11	153,202.76
Total for All Cases	\$605.00	\$12,392.68	\$384,172.94

Currently, contracted fees for IRO services are between \$470 and \$690 for a standard review, and \$800 and \$895 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 health plans for the 84 reviews performed during 2008 was \$605.

An IRO may charge a health plan a cancellation fee if the health plan reverses its own decision after the IRO has proceeded with the review. These charges range from \$150 to \$395 for a standard review and \$205 to \$395 for an expedited review.

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. For cases that were accepted for review in 2008, 89 surveys were sent at the completion of an external review. Only 43.8 percent of consumers or authorized representatives completed the survey and returned it to the HCR Program. Of those cases that were overturned by the IRO, 20 of 30 persons responded (66.7%) and of those cases that were upheld by the IRO, 16 of 54 persons responded (29.6%). In cases where the health plan reversed its own decision, three of five persons responded.

Overall, responders are generally pleased with the customer service they receive after contacting the Healthcare Review 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 (93.8%), would also tell a friend about external review. As shown in Table 9, 97.4 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 9: Consumer Satisfaction Survey Analysis: 2008

Outcome of External Review	Number of Surveys Sent	Number of Surveys Received	Percentage of Respondents	Percentage of Respondents who would “Tell a Friend”
Overtuned	30	20	66.7	100.0
Upheld	54	16	29.6	93.8
Reversed	5	3	60.0	100.0
Total	89	39	43.8	97.4

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/media interviews and articles. In 2008, HCR Program staff conducted onsite educational presentations to skilled nursing facilities. Other HCR Program outreach resources available to consumers include the HCR Program web page, the Program brochure entitled *A Consumer's Guide to External Review* and the Consumer Counseling web page to facilitate ease of use and provide additional information about services available through the Program.

The HCR Program continues to seek out new and different opportunities to promote awareness of external review services through a variety of community outreach and education initiatives. Initiatives are underway to produce a web video to broaden communication to consumers and providers who are seeking assistance with their health plan denials or who want to learn more about external review services. Along with the production of a web video, the HCR Program staff is working with the Department's Public Information Office to develop a Facebook page, which provides another vehicle for consumers to access information and provide comments about the Program.

Beginning in 2007 through 2008, the Department and Healthcare Review Program provided input to members of the National Association of Insurance Commissioner's (NAIC) Regulatory Framework (B) Task Force in the development of the Uniform Health Carrier External Review Model Act. This Model was drafted to achieve a national standard and uniform approach for processing, conducting, and making external review determinations and provides the basis for national uniformity as it relates to the external review process. The Model was adopted by NAIC on June 2, 2008. During the 2009 Legislative Session, the Department proposed technical changes to North Carolina's External Review law based on the adopted Model.

Beginning in late 2008, the HCR Program staff began working with the NAIC's State Based Systems (SBS) team to design and develop an SBS External Review database to accommodate the NAIC Model Law – Uniform Health Carrier External Review Model Act. In developing a module to assist participating SBS states in managing external review cases, SBS chose to use the database of North Carolina's HCR Program as its model for this new service. HCR Program staff are collaborating with the SBS team in developing this product and service which will offer improved efficiencies of SBS states' in workflow, project tracking, reporting, correspondence, and allow for relationships of data.

Conclusion

Since the Program's inception almost seven years ago, consumers and providers on behalf of consumers have accessed the HCR Program seeking information or counseling on utilization review and internal insurer appeal and grievance procedures or external review services. North Carolina's external review law provides consumers with another option for resolving coverage disputes with their health plan using this efficient, cost-effective process.

The Program remains an important resource for North Carolina consumers and has provided measurable value to the lives of North Carolinians. To date, the Program has provided services that have resulted in consumers obtaining over \$3 million worth of services that had been denied by their health plan.

The HCR Program will continue to track external review results and trends. The Department and HCR Program staff will also continue to monitor developments on the state and federal level which could impact patient protections in North Carolina. The Department is committed to assuring that consumers are informed and are able to access the critical protections that North Carolina's external review law provides.