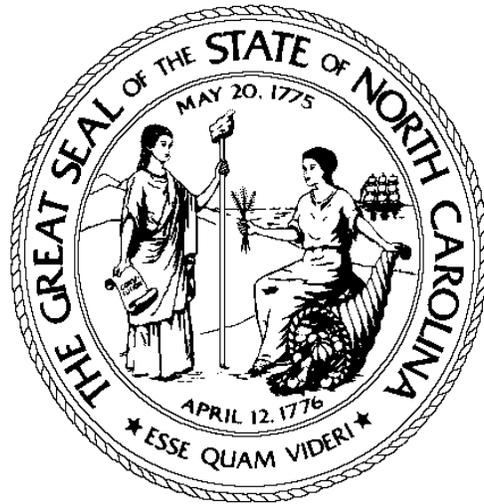


North Carolina Department of Insurance



Healthcare Review Program Semiannual Report

for the period July 1, 2002 - June 30, 2003

James E. Long
Commissioner of Insurance

A REPORT ON EXTERNAL REVIEW REQUESTS IN NORTH CAROLINA

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Executive Summary

The Healthcare Review (HCR) 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 to assure that insureds have the opportunity for an independent medical review of denials made by their health plan.

In North Carolina, external review is available to covered persons when their insurer denies coverage for services on the grounds that they are not medically necessary. This type of denial is referred to as a “noncertification decision”. Denials for cosmetic or experimental services may be eligible for external review, depending on the specific circumstances of a case. The law applies to persons covered under fully insured health benefit plans, the North Carolina Teachers’ and State Employees’ Comprehensive Major Medical Plan, and the Health Insurance Program for Children (CHIP).

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

Once a request is accepted for external review, the case is assigned to an independent review organization (IRO) for clinical review. Assignment of a case is done on an alphabetical rotation. Currently, the Department contracts with five IROs; four IROs are multi-specialty and one is a single-service mental health/substance abuse review organization. Case assignments are screened for conflict of interest between the insurer and IRO. The medical professional(s) assigned to review the case is a clinical expert in the treatment of the covered person’s injury, illness, or medical condition that is the subject of the external review. The IRO issues its determination of the case which is binding on both the insured and covered person, except to the extent that the covered person has remedies under State or Federal law. Insurers may voluntarily reverse their denial at any time following receipt of a request for external review. There is no cost for the person who requested the external review. The HCR Program pays the IRO for its services and the insurer is required to reimburse the Program for the cost of the review.

Once a case is assigned to an IRO, a decision must be rendered within the time frames mandated under North Carolina law. Most standard cases were decided between 36 and 45 days. The average time to decide an expedited case is 2.5 days and average time for a standard review to be decided was 31.17 days. All IRO decisions were issued within the required time frames.

During the HCR Program’s first year of operation, 162 requests for external review were received. For the first six months of the Programs’ operation (July 1, 2002 – December

31, 2002), 56 requests were received. Requests increased by 75 percent, to 103, for the following six month reporting period (January 1, 2003 – June 30, 2003). An analysis of the request type of accepted cases for the first year of operation showed that 5 cases involved decisions that services were cosmetic, 17 cases involved decisions that services were experimental and 43 cases involved medical necessity determinations. Based on the case volume seen in other states' external review programs – which vary in comparability to North Carolina's program, the number of cases is at or above expected levels.

The HCR Program staff determines eligibility of external review requests. During the first year, 162 were received, 12 involved re-submission of a request previously denied because it was incomplete. Therefore, 150 different individuals requested external review. The HCR Program determined that 65 (43%) of these requests were eligible for external review. Requests that were submitted before the insurer's appeal process was exhausted and those cases involving issues other than a medical necessity determination – both of which relate to eligibility, made up the largest percent of those cases not accepted for review.

For the 65 cases accepted for review during the Program's first year of operation, the insurer reversed its noncertification prior to the case being assigned to the IRO in 3 cases (5%), and IRO decisions were issued in the remaining 62 cases. In 29 cases (45%), the IRO overturned the insurer's decision, and in 33 cases (50%), the IRO upheld the insurer's decision. For those cases where the IRO overturns the insurer's denial, or where the insurer reverses itself, the cost of covering the service is reported. The average amount of allowed charges assumed by the insurer when they reversed their own noncertification was \$1,270. For decisions overturned in favor of the consumer, the average amount of allowed charges assumed by the insurer was \$8,106. For the first full year of service, external review resulted in providing applicable coverage for \$226,973 worth of services to consumers. The IRO charges for reviewing cases are per case fees which range from \$300 to \$900, depending on the IRO assigned and whether the review was conducted under a standard or expedited time frame. The average charge for the 62 reviews performed was \$484.

During the period of July 1, 2002 to June 30, 2003, 11 different insurers had a total of 65 cases that were eligible for external review. With 26 requests, the Teachers' and State Employees' Comprehensive Major Medical Plan is the insurer that has experienced the highest number of cases accepted for external review. Blue Cross Blue Shield of North Carolina, the State's largest insurer, had the second-largest number of accepted cases (14) and CIGNA Healthcare of North Carolina had 10 accepted cases. The remaining insurers had a small number of cases. Current data only provides an accounting of the number of cases accepted for review by insurer. Future reports will compare insurers on volume of accepted cases using a rate of cases per member per month.

The HCR Program also provides consumer counseling on utilization review issues and insurers' internal appeal and grievance process. During the period of July 1, 2002 through June 30, 2003, the HCR Program staff received 326 requests for assistance by consumers. Data collected indicates that the majority of calls are received directly from consumers,

rather than through internal referrals from the Consumer Service Division or another division. The volume of requests from consumers has grown steadily over the year.

Finally, the HCR Program continues its efforts to promote consumer awareness of external review services through a comprehensive community outreach and education program. While consumers are notified by their insurer of their right to external review whenever the insurer's decision to deny reimbursement for covered services is based on a medical necessity determination, many consumers still do not avail themselves of this program. The HCR Program staff has participated in health fairs, speaking engagements, outreach to the medical community and expanded web site information and internet access to the HCR Program as part of our strategy to increase consumer awareness of the availability of these services.

I. Introduction

The Department of Insurance (the Department) established the Healthcare Review Program (HCR Program, or Program) to administer North Carolina's External Review Law. The External Review Law (NCGS 58-50-75 through 58-50-95) 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.

This report, which is required under GS 58-50-95, is intended to provide a summary and analysis of the HCR Program's external review activities and consumer contact with the HCR Program. Detailed information is provided about the requests received and, for those cases that were eligible to receive external review, about the nature of the request and the outcome. Data is also provided with respect to the insurers whose decisions were the subject of requests for external review and about the independent review organizations that reviewed accepted cases.

Readers are cautioned that, while the Program has completed one year of operation, the number of requests for review and accepted cases is still a relatively small number. Much of the data in this report is not suitable for identifying trends or drawing general conclusions about specific services, individual services or individual insurers at this time, since the quantity of data is not great. The data is presented for review, both in the name of disclosure and because its validity will grow over time as the number of requests for review and cases accepted for review grow.

II. Background of the Healthcare Review Program

The HCR Program became effective on July 1, 2002, as part of North Carolina's Patients' Bill of Rights legislation. Requests for review are made directly to the Department and screened for eligibility by HCR staff, but the actual medical reviews are conducted by Independent Review Organizations (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, 2 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 2 board-certified physicians to provide on-call case evaluations of expedited external review requests for the State's independent external review program. 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.

Currently, the HCR Program contracts with five IROs. Four of the IROs are multi-specialty and one IRO is a single-service provider for mental health and substance abuse cases. The Program screens all IROs for any potential conflict of interest prior to case assignments.

The Department's initial semiannual report on the HCR Program, which covered the period July 1 through December 31, 2002, provides a more comprehensive discussion and summary of the External Review law. That report can be accessed on the Department's web site, at www.NCDOI.com.

III. Program Activities

A. External Review

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 medical 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 4 days of the request.

B. Oversight of IROs

Requests for external review are made to the HCR Program but the reviews are conducted by IROs that were determined to meet the minimum qualifications set forth in NCGS 58-50-87 and have agreed to the contractual terms and written requirements regarding the procedures for handling a review.

The HCR Program is responsible for monitoring IRO compliance with statutory requirements on an ongoing basis. The HCR Program audits 100% 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. Required reporting of case data is reviewed regularly. Beginning in June, 2003, the HCR Program began an on-site auditing program to determine if each 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. As of the writing of this report, one on-site audit has been completed, and it was determined

that the IRO continued to meet the requirements under NCGS 58-50-87. These monitoring activities are intended to ensure that each IRO satisfies the minimum qualifications and additional requirements established by law or contract.

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 person 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. When a case is decided in favor of the covered person, the insurer must provide notification that payment or coverage will be provided. This notice must be sent to the covered person and their provider and is required to be sent within 3 business days in the case of a standard review decision and 1 calendar day in the case of an expedited review decision. Insurers are required to send a copy of this notice to the HCR Program, as well as to send evidence of payment once the claim is paid.

The Program's experience to date has been that insurers are generally cooperative during the handling of external review cases and are meeting their statutory obligations with respect to deadlines and payment notifications. One problem regarding enforceability for the External Review Law must be noted here – since the Teachers' and State Employees' Comprehensive Major Medical Plan is not subject to regulation by the Department, the HCR Program cannot enforce this law if this health plan chooses not to comply with one or more provisions of the law. There was one instance during this reporting period where the Plan did not comply with the requirement that it abide by the decision of the IRO. See the footnote for Table 3 for an explanation of the specific problem that occurred.

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. Counseling is provided on a referral basis, upon the recommendation of the Department's Consumer Services Division, and is also available to consumers who contact the HCR Program directly. 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, 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 consumers 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 Services

In its first year of operation, the HCR Program has focused on informing and educating consumers and providers of the availability of external review services. Consumers are notified of their right to external review by their insurer when a request for service or coverage is denied as being not medically necessary. Still, consumer outreach and education is necessary to ensure that consumers are fully aware of their rights under the external review law.

In an effort to increase consumer familiarity with the HCR Program, staff have participated in health fairs, made presentations to insurers and providers, and written several articles for publication in trade newsletters in hopes of increasing the public's awareness of external review services. In addition, the HCR Program expanded its web site information to include the availability of consumer counseling services.

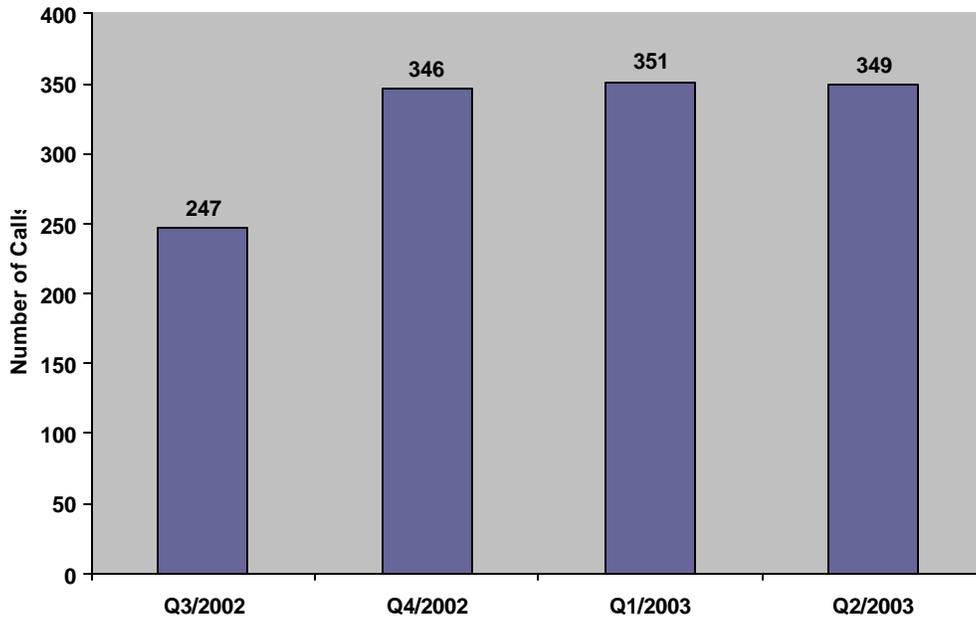
IV. Program Activity Data

A. Consumer Contacts

Consumer Telephone Calls

The HCR Program received 1,293 calls from consumers related to external review and consumer counseling services during the period of July 1, 2002 through June 30, 2003. Figure 1 identifies the number of calls the Program received for each quarter since the Program began on July 1, 2002. Following a roughly 40 percent increase between the first and second quarter of the Program's operation, the number of calls remained constant for each quarter, identifying a steady need for consumer information. Currently, approximately 350 calls are received each quarter.

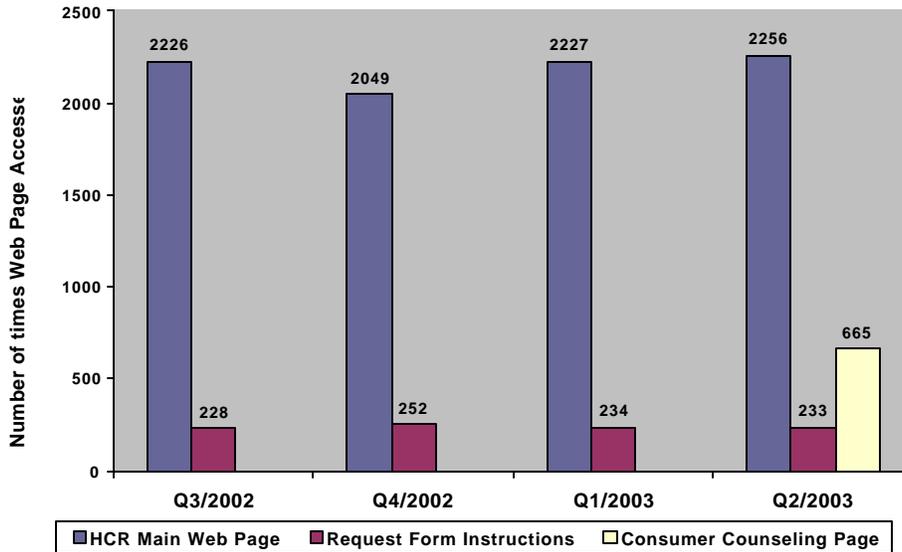
**Figure 1: External Review and Consumer Counseling Calls
Received by the HCR Program
July 1, 2002 – June 30, 2003**



Consumer Web Site Contacts

The data shown in Figure 2 represents the number of consumers who accessed the HCR Program website by each quarter since the Program began its operations. The data revealed that a large number of consumers were accessing this site each month, but a smaller percentage of consumers were accessing the External Review Request Form and its instructions. The wide difference between the number of individuals accessing the main page and the Request Form page appeared to identify that consumers were seeking information. With the addition of a Consumer Counseling web page in May of 2003, the Program saw that the number of individuals accessing the main page remained consistent, however a larger number of individuals accessed the Consumer Counseling web page. Since the data collection began in May 2003, over 300 consumers accessed this site each month.

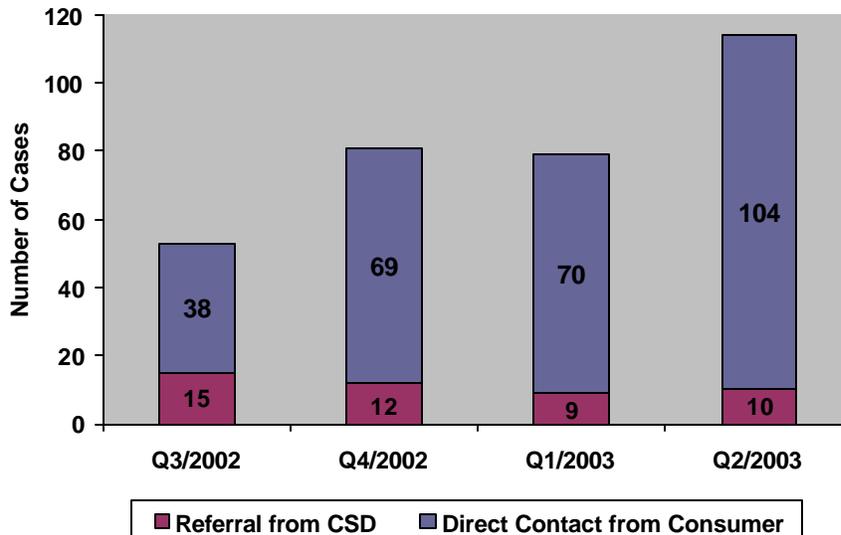
**Figure 2: Frequency of HCR Program Web Site Page Access
July 1, 2002 – June 30, 2003**



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

The HCR Program counseled 341 consumers during the 12-month period ending June 30, 2003. As shown in Figure 3 below, the number of consumers counseled doubled between the first and fourth quarters of the reporting period. The data further shows that, while the number of cases referred from the Consumer Services Division has been constant, the number of self-referrals has increased dramatically.

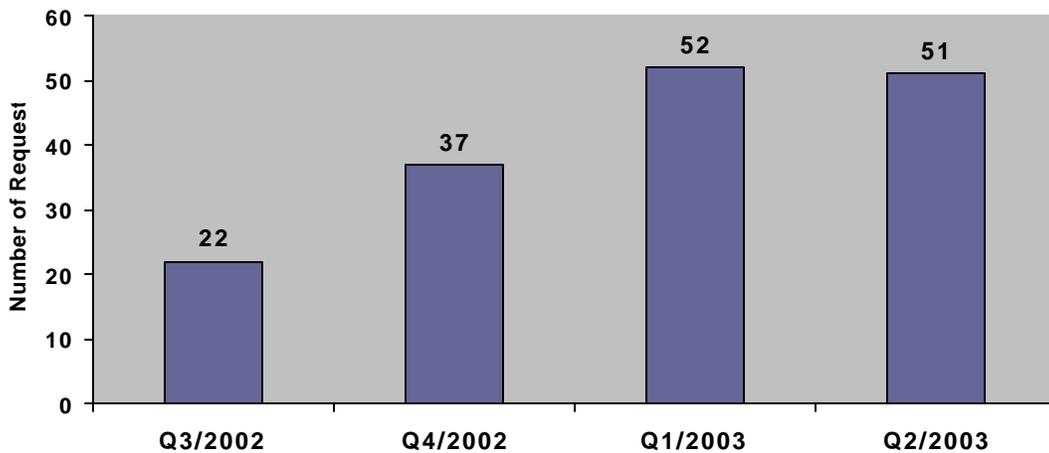
**Figure 3: Consumer Counseling Cases Received by the HCR Program
July 1, 2002 – June 30, 2003**



C. External Review Requests

During its first full year of operation, the HCR Program received 162 requests for external review. Figure 4 shows the volume of requests by quarter since July 1, 2002. During the first six months of activity, the Program received 59 requests. Requests increased by 75 percent, to 103, for the next six months. The HCR Program anticipates continued growth with a steady increase in the number of requests for review received, given the increased volume in the second half-year reporting period and current and planned outreach activities. Based on the case volume seen in other states' external review programs—which vary in comparability to North Carolina's program, the number of cases is at or above expected levels.

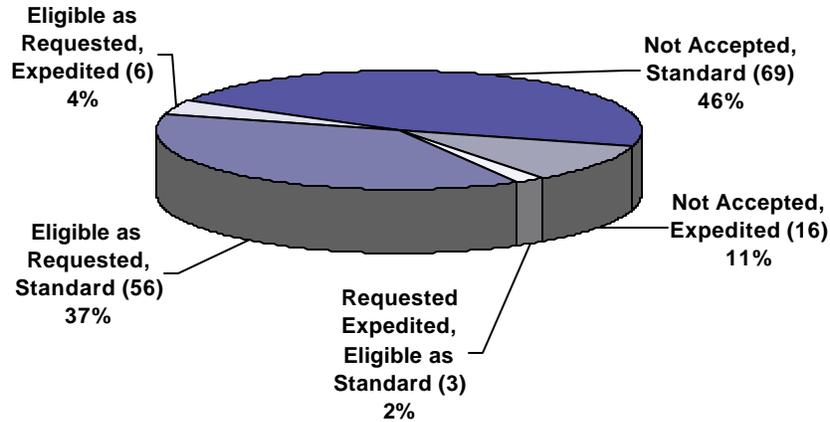
**Figure 4: External Review Requests Received by the HCR Program
July 1, 2003 – June 30, 2003**



D. Eligibility Determinations on Requests for External Review

Of the 162 requests received in the first full year of operation, 12 involved re-submission of a request previously denied because it was incomplete. Therefore, 150 different individuals requested external review. The HCR Program determined that 65 (43%) of these requests were eligible for external review. Fifty-nine cases were accepted to be reviewed on a standard basis, including 3 cases that were requested but were not eligible to be reviewed on an expedited basis. Six cases were requested and accepted on an expedited basis. The information illustrated in Figure 5 shows the disposition of 150 individuals' requests for external review received by the Program.

**Figure 5: Disposition of External Review Requests Received
July 1, 2002 – June 30, 2003**



A large number of requests received by the Program were not accepted for external review. The reason why a case would not be accepted falls into two 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 or those policies whose contract holds a situs 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. Figure 6 shows the share of requests that were accepted, not accepted for eligibility reasons and not accepted for jurisdiction reasons.

**Figure 6: Eligibility Determinations for Requests Received
July 1, 2002 – June 30, 2003**

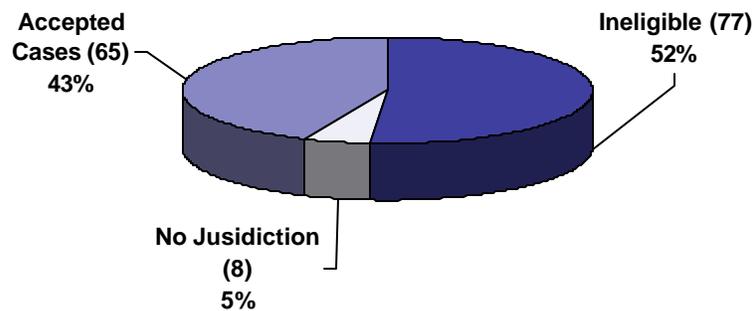


Table 1 shows the numbers of cases, by case type, that were not accepted for review and the reasons for which they were not accepted for review. Requests that were submitted before the insurer’s appeal process was exhausted and those cases involving issues other

than a medical necessity determination, both of which relate to eligibility, made up the largest percent of those cases not accepted for review.

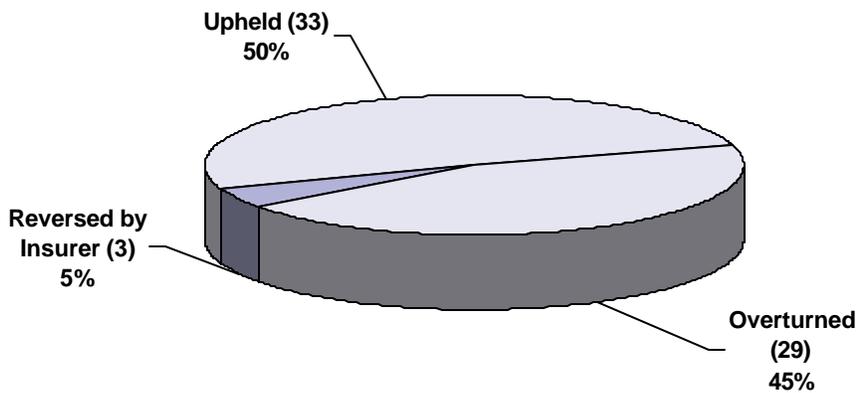
**Table 1: Reasons for Non-Acceptance by Type of Review Requested
July 1, 2002 – June 30, 2003**

Reason for Non-acceptance	Standard Requests	Expedited Requests	All Requests
INELIGIBLE			
Criteria Not Met for Expedited, not Eligible as Standard	0	6	6
Expedited External Request, but Standard Appeal Requested with Insurer	0	2	2
No Medical Necessity Determination	18	2	20
No Denial	0	1	1
Request Withdrawn	0	2	2
Retrospective Services on Expedited Request, not Eligible as Standard	0	1	1
Service Excluded	9	2	11
Denial Decision Pre-Dates Law	3	0	3
Ineligible for Coverage	1	0	1
Past 60 Day Request Time Frame	3	0	3
Insurer Appeal Process not Exhausted	18	0	18
Insurance Type not Eligible for External Review	2	0	2
Request is Incomplete, no resubmission of request	7	0	7
TOTAL INELIGIBLE	61	16	77
NO JURISDICTION			
Contract Situs not in NC	3	0	3
Self-Funded	5	0	5
TOTAL NO JURISDICTION	8	0	8
TOTAL REQUESTS NOT ACCEPTED	69	16	85

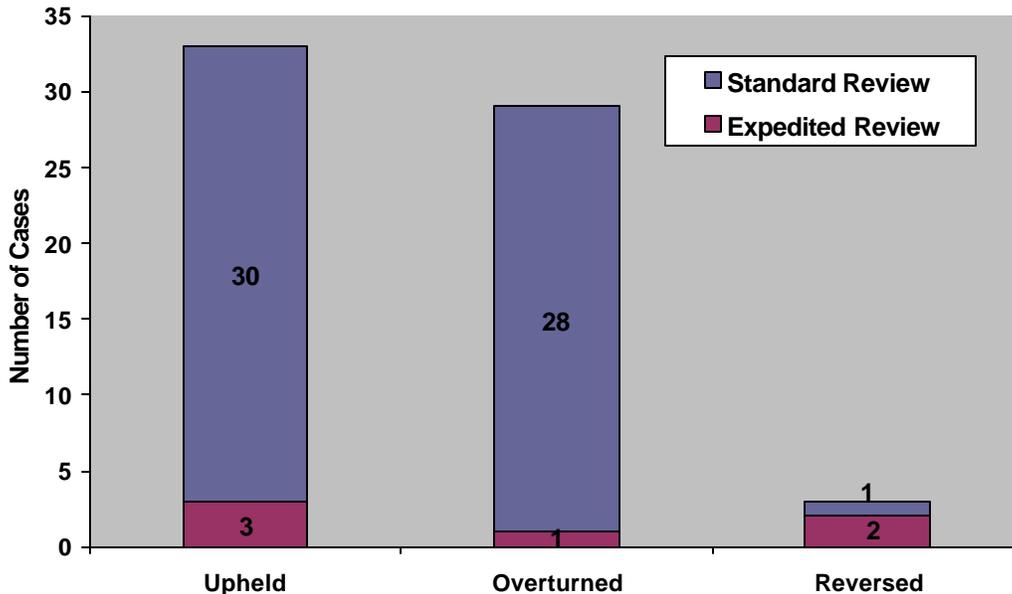
E. Outcomes of Accepted Cases

Figure 7 shows the outcomes of all external reviews performed between July 1, 2002, and June 30, 2003. Of the 65 cases that were accepted for review, approximately one-half were decided in favor of the consumer, due either to the insurer reversing its own denial or the IRO overturning the insurer's noncertification. In each of the 3 cases that were reversed by the insurer, the insurer made that decision prior to the case being assigned to an IRO. Figure 8 shows these outcomes by the type of review granted. This data is consistent with the outcomes for the first six-month reporting period.

**Figure 7: Outcomes of Accepted Cases
July 1, 2002 – June 30, 2003**



**Figure 8: Outcomes of Accepted Cases by Type of Review Requested
July 1, 2002 – June 30, 2003**



Because the number of cases accepted for expedited review is so small, it is not possible to say that a trend exists toward any particular outcome based on the type of review granted. However, since 2 of the 3 reversals that were made involved a case accepted for expedited review, it will be worthy to note over time whether there is a greater likelihood of an insurer reversal when a case is accepted for expedited review.

F. 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 review, the IRO has until the 4th calendar day following the HCR Program’s receipt of the request. The information presented in Table 2 shows the distribution of the actual decision times for all accepted cases. Most standard cases were decided between 36 and 45 days. The average time to decide an expedited case was 2.5 days and average time for a standard review to be decided was 31.17 days. In no case was the mandated deadline for a decision not met. The 1 standard review case that was decided in less than 5 days was a reversal by the insurer, rather than a decision by the IRO; the same is true for the 2 expedited cases that were decided in 0 to 1 day.

**Table 2: Distribution of Number of Days to Reach Review Determinations
July 1, 2002 – June 30, 2003**

Type of Review	Number of Days to Reach Review Determination	Number of Cases
Expedited	0 - 1	2
	2 - 3	2
	4	2
Standard	< 5	1
	5 - 15	2
	16 - 25	15
	26 - 35	17
	36 - 45	24

G. Average Cost of Reviewed Cases

The cost of an external review for a specific case can be comprised of one or two components. All cases incur administrative costs—the fee charged by the IRO to perform the review. For those cases where the IRO overturns the insurer’s denial, or

where the insurer reverses itself, there is also the cost of covering the service. The most consistent measure of coverage cost available is the insurer's allowed charged for 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.

Currently, contracted fees for IRO services are between \$300 and \$850 for a standard review, and \$400 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 reviewed. The average cost to insurers for all reviews performed was \$504.

The average amount of allowed charges assumed by the insurer when they reversed its own noncertification was \$1270. Due to the prospective nature of some of the decisions that were overturned, the cost of the allowed charges has not been reported for two cases. For the remainder of the decisions that were overturned in favor of the consumer, the average amount of allowed charges assumed by the insurer was \$8,106. During the first full year of service, external review resulted in providing \$226,973 worth of services to consumers.

Table 3 shows the average total cost of the IRO review and cost of allowed charges for cases that were reversed by the insurer or overturned by type of service requested. The last column shows the cumulative total of the allowed charges by type of service.

Table 3: Cost of IRO Review, Average and Cumulative Allowed Charges by Type of Service Requested, July 1, 2002 – June 30, 2003

Type of Service Requested	Average Costs for Requests Reversed or Overturned		Cumulative Total Allowed Charges for Overturned or Reversed Service
	Cost of IRO Review	Cost of Allowed Charges	
Durable Medical Equipment*	\$595	\$5,536	\$22,144
Emergency Room Services	450	1,096	1,096
Home Health Nursing	450	11,408	11,408
Hospital Length of Stay	400	33,892	101,675
Lab, Imaging, Testing	300	1,126	1,126
Pharmacy	300	777	1,554
Rehabilitation Services	550	2,537	5,073
Skilled Nursing Facility**	567	4,139	12,417
Surgical Services***	463	6,407	70,480
All Cases	\$484	\$8,106	\$226,973

* Excludes one overturned service where consumer has not obtained DME.

** Includes cases where IRO made a decision to partially overturn the insurer's decision.

*** Excludes one outstanding service and one case where the health plan has not complied with the External Review Law. Insurers are required to abide by the decision of the IRO. In one State Health Plan case for surgical services, the Plan claimed the decision was rendered contrary to the statute and requested a *de novo* review. While the Department maintains that the review and the decision were fully compliant and no *de novo* review was granted, the Department had no authority to compel payment and the service remains unpaid.

V. Activity by Type of Service Requested

The HCR Program recently began to classify requests for review and accepted cases into several major service-type categories, rather than classifying them according to the diagnostic categories that had been used previously. Whereas a listing of diagnostic categories identified the specific health condition that the patient experienced, it was too specific to identify trends or to provide meaningful analysis. As requests were received, the list of diagnostic categories grew to meet the specific condition of the patient, and the diagnostic category did not clearly identify the kind of service that was requested. For this reason, this and all future reports will analyze the activity of the HCR Program by the type of service requested. This information on an industry-wide basis may be of use to insurers, providers, health care researchers and policy makers. Table 4 gives the reader a listing of the types of diagnostic categories that made up the broader type of service category used for reporting.

Table 4: Type of Service and Diagnostic Category

Type of Service and Diagnostic Category		
Durable Medical Equipment	Lab, Imaging Testing	Skilled Nursing Facility
<ul style="list-style-type: none"> • Cranial Banding • Respiratory Airway Clearance • Stair Lift (Orthopedic) 	<ul style="list-style-type: none"> • Sleep Disorder 	<ul style="list-style-type: none"> • Orthopedic • Neurology
Emergency Room Services	Mental Health Services	Surgical Services
<ul style="list-style-type: none"> • Infectious Disease 	<ul style="list-style-type: none"> • Counseling 	<ul style="list-style-type: none"> • Abdominoplasty • Cancer • Gynecology • Mammoplasty • Morbid Obesity • Neurology • Orthopedic/ Musculoskeletal • TMJ • Vein Surgery • Gastroenterology • Skin Disorder • In Utero Surgery
Home Health Nursing	Pharmacy	
<ul style="list-style-type: none"> • Neurology, Private Duty Nursing 	<ul style="list-style-type: none"> • Chelation Therapy • Orthopedic/Musculoskeletal • Infectious Disease • Neurology 	
Hospital Admission	Physician Services	
<ul style="list-style-type: none"> • Mental Health / Substance Abuse 	<ul style="list-style-type: none"> • Orthopedic • Podiatry 	
Hospital Length of Stay	Rehabilitation Services	
<ul style="list-style-type: none"> • Mental Health/Substance Abuse • Gastroenterology 	<ul style="list-style-type: none"> • Physical Therapy • Speech Therapy 	

Figure 9 shows the number of accepted cases by type of service requested. Surgical services were by far the most frequent subject of accepted cases, representing nearly one-half of the 65 accepted cases for review during the reporting period. Durable medical equipment is a distant second in terms of numbers of accepted cases, and all other services represent only a small share of the total accepted cases.

**Figure 9: Accepted Cases by Type of Service Requested
July 1, 2002 – June 30, 2003**

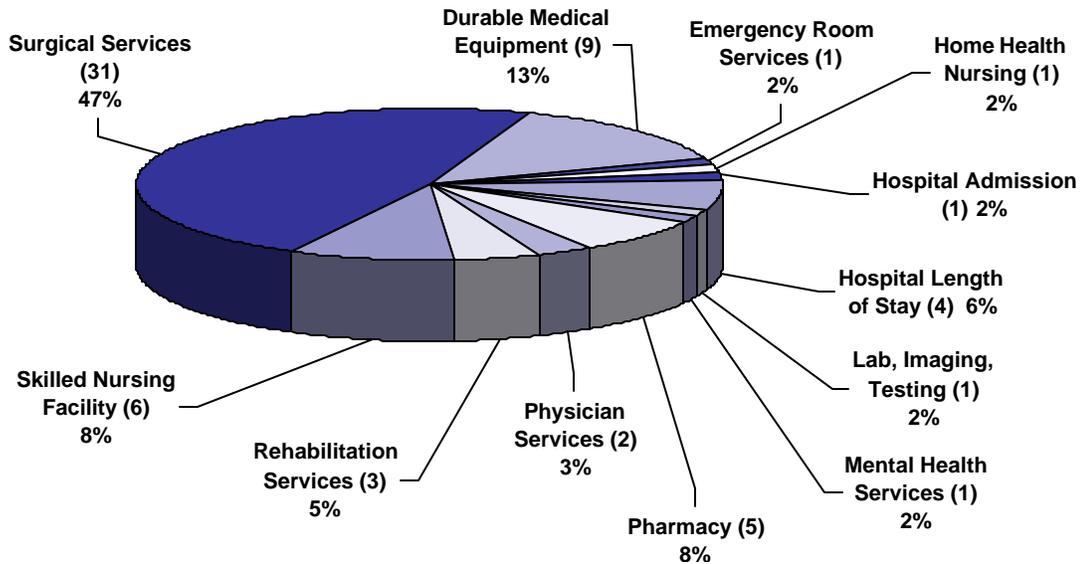


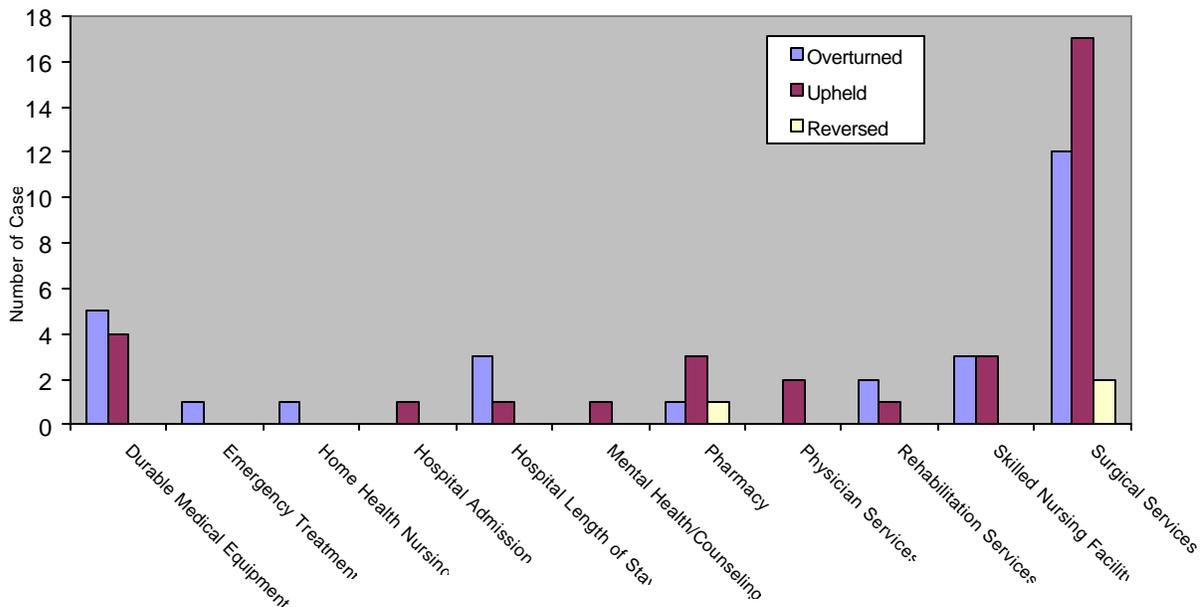
Table 5 shows the *percentage share* that each service type held for all accepted cases as well as for each case outcome (e.g., *Cases involving pharmacy represented 7.7 percent of all accepted cases, but 3.5 percent of cases overturned and 9.1 percent of cases upheld.*) The number of cases is too small to say whether any service has outcomes of one type or another disproportionate to its share of all accepted cases.

**Table 5: Percentage Share of Review Activity by Type of Service Requested
July 1, 2002 – June 30, 2003**

Type of Service	Percent of All Accepted Cases	Outcome of Accepted Cases		
		Percent of All Cases Overturned	Percent of All Cases Reversed	Percent of All Cases Upheld
Durable Medical Equipment	13.9	17.2	--	12.1
Emergency Room Services	1.5	3.5	--	--
Home Health Nursing	1.5	3.5	--	--
Hospital Admission	1.5	--	--	3.0
Hospital Length of Stay	6.2	10.3	--	3.0
Lab, Imaging Testing	1.5	3.5	--	--
Mental Health Services	1.5	--	--	3.0
Pharmacy	7.7	3.5	33.3	9.1
Physician Services	3.1	--	--	6.1
Rehabilitation Services	4.6	6.9	--	3.0
Skilled Nursing Facility	9.2	10.3	--	9.1
Surgical Services	47.7	41.2	66.7	51.5

Figure 10 shows, in graph form, the outcomes of each eligible request by type of service requested by type of review granted. The number of cases per type of service are too small to reliably state what the chances are of any case type being upheld, reversed or overturned.

**Figure 10: Outcomes of Requests by Type of Service Requested by Type of Review Granted
July 1, 2002 – June 30, 2003**



A. Insurer and Type of Service Activity

During the period from July 1, 2002, to June 30, 2003, 11 different insurers had a total of 65 cases that were eligible for external review. Figure 11 shows the distribution of cases among those insurers. With 26 requests, the Teachers' and State Employees' Comprehensive Major Medical Plan is the insurer that has experienced the highest number of cases accepted for external review. Blue Cross Blue Shield of North Carolina, the State's largest insurer, had the second-largest number of accepted cases (14) and CIGNA Healthcare of North Carolina had 10 accepted cases. The remaining 8 insurers each had a small number of cases. *It is important to note that the only basis upon which to compare insurers on volume of accepted cases is using a rate of cases per member per month. Beginning with the next semiannual report on external review activity, which will be for the calendar year 2003, insurer rates of accepted cases will be available. Therefore, the information presented in Figure 11 merely provides an accounting of the cases accepted for review.*

**Figure 11: Insurer's Share of Accepted External Review Requests
July 1, 2002 – June 30, 2003**

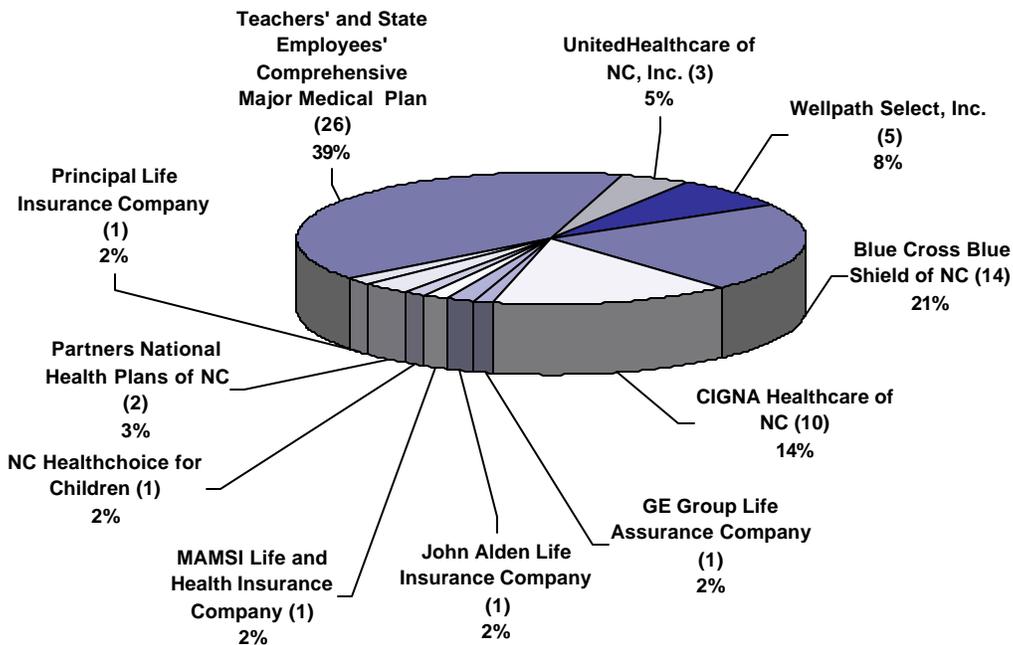


Table 6 contains information about the nature of services that were the subject of each insurer's external review cases and the outcome of these cases. This information is expressed in terms of the numeric and percentage distribution of insurer's cases, by type of service, and the outcomes for each type of service, expressed as a percent of total cases for the type of service. Due to the relatively small number of requests per insurer, it is premature to draw any conclusions about any individual insurer's distribution of cases or case outcomes.

**Table 6: Accepted Case Activity by Insurer and Type of Service Requested
July 1, 2002 – June 30, 2003**

Insurer and Type of Service	Number of Accepted Cases	Percentage of Insurer's Cases	Outcome		
			Percent Overturned	Percent Reversed	Percent Upheld
Blue Cross Blue Shield of NC	14				
• Durable Medical Equipment	6	42.86	50.00	--	50.00
• Surgical Services	7	50.00	42.86	--	57.14
• Hospital Length of Stay	1	7.14	--	--	100.00
CIGNA Healthcare of NC	10				
• Pharmacy	2	20.00	--	50.00	50.00
• Rehabilitation	1	10.00	--	--	100.00
• Surgical Services	4	40.00	75.00	25.00	
• Hospital Length of Stay	1	10.00	100.00	--	--
• Physician Services	2	20.00	--	--	100.00
GE Group Life Assurance Company	1				
• Lab, Imaging, Testing	1	100.00	100.00	--	--
John Alden Life Insurance Company	1				
• Rehabilitation Services	1	100.00	100.00	--	--
MAMSI Life and Health Insurance Company	1				
• Emergency Treatment	1	100.00	100.00	--	--
NC Healthchoice for Children	1				
• Surgical Services	1	100.00	100.00	--	--
Partners National Health Plans of NC	2				
• Durable Medical Equipment	1	50.00	100.00	--	--
• Surgical Services	1	50.00	--	--	100.00
Principal Life Insurance Company	1				
• Pharmacy	1	100.00	--	--	100.00
Teachers' and State Employees' Comprehensive Major Medical Plan	26				
• Durable Medical Equipment	2	7.69	50.00	--	50.00
• Home Health Nursing	1	3.85	100.00	--	--
• Pharmacy	1	3.85	--	--	100.00
• Skilled Nursing Facility	6	23.08	50.00	--	50.00
• Surgical Services	12	46.15	16.67	--	83.33
• Hospital Admission	1	3.85	--	--	100.00
• Hospital Length of Stay	1	3.85	100.00	--	--
• Mental Health/Substance Abuse	1	3.85	--	--	100.00
• Rehabilitation Services	1	19.23	100.00	--	--
UnitedHealthcare of NC, Inc.	3				
• Hospital Length of Stay	1	33.33	100.00	--	--
• Pharmacy	1	33.33	100.00	--	--
• Surgical Services	1	33.33	100.00	--	--
Wellpath Select, Inc.	5				
• Surgical Services	5	100.00	40.00	20.00	40.00

VI. Activity by IRO

A. Summary by IRO

During the period of July 1, 2002 through June 30, 2003, 62 cases were assigned to an IRO for review. Table 7 shows the number of cases assigned to each IRO, along with the number and percentages of types of review decisions for each IRO. This data does not include those requests that the insurer reversed its own noncertification prior to the IRO assignment. One IRO (a single-service provider for mental health and substance abuse services) was not assigned any cases during the past twelve months. 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 peer reviewer.

Table 7: IRO Activity Summary

IRO	Number Assigned	Upheld		Overturned	
		Number	Percent	Number	Percent
Carolina Center for Clinical Information	6	0	--	6	100.00
Hayes, Plus	19	16	84.21	3	15.79
IPRO	19	9	46.35	10	52.63
Maximus CHDR	18	8	44.44	10	55.56
Prest & Associates	0	0	--	0	--
All Cases	62	33	53.23	29	46.77

B. Decisions by Type of Service Requested and Insurer

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

Table 8 presents case outcomes by type of service for each IRO. Due to the small number of reviews conducted by each IRO, the data should not be used at this time to draw any conclusions about any IRO's tendency to decide one way or another on a case involving a particular type of service.

**Table 8: IRO Decisions by Type of Service Requested
July 1, 2002 – June 30, 2003**

IRO and Type of Service	Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld
Carolina Center for Clinical Information	6		
• Hospital Length of Stay	1	100.00	--
• Lab, Imaging, Testing	1	100.00	--
• Pharmacy	1	100.00	--
• Surgical Services	3	100.00	--
Hayes, Plus	19		
• Durable Medical Equipment	5	20.00	80.00
• Hospital Admission	1	--	100.00
• Mental Health/Substance Abuse	1	--	100.00
• Pharmacy	1	--	100.00
• Rehabilitation Services	3	33.33	66.66
• Surgical Services	8	12.50	87.50
IPRO	19		
• Durable Medical Equipment	4	100.00	--
• Pharmacy	1	--	100.00
• Rehabilitation Services	2	50.00	50.00
• Skilled Nursing Facility	2	100.00	--
• Surgical Services	10	30.00	70.00
Maximus, CHDR	18		
• Emergency Service	1	100.00	--
• Home Health Nursing	1	100.00	--
• Hospital Length of Stay	2	100.00	--
• Pharmacy	1	--	100.00
• Physician Services	2	--	100.00
• Rehabilitation Services	1	--	100.00
• Skilled Nursing Facility	1	100.00	--
• Surgical Services	9	55.56	44.44

Table 9 shows each IRO's decisions by individual insurer and then for all insurers. The data after the full year remains insufficient to draw any conclusions relating to any IRO's treatment of any individual insurer.

**Table 9: IRO Decisions by Insurer
July 1, 2002 – June 30, 2003**

IRO and Insurer	Number of Decisions	Percent Overturned	Percent Upheld
Carolina Center for Clinical Information			
• GE Group Life Assurance Company	1	100.00	--
• UnitedHealthcare of NC, Inc.	3	100.00	--
• Wellpath Select, Inc.	2	100.00	--
• All Plans	6	100.00	--
Hayes, Plus			
• Blue Cross Blue Shield of NC	7	28.57	71.43
• Teachers' and State Employees' Comprehensive Major Medical Plan	12	8.33	91.67
• All Plans	19	15.79	84.21
IPRO			
• Blue Cross Blue Shield of NC	6	66.67	33.33
• John Alden Life Insurance Company	1	100.00	--
• NC Healthchoice for Children	1	100.00	--
• Partners National Health Plans of NC, Inc.	1	100.00	--
• Principal Life Insurance Company	1	--	100.00
• Teachers' and State Employees' Comprehensive Major Medical Plan	7	42.86	57.14
• Wellpath Select, Inc.	2	--	100.00
• All Plans	19	52.63	47.37
Maximus CHDR			
• Blue Cross Blue Shield of NC	1	--	100.00
• CIGNA Healthcare of North Carolina, Inc.	8	50.00	50.00
• MAMSI Life and Health Insurance Company	1	100.00	--
• Partners National Health Plans of NC, Inc.	1	100.00	--
• Teachers' and State Employees' Comprehensive Major Medical Plan	7	71.43	28.57
• All Plans	18	55.56	44.44

VII. HCR Program Evaluation

The HCR Program continues to utilize its consumer satisfaction survey with all accepted cases. A survey is mailed to the consumer or authorized representative at the completion of each accepted case. Each of the 65 cases had a survey sent and at the time of this report, 34 consumers had responded.

The outcomes of the cases of the responding consumers were: 18 overturned, 14 upheld and 2 reversed by insurer. Most responders reported satisfaction with the HCR Program staff and information. Of the 14 responders who reported difficulty understanding the reasoning or final decision made by the IRO, 3 reported that they were confused related to the medical terminology used within the notice. The remaining 11 reported that they did not understand the rationale or reasoning behind the decision. As one might assume, the cases decisions for these responders were upheld. What is not surprising is that these responders did not feel that the External Review Program resolved their problem, but what was unexpected was the number of responders who would recommend the External Review Program to their friends. Only 6 of the 34 responders stated they would not recommend the service. This can be construed that although the outcome may not have been what was desired, the process provides value to consumers. The following chart breaks down the responses received.

**Responses to HCR Program Consumer Satisfaction Survey
July 1, 2002 – June 30, 2003**

Question	Answers
<u>HCR Program</u>	
1. Where did you learn about the Independent External Review Program?	Insurer 18
	NCDOI CSD 5
	NCDOI Website 3
	Word of Mouth 2
	Other 6
2. Was the request form easy to use and understand?	Yes 28
	No 3
	N/A 1
	No response 2
3. Was your telephone call answered promptly?	Yes 32
	No 0
	No response 2
4. Was your call handled in a courteous manner?	Yes 32
	No 0
	No response 2
5. Did the Department answer all your questions and help you get the information you were looking for?	Yes 30
	No 2
	No response 2
6. Were you able to reach a staff member during non-business hours?	Yes 4
	No 3
	N/A 26
	No response 1
7. Did the correspondence you received from the Department give you adequate information about the External Review process?	Yes 29
	No 3
	N/A 1
	No response 1
8. Did you receive information from the Department in the time frames you were promised?	Yes 32
	No 0
	No response 2
<u>IRO</u>	
9. Did you receive a decision from the IRO in the time frame you were promised?	Yes 31
	No 1
	No response 2
9. Did you have any difficulty understanding the reasoning and final decision made by the IRO?	Yes 16
	No 18
<u>Problem Resolution</u>	
11. Did the Healthcare Review Program help to resolve your concern?	Yes 21
	No 13
12. Did the Clinical Review Analyst help you understand the eligibility requirements for external review?	Yes 26
	No 4
	N/A 2
	No response 2
13. Would you tell a friend about the External Review Program?	Yes 26
	No 6
	No response 2

VIII. Conclusion

This report focuses on the first year of the implementation of the Department's Healthcare Review Program, providing external review and consumer counseling services. While the quantity of data is still small, and general conclusions cannot be made, nor discernable trends reported, some overall observations can be made based upon the data we have available.

In its first year of operation, the HCR Program received 162 requests for external review. During the first six months of the Program, 59 requests were received. Requests increased by 75 percent, to 103, for the next six-month period. Based on the case volume seen in other states' external review programs – which vary in comparability to North Carolina's program, the number of cases is at or above expected levels. The HCR Program expects continued growth in the volume of requests it receives, in part based on its community outreach initiatives, which inform and educate consumers of their rights under North Carolina's external review law.

Of the 162 requests received, 12 cases involved re-submission of a request previously denied because it was incomplete. Therefore, 150 different individuals requested an external review, and the HCR Program determined that 65 (43%) of the total requests were eligible. Of those cases determined to be not eligible, the reason for non-acceptance most often was either because the consumer submitted a request prior to exhausting the insurer's appeal process or the case involved issues other than a medical necessity determination.

For the 65 cases accepted for review, approximately one-half were decided in favor of the consumer, due either to the insurer reversing its own denial or the IRO overturning the insurer's noncertification. These decisions, overturned in favor of the consumer, resulted in providing \$226,973 worth of services to consumers during the first year of the Program.

The HCR Program contracts with five IROs to provide external review services. All IRO determinations were compliant with notice and time frame requirements as mandated under North Carolina law. In reporting the decision times for all accepted cases, most standard cases were decided between 36 and 45 days. The average time to decide an expedited case was 2.5 days and average time for a standard review was 31.17 days.

During the first year of operation, 62 cases were assigned to four IROs. One IRO, a single-service mental health/substance abuse organization, was not assigned any cases during this period, due to conflict of interest between the IRO and the insurer involved in each case considered for assignment. While the HCR Program has collected data on the number and types of review decisions for each IRO, given the small number of reviews, the data should not be used at this time to draw any conclusions about any IRO's tendency to decide a case one way or another.

Over the last year, the HCR Program has found insurers to be generally cooperative during the handling of external review cases and in meeting their statutory obligations with respect to deadlines and payment notifications. A weakness was found in the External Review Law, in that the Teachers' and State Employees' Comprehensive Major Medical Plan can only be made to comply with the Law if judicial intervention is sought.

In reviewing the number of eligible requests by insurer, the Teachers' and State Employees' Comprehensive Major Medical Plan had the highest number of cases with 26 requests. Blue Cross Blue Shield of North Carolina had the second-largest number of accepted cases (14). Currently, the HCR Program only provides an accounting of accepted cases by insurer. However, in future reports, insurers will be compared on volume of accepted cases using a rate of cases per member per month. Similarly, information about the nature of services that were the subject of each insurer's external review cases and outcomes is reported. However, due to the relatively small number of requests per insurer, it is premature to draw any conclusions about any individual insurer's distribution of cases or case outcomes.

The HCR Program has experienced a steady increase in the number of consumers who contact our office to request information and guidance with their insurer's internal appeals and grievance processes, and/or to request an external review. During the first year, 1,293 calls were received from consumers related to external review and consumer counseling services. After a roughly 40 percent increase between the first and second quarter of the Program's operation, the number of calls has since remained constant for each quarter, identifying a steady need for consumer information. The Program also counseled 341 consumers during this 12-month period, with the number of cases doubling between the first and fourth quarters of the reporting periods. In addition to a steady increase in the number of consumers counseled, the number of consumers contacting the Program directly versus being referred by another area of the Department has increased dramatically.

Information about external review services has been available to consumers on the Department's web site since the Program began. However, the addition of a Consumer Counseling web page in May of 2003 which included email access to the HCR Program staff, was quickly accessed by consumers' seeking assistance. Since data collection began in May, 2003 over 300 consumers have accessed the Consumer Counseling web page each month.

The HCR Program surveys consumers whose cases are accepted for external review. Of the 65 consumers whose cases were accepted, 34 consumers responded. Information collected indicated general satisfaction with the HCR Program staff, information and accessibility. While 14 responders reported difficulty understanding the reasoning or rationale for the final decision made by the IRO, only 6 of the 34 responders stated that they would not recommend the service. While consumers did not always receive the decision they hoped for, most found the process to be valuable.

External review services are an important consumer protection, providing a way for consumers to resolve disputes with their insurer in a fair and efficient manner. This service is available to consumers at no cost. As a result of this Program, consumers have gained access to reimbursement for medically necessary health care services that were previously denied by their insurer.

The HCR Program will continue to collect data about insurers whose decisions are the subject of requests for external review and about independent review organizations that reviewed accepted cases. While current numbers remain relatively small, future data will begin to identify trends and allow for general conclusions about specific clinical services, individual insurers and independent review organizations.