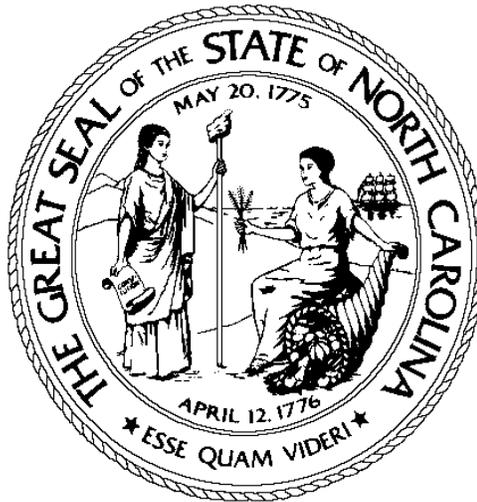


North Carolina Department of Insurance



Healthcare Review Program Semiannual Report

for the period of July 1, 2002 – December 31, 2003

James E. Long
Commissioner of Insurance

A REPORT ON EXTERNAL REVIEW REQUESTS IN NORTH CAROLINA

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Healthcare Review Program Semiannual Reports

Release I July 1, 2002 – December 31, 2002

Release II July 1, 2002 – June 30, 2003

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Executive Summary

North Carolina's External Review law assures consumers the opportunity to request an independent medical review of a health plan denial of coverage, thus offering another option for resolving coverage disputes between a covered person and their insurer. In North Carolina, external review is available to covered persons when their insurer denies coverage for services on the grounds that they are not medically necessary. Denials for cosmetic or investigational / experimental services may be eligible for external review depending on the nature of the case. North Carolina's External Review law applies to persons covered under a fully insured health plan, the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan, (known as State Health Plan), and the Health Insurance Program for Children (known as CHIP). There is no charge to the consumer for requesting an external review.

Since the HCR Program began in July 2002, 279 requests for external review were received and 111 cases accepted. In 3 cases (3%), the insurer reversed its noncertification prior to the case being assigned to an independent review organization (IRO), and IRO decisions were issued in the remaining 108 cases. In 49 cases (44%), the IRO overturned the insurer's decision, and in 59 cases (53%), the IRO upheld the insurer's decision.

In reviewing the external review activity for 2003, 220 requests were received and 90 requests were accepted. In one case (1%), the insurer reversed its noncertification prior to the case being assigned to an IRO, and IRO decisions were issued in the remaining 89 cases. In 40 cases (44%), the IRO overturned the insurer's decision, and in 49 cases (55%), the IRO upheld the insurers decision. An analysis of the request type of accepted cases for 2003 showed that 7 cases (8%) involved decisions that services were cosmetic, 30 cases (33%) involved decisions that services were experimental / investigational, and 53 cases (59%) involved medical necessity determinations.

Of the accepted cases in 2003, IROs overturned 5 of the (72%) cosmetic cases, 10 of the (33%) experimental / investigational cases and 25 of the (47%) medical necessity cases. Accepted cases involving surgical services continues to represent the largest percentage of cases accepted as well as cases overturned. Vein surgery (10 cases) represents the largest number of accepted surgical cases, followed by gastric bypass surgery (9 cases).

External review decisions that were overturned in 2003 resulted in \$478,590 worth of services being provided to consumers. Due to the prospective nature of five cases overturned in 2003, the cost of the allowed charges for these cases has not yet been reported. To date, the cumulative total of services provided to consumers as a result of external review is \$542,377.

A request for external review is made directly to the HCR Program. The HCR Program staff reviews each request for completeness and eligibility. Eligible cases are assigned to a contracted IRO on an alphabetical rotation. The 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. All clinical reviewers assigned by the IRO to conduct external reviews must be medical doctors or other appropriate health care providers who meet the requirements under North Carolina General Statute 58-50-87(b)(1 – 5).

Once a case is assigned to an IRO, a decision must be rendered within the time frames mandated under law. For Standard Requests, decisions by the clinical expert are required to be made within 45 days of receipt of the covered person's request. For an Expedited Request, a decision is made within 4 days of receipt. During 2003, most standard cases were decided between 36 and 45 days, and expedited cases were decided in four days. All IRO decisions issued to date have been within the required time frames.

During the period of January 1, 2003 to December 31, 2003, 18 different insurers, plus the Teachers' and State Employees' Comprehensive Major Medical Plan, had a total of 90 cases that were eligible for external review. With 39 accepted cases, the State Health Plan continues as the health plan 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 (15) and CIGNA Healthcare of North Carolina had 10 accepted cases. The remaining insurers had a small number of cases. Thus, this reporting provides an accounting of the cases accepted for review, but case volume is too small to draw about insurers or how they compare to one another. A comparison of insurers who reported total member months data for 2003 showed most insurers to have less than one case per 100,000 member months. Those insurers whose member months data indicated one case per 100,000 also reported the smallest number of member months.

The HCR Program also provides counseling to consumers who have questions or need assistance with issues involving their insurer's utilization review or internal appeal and grievance process. Consumers receive counseling from a staff of professional nurses who understand the clinical aspects of case. In 2003, the HCR Program received 396 requests for assistance from consumers. The majority of requests are received by phone. The data shows that 93% of the calls are received directly from consumers, rather than through internal referrals from Consumer Service Division or another division. Since July 2002, more than 2000 calls have been received from consumers whose calls have been related to external review or consumer counseling assistance.

During 2003, the HCR Program continued to actively promote consumer and provider awareness of external review services through a comprehensive community outreach and education program. While insurers are statutorily required to notify consumers of their right to external review, many consumers remain unaware of the Program and do not avail themselves of this service. Community outreach and education activities have included participation in health fairs, speaking engagements to consumer, physicians and office practice administrators, hospital administration, TV interviews, and a letter from the Commissioner of Insurance to nearly 16,000 actively practicing physicians in North Carolina which explained the importance of external review services and included a brochure about the Program.

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 NCGS 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 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.

The Program has completed 18 months of operation (July 1, 2002 – December 31, 2003). Readers are cautioned that the number of requests for review and accepted cases still remains a relatively small number for statistical purposes. Therefore the validity of using the data for the purpose of identifying discernable trends or drawing general conclusions about specific services, or insurers still remains limited. The data is presented for review, both in the name of disclosure and because its validity will increase over time as the number of requests for review and cases accepted for review grow.

II. Background of the Healthcare Review Program

The HCR Program became effective 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 external review. 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.

Since July 1, 2002, the HCR Program has contracted with five IROs to provide the clinical review of cases. 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.

In August, 2003, the Department issued a request for proposal, seeking additional IROs to provide independent medical review of health plan coverage denials, in order to reduce reliance on any one IRO and reduce limitations on assignment due to conflict of interest. One IRO, Permedion, responded to the proposal. Pursuant to NCGS 58-50-94, the proposal was reviewed by an Evaluation Committee consisting of eight (8) voting members, representing insurers, health care providers, and insureds. The Committee recommended acceptance of the proposal based on the IRO satisfying the minimum qualifications as set forth by NCGS 58-50-85, NCGS 58-50-87, and NCGS 58-50-94. The Committee's recommendation was accepted, and Permedion became effective as a contract IRO for the Department on January 1, 2004.

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 clinical experts to review each case, issuing a determination as to whether an insurer's denial should be upheld or overturned. Decisions are required to be made within 45 days of the request for a standard review. Cases accepted for expedited review require a decision to be rendered within 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 contractual terms and written requirements regarding the procedures for handling a review.

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

- Accept assignment of cases from a wide variety of insurers without the presence of conflict of interest.
- Identify the relevant clinical issues of the case and the question to be asked of the expert clinical peer reviewer.
- Identify and assign an appropriate expert clinical peer reviewer who is free from conflict and who meets the minimum qualifications of a clinical peer reviewer, to

review the disputed case and render a decision regarding the appropriateness of the denial for the requested treatment of service.

- Issue determinations that are timely and complete, as defined in the statutory requirements for standard and expedited review.
- Notify all required parties of the decision made by the expert clinical reviewer.
- Provide timely and accurate reports to the Commissioner, as requested by the Department.

The HCR Program is responsible for monitoring IRO compliance with statutory requirements on an ongoing basis. 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.

C. Oversight of Insurers (External Review)

The External Review law places several requirements on insurers. Insurers are required to provide notice of external review rights to covered persons in their noncertification decisions and notices of decision on appeals and grievances. Insurers are also required to include a description of external review rights and external review process in their certificate of coverage or summary plan description. When the HCR Program receives a request for external review, the insurer is required to provide certain information to the Program, within statutory time frames, so that an eligibility determination can be made.

When a case is accepted for review, the insurer is required to provide information to the IRO assigned to the case. 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 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.

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 consumer's continuity in those cases where the appeal process does not conclude the matter and an external review is requested.

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

In order for the HCR Program to achieve its maximum effectiveness, it is essential that consumers and their health care providers are aware of their rights under North Carolina's External Review law, and the availability of these services through the Department. The HCR Program has focused on activities to promote awareness that are in addition to the statutorily required notifications by the insurers.

Throughout 2003, the HCR Program activities primarily focused on providing information about the North Carolina's External Review law, and the review process in particular, to consumers and health care providers. Most activities were accomplished through direct personal contact with groups and organizations. When available, the media was used to broadcast the information to a broader geographical audience. This past year, the HCR staff has participated in health fairs, speaking engagements to consumer and physician groups, hospital administrators, and medical group managers, participated in TV interviews, and sent out a letter from the Commissioner of Insurance to nearly 16,000 actively practicing physicians in North Carolina which explained the importance of external review services and included a brochure about the Program.

IV. Program Activity Data

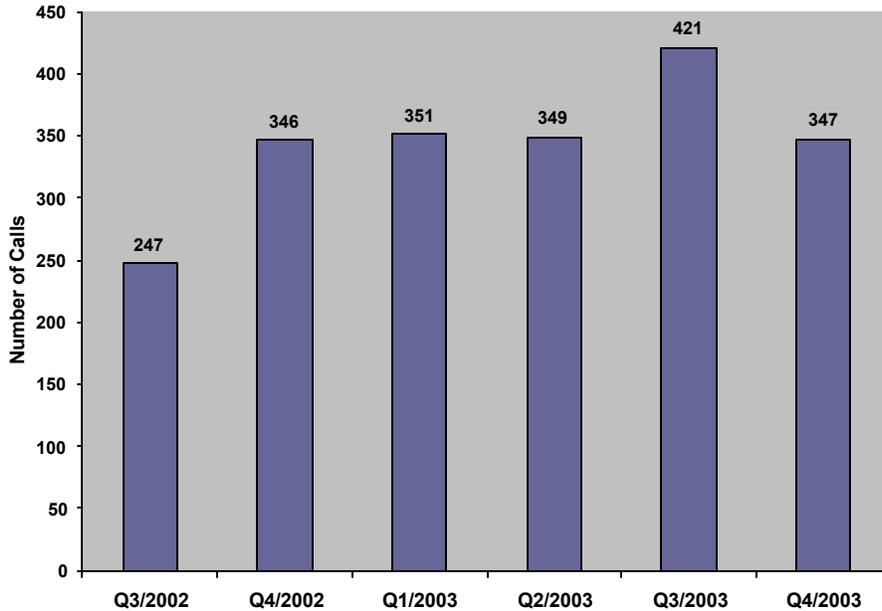
A. Consumer Contacts

Consumer Telephone Calls

The HCR Program received 2,061 calls from consumers related to external review and consumer counseling services during the period of July 1, 2002 through December 31, 2003. Figure 1 identifies the number of calls the Program received for each quarter since the Program began July 1, 2002. During the Programs' start-up period, there was a significant increase in call volume between the first and second quarter. Since that time,

the volume of calls has remained constant, averaging approximately 350 calls received each quarter.

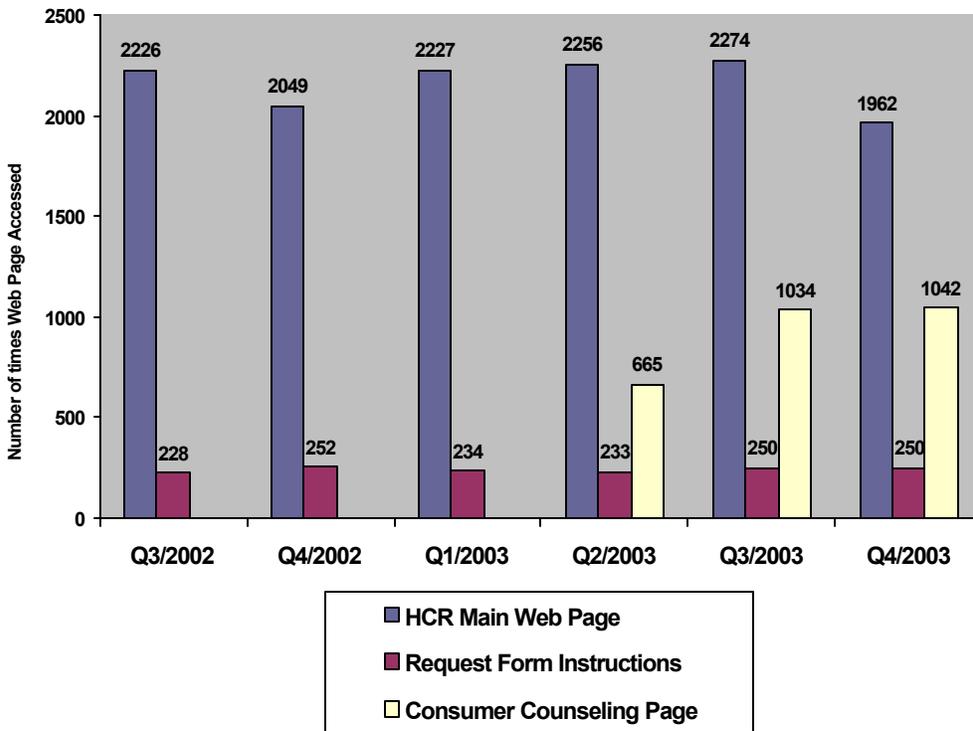
Figure 1: External Review and Consumer Counseling Calls Received by the HCR Program July 1, 2002 – December 31, 2003



Consumer Web Site Contacts

The data shown in Figure 2 represents the number of consumers who accessed the HCR Program website by quarter since the Program began its operation. The data shows that a large number of consumers continue to access this website each month, with a small percentage of consumers accessing the External Review Request Form and its instructions. Most notable is the number of consumers who are accessing the consumer counseling information, which was added to the website in May, 2003. Nearly one-half of consumers who visit the main web page continued on to access information on consumer counseling.

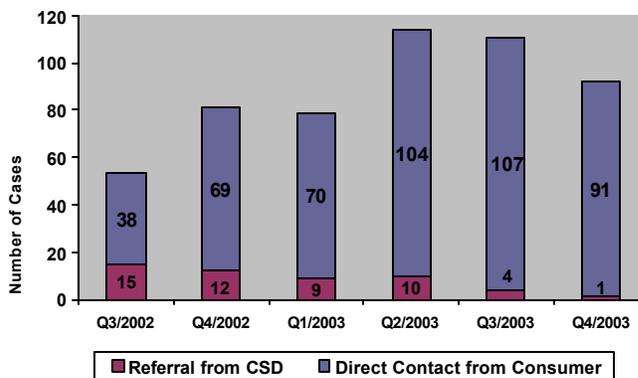
**Figure 2: Frequency of HCR Program Web Site Page Access
July 1, 2002 – December 31, 2003**



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

The HCR Program counseled 544 consumers during the period of July 1, 2002 through December 31, 2003 – 396 of whom were assisted in 2003. After annualizing 2002 data to adjust for the fact that counseling was available for only six months during that year, counseling case volume increased by one-third in 2003. Most consumers contact the HCR Program directly. Figure 3 shows the volume of consumer cases by quarter since July 1, 2002.

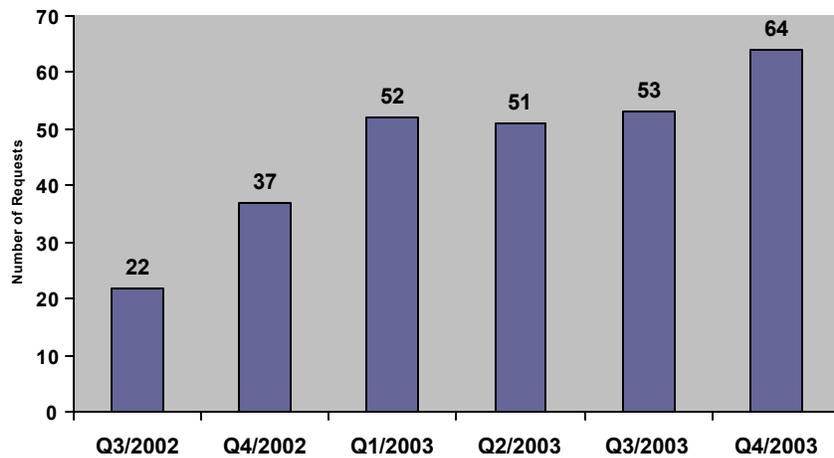
**Figure 3: Consumer Counseling Cases Received by the HCR Program
July 1, 2002 – December 31, 2003**



C. External Review Requests

During the first 18 months of operation, the HCR Program received 279 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. For the last six months (Quarter 3 and 4, 2004), requests increased again, by 14%. The HCR Program expects the volume of requests to continue to increase as public awareness about the Program grows, and consumers seek out information and request external review services when needed.

**Figure 4: External Review Requests Received by the HCR Program
July 1, 2002 – December 31, 2003**

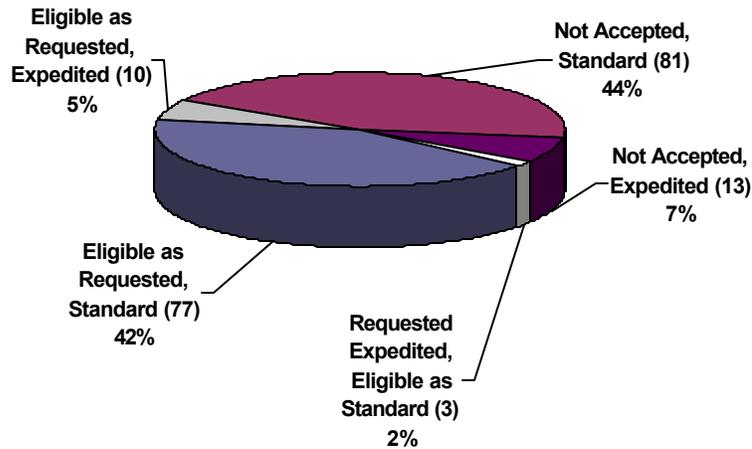


D. Eligibility Determinations on Requests for External Review

Of the 220 requests received during the period of January 1, 2003 – December 31, 2003, 36 involved re-submission of a request previously denied because it was incomplete. Therefore, 184 different individuals requested external review in 2003. The HCR Program determined that 90 (49%) of these requests were eligible for external review in 2003. In comparison, for the reporting period of July 1, 2002 – December 31, 2002, the Program received 59 requests and determined that 21 (36%) requests were eligible for review.

Of the 90 cases determined to be eligible in 2003, 80 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. Ten cases were requested and accepted on an expedited basis. The information illustrated in Figure 5 shows the disposition of 184 individuals' requests for external review by the Program.

**Figure 5: Disposition of External Review Requests Received
January 1, 2003 – December 31, 2003**



Just over one-half 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
January 1, 2003 – December 31, 2003**

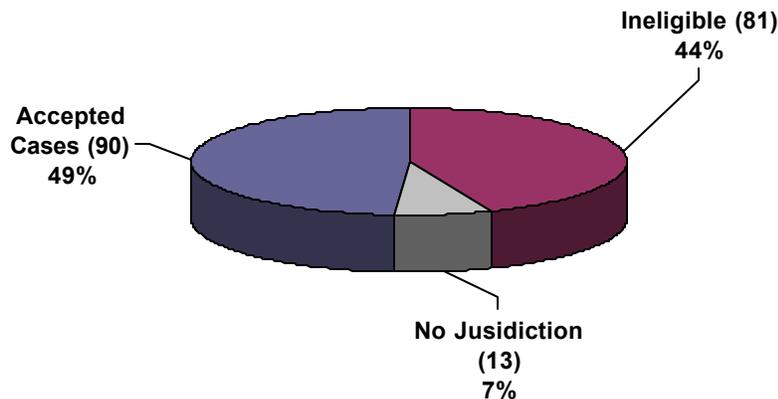


Table 1 shows the numbers of cases, by case type, that were not accepted for review and the reasons for which they were not accepted for review. Requests that were submitted before the insurer's appeal process was exhausted and those cases involving issues other than a medical necessity determination, both of which relate to eligibility, made up the largest percent of those cases not accepted for review.

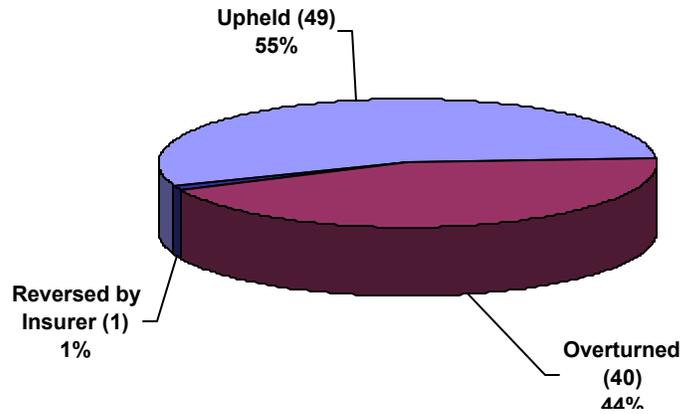
**Table 1: Reasons for Non-Acceptance by Type of Review Requested
January 1, 2003 – December 31, 2003**

Reason for Non-acceptance	Standard Requests	Expedited Requests	All Requests
INELIGIBLE			
Criteria Not Met for Expedited, not Eligible as Standard	0	8	8
No Medical Necessity Determination	16	2	18
Request Withdrawn	0	1	1
Service Excluded	12	2	14
Denial Decision Pre-Dates Law	1	0	1
Past 60 Day Request Time Frame	7	0	7
Insurer Appeal Process not Exhausted	17	0	17
Insurance Type not Eligible for External Review	5	0	5
Request is Incomplete, no resubmission of request	10	0	10
TOTAL INELIGIBLE	68	13	81
NO JURISDICTION			
Contract Situs not in NC	3	0	3
Self-Funded	9	0	9
Medicare HMO	1	0	1
TOTAL NO JURISDICTION	13	0	13
TOTAL REQUESTS NOT ACCEPTED	81	13	94

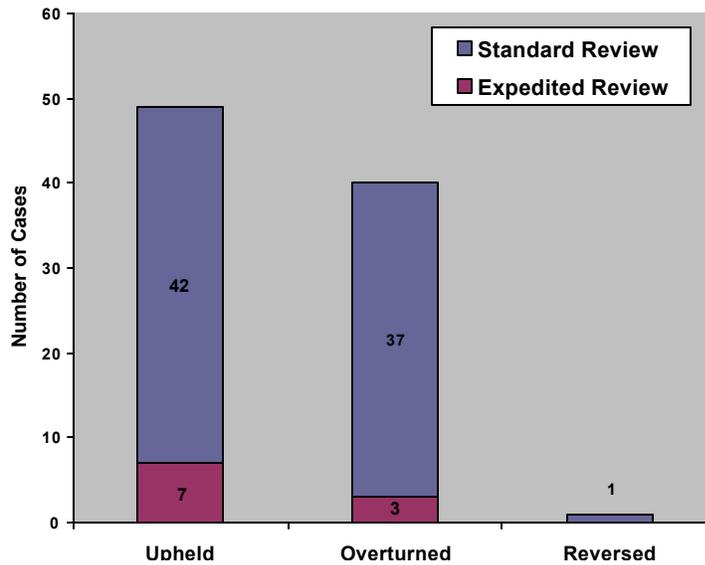
E. Outcomes of Accepted Cases

Figure 7 shows the outcomes of all external reviews performed between January 1, 2003 and December 31, 2003. Of the 90 cases that were accepted for review, almost half (45%) were decided in favor of the consumer, due either to the insurer reversing its own denial prior to IRO assignment, or the IRO overturning the insurer's noncertification. Figure 8 shows these outcomes by the type of review granted. The data remains consistent with the outcomes seen in previous reporting periods.

**Figure 7: Outcomes of Accepted Cases
January 1, 2003 – December 31, 2003**



**Figure 8: Outcomes of Accepted Cases by Type of Review Requested
January 1, 2003 – December 31, 2003**



In the 18 months of the Program’s operation, 111 cases have been accepted for review. The data shows that nearly half (47%) of the cases 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 53% of the cases, the IRO upheld the insurer’s decision.

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 request, 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, with 78% of IRO decisions issued between the 26th and 45th day. 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. For expedited cases, 90% of the cases had a decision issued by an IRO on the 4th day. In no case was the mandated deadline for a decision not met.

**Table 2: Distribution of Number of Days to Reach Review Determinations
January 1, 2003 – December 31, 2003**

Type of Review	Number of Days to Reach Review Determination	Number of Cases
Expedited	0 - 1	0
	2 - 3	1
	4	9
Standard	< 5	1
	5 - 15	1
	16 - 25	15
	26 - 35	25
	36 - 45	38

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 cost – 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 covered. In 2003, the average cost to insurers for all reviews performed was \$510.

In 2003, the amount of allowed charge assumed by the insurer in the single case where the insurer reversed its own noncertification was \$104. The average amount of allowed charges assumed by the insurer for decisions that were overturned in favor of the consumer was \$13,674. As of March 31, 2004, external review decisions that were overturned in 2003 resulted in \$478,590 worth of services being provided to consumers. Due to the prospective nature of five cases overturned in 2003, the cost of the allowed charges for these cases has not yet been reported. **To date, the cumulative total of services provided to consumers as a result of external review since the Program commenced is \$542,377 (not including the five cases for which services have not yet been provided.)**

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 in 2003, 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, January 1, 2003 – December 31, 2003

Type of Service Requested	Average Costs of IRO Review for Requests Upheld	Average Costs for Requests Reversed or Overturned		Cumulative Total Allowed Charges for Overturned or Reversed Service
		Cost of IRO Review	Cost of Allowed Charges	
Durable Medical Equipment*	\$550	\$560	\$2,463	\$12,314
Home Health Nursing	498	0	0	0
Hospital Admission	550	0	0	0
Hospital Length of Stay	795	400	36,696	110,089
Inpatient Rehabilitation	450	0	0	0
Lab, Imaging, Testing	625	438	1,348	2,697
Mental Health/Substance Abuse	525	0	0	0
Oncology*	795	900	*	*
Pharmacy	623	438	986	1,972
Physician Services	425	0	0	0
Rehabilitation Services	0	463	1,876	3,752
Skilled Nursing Facility	475	538	3,876	15,503
Surgical Services*	530	444	9,161	146,577
Transplant	475	625	185,686	185,686
All Cases	\$535	\$481	\$13,674	\$477,289

*Outstanding Cost of Service

V. Activity by Type of Service Requested

The HCR Program classifies accepted cases into service-type categories. Table 4 gives the reader a listing of the types of diagnostic categories, along with the number of accepted cases in that diagnostic category, that made up the broader type of service category used for reporting.

Table 4: Type of Service and Diagnostic Category

Type of General Service and Specific Services Requested		
Durable Medical Equipment	Mental Health Services	Surgical Services
<ul style="list-style-type: none"> • Cranial Banding (4) • Glucose Monitoring (1) • Stair Lift (1) • Portable Hyperbaric Oxygen Chamber (1) 	<ul style="list-style-type: none"> • Psychoanalysis (1) • Residential Treatment Center (3) 	<ul style="list-style-type: none"> • Panniculectomy (3) • Cholecystectomy (1) • Breast Reduction (3) • Gastric Bypass (9) • Hysterectomy (2) • In Utero Surgery (1) • Lumbar Laminectomy (1) • Craniectomy (1) • Electrothermal Arthroscopic Capsulorrhaphy (2) • Osteochondral Autograft Transfer (1) • TMJ (3) • Vein Surgery (10) • Mole Removal (1) • Dermatocholasia (1) • Lipoma (1) • Metal on Metal Resurfacing of Hip (1)
Home Health Nursing	Oncology	
<ul style="list-style-type: none"> • Private Duty Nursing (2) 	<ul style="list-style-type: none"> • SIR-Spheres Therapy (2) • Renal Ablation (1) 	
Hospital Admission	Pharmacy	
<ul style="list-style-type: none"> • Mental Health / Substance Abuse (2) 	<ul style="list-style-type: none"> • Primaxin (1) • Botox (3) • Celebrex (1) 	
Hospital Length of Stay	Physician Services	
<ul style="list-style-type: none"> • Cardiac (1) • Gastroenterology (1) • Mental Health / Substance Abuse (2) 	<ul style="list-style-type: none"> • Chelation Therapy (1) • Extracorporeal Shock Wave Therapy (3) • Chiropractics (1) 	
Inpatient Rehabilitation	Rehabilitation Services	
<ul style="list-style-type: none"> • Orthopedic (1) 	<ul style="list-style-type: none"> • Speech Therapy (2) 	
Lab, Imaging, Testing	Skilled Nursing Services	
<ul style="list-style-type: none"> • PET Scans (1) • Cardiac Arrhythmia Monitoring (1) • Polysomnogram (1) 	<ul style="list-style-type: none"> • Skilled Nursing Facility (9) 	<ul style="list-style-type: none"> • Autologous Stem Cell/Bone Marrow (2)

Figure 9 shows the number of accepted cases by type of service requested. Surgical services continues to be the most frequent subject of accepted cases, representing nearly one-half of the 90 accepted cases for review during the reporting period. Skilled nursing facility services (10%) is a distant second in terms of accepted cases, followed closely by durable medical equipment (8%). All other services represent only a small share of the total accepted cases.

**Figure 9: Accepted Cases by Type of Service Requested
January 1, 2003 – December 31, 2003**

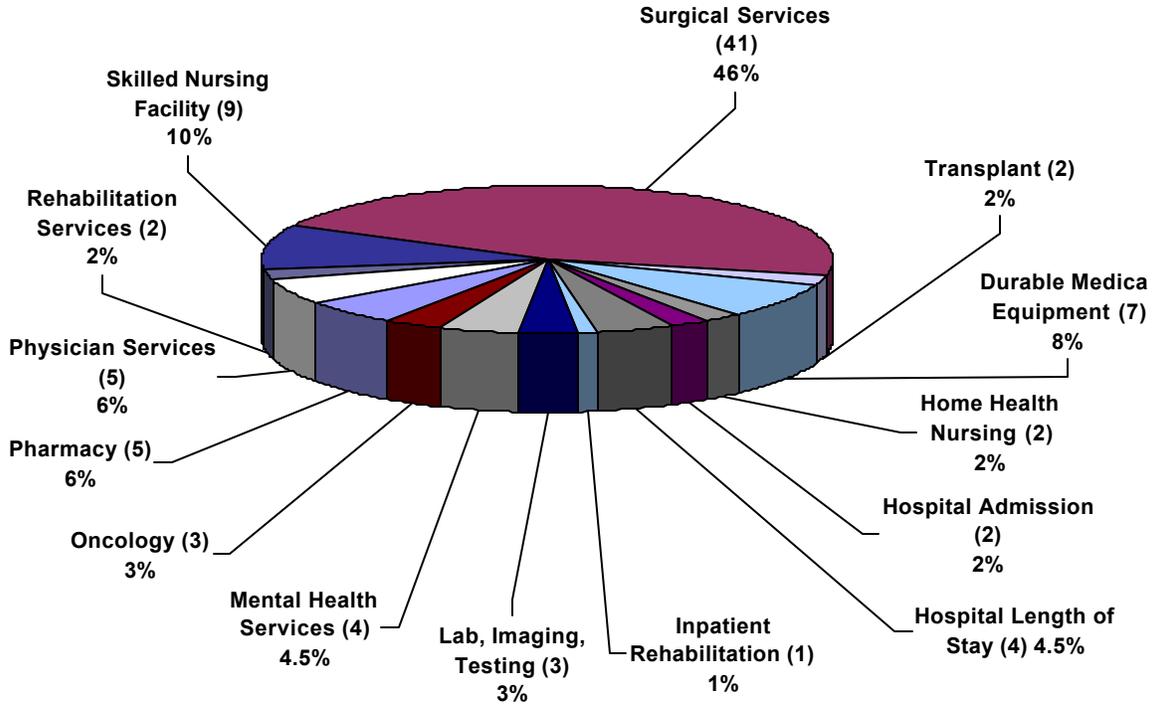


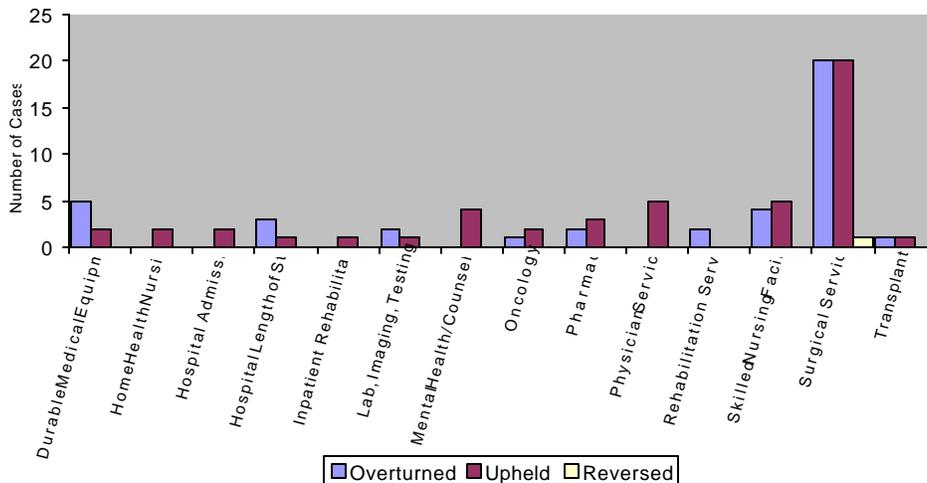
Table 5 shows the percentage share that each service type held for all accepted cases as well as for each case outcome. For surgical cases (the only service with a sizeable number of cases), the share of all cases, share of cases upheld and share of cases overturned are similar. The same is generally true for other service types, but the numbers of cases for each of these is small and therefore not credible for making generalizations about frequency of case outcomes.

**Table 5: Percentage Share of Review Activity by Type of Service Requested
January 1, 2003 – December 31, 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	7.9	12.5	0	4.1
Home Health Nursing	2.3	0	0	4.1
Hospital Admission	2.3	0	0	4.1
Hospital Length of Stay	4.5	7.5	0	2.0
Inpatient Rehabilitation	1.1	0	0	2.0
Lab, Imaging Testing	3.4	5.0	0	2.0
Mental Health Services	4.5	0	0	8.3
Oncology	3.4	2.5	0	4.1
Pharmacy	5.6	5.0	0	6.1
Physician Services	5.6	0	0	10.2
Rehabilitation Services	2.3	5.0	0	0
Skilled Nursing Facility	10.0	10.0	0	10.2
Surgical Services	44.8	50.0	100.0	40.8
Transplant	2.3	2.5	0	2.0
Total	100%	100%	100%	100%

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 for each type of service remains 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
January 1, 2003 – December 31, 2003**



A. Insurer and Type of Service Activity

During the period of January 1, 2003, to December 31, 2003, 18 different insurers plus the State Health Plan had a total of 90 cases that were eligible for external review. Figure 11 shows the distribution of cases among those insurers, providing an accounting of cases accepted for review. With 39 accepted cases, the Teachers' and State Employees' Comprehensive Major Medical Plan is the health plan 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 (15) and CIGNA Healthcare of North Carolina, Inc. had 10 accepted cases.

**Figure 11: Insurer's Share of Accepted External Review Requests
January 1, 2003 – December 31, 2003**

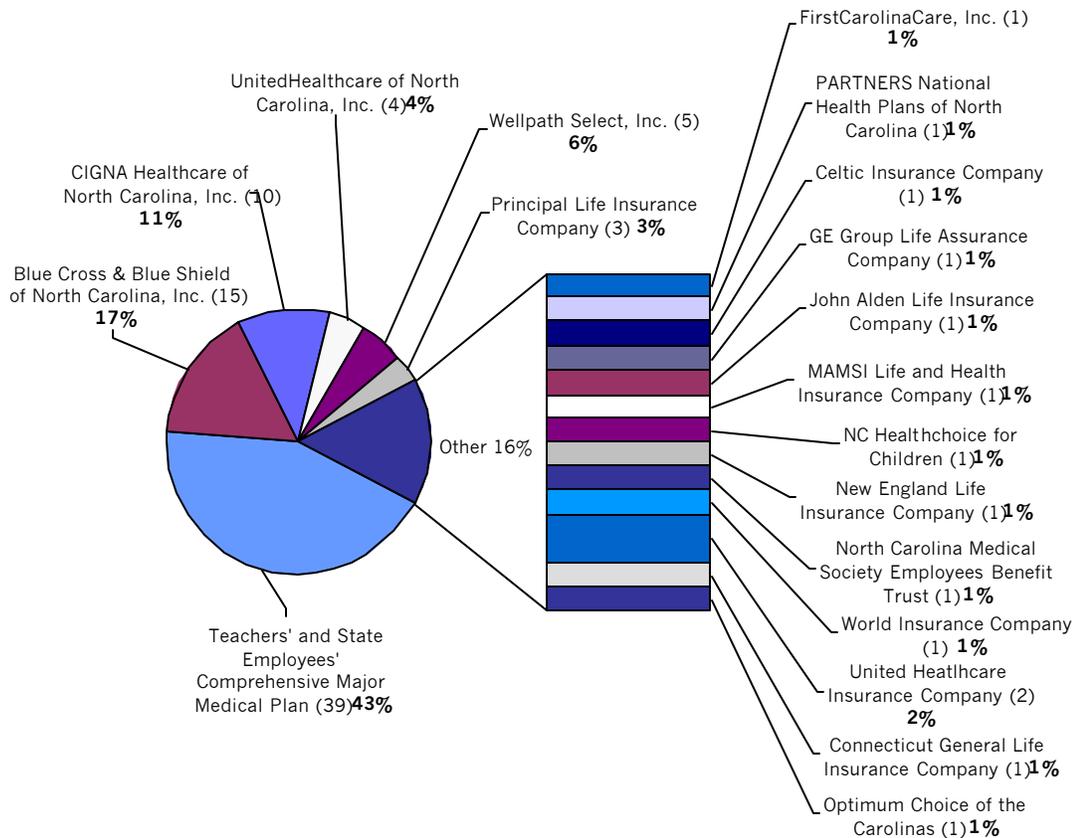


Table 6 compares insurers on volume of accepted cases using a rate of cases per member per month for calendar year 2003, for those companies for which member month data is available. (HMOs annually report member months to the Department. Insurers offering indemnity and PPO plans are not required to report member months, and frequently these companies do not even have this data.) An analysis of member months data by insurer shows that most insurers have a case rate of less than one per 100,000 member months. Those insurers whose case rate is one, also have the smallest number of member months.

Due to the small number of accepted cases for all insurers with accepted cases, it would be premature to make any judgment about insurer performance based on this data.

**Table 6: Accepted Case Activity by Insurer by Member Months
January 1, 2003 – December 31, 2003**

Insurer and Type of Service	Number of Accepted Cases	Number of Member Months	Number of Cases per 100,000 Member Months
Blue Cross Blue Shield of NC (HMO)	6	2,158,617	0.28
Blue Cross Blue Shield of NC (Non-HMO)	9	NR	N/A
CIGNA Healthcare of NC	10	1,573,647	0.64
Celtic Insurance Company	1	NR	N/A
Connecticut General Life Insurance Co.	1	NR	N/A
FirstCarolinaCare, Inc.	1	93,382	1.07
GE Group Life Assurance Company	1	NR	N/A
John Alden Life Insurance Company	1	NR	N/A
MAMSI Life and Health Insurance Company	1	NR	N/A
NC Healthchoice for Children	1	1,243,429	0.08
New England Life Insurance Company	1	NR	N/A
North Carolina Medical Society Employees Benefit Trust (MEWA)	1	NR	N/A
Optimum Choice of the Carolinas	1	172,470	0.58
Partners National Health Plans of NC	1	327,782	0.31
Principal Life Insurance Company	3	NR	N/A
Teachers' and State Employees' Comprehensive Major Medical Plan	39	6,742,967	0.58
UnitedHealthcare of NC, Inc.	4	2,980,756	0.13
United Healthcare Insurance Company	2	NR	N/A
Wellpath Select, Inc.	5	739,089	0.68
World Insurance Company	1	NR	N/A

NR-Not Reported
N/A-Not Applicable

Table 7 reports 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 percentage 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 7: Accepted Case Activity by Insurer and Type of Service Requested
January 1, 2003 – December 31, 2003**

Insurer and Type of Service	Number of Accepted Cases	Insurer's Outcome		
		Insurer's Percent Overturned	Insurer's Percent Reversed	Insurer's Percent Upheld
Blue Cross Blue Shield of NC	15			
• Durable Medical Equipment	2	100.00	--	--
• Home Health Nursing	1	--	--	100.00
• Hospital Length of Stay	1	--	--	100.00
• Inpatient Rehabilitation	1	--	--	100.00
• Physician Services	1	--	--	100.00
• Surgical Services	9	33.33	--	66.67
Total Percentage for Insurer		33.00	--	66.67
CIGNA Healthcare of NC	10			
• Durable Medical Equipment	1	--	--	100.00
• Hospital Length of Stay	1	100.00	--	--
• Oncology	1	100.00	--	--
• Pharmacy	1	--	--	100.00
• Physician Services	2	--	--	100.00
• Surgical Services	4	75.00	25.00	--
Total Percentage for Insurer		50.00	10.00	40.00
Celtic Insurance Company	1			
• Surgical Services	1	100.00	--	--
Total Percentage for Insurer		100.00	--	--
Connecticut General Life Insurance Company	1			
• Pharmacy	1	--	--	100.00
Total Percentage for Insurer		--	--	100.00
FirstCarolinaCare, Inc.	1			
• Surgical Services	1	100.00	--	--
Total Percentage for Insurer		100.00	--	--
GE Group Life Assurance Company	1			
• Lab, Imaging, Testing	1	100.00	--	--
Total Percentage for Insurer		100.00	--	--
John Alden Life Insurance Company	1			
• Physician Services	1	--	--	100.00
Total Percentage for Insurer		--	--	100.00
MAMSI Life and Health Insurance Company	1			
• Mental Health/Substance Abuse	1	--	--	100.00
Total Percentage for Insurer		--	--	100.00
NC Healthchoice for Children	1			
• Pharmacy	1	100.00	--	--
Total Percentage for Insurer		100.00	--	--
New England Life Insurance Company	1			
• Home Health Nursing	1	--	--	100.00
Total Percentage for Insurer		--	--	100.00
North Carolina Medical Society Employees Benefit Trust (MEWA)	1			
• Surgical Services	1	--	--	100.00
Total Percentage for Insurer		--	--	100.00
Optimum Choice of the Carolinas	1			
• Hospital Length of Stay	1	100.00	--	--
Total Percentage for Insurer		100.00	--	--

**Table 7: Accepted Case Activity by Insurer and Type of Service Requested
January 1, 2003 – December 31, 2003**

Insurer and Type of Service	Number of Accepted Cases	Insurer's Outcome		
		Insurer's Percent Overturned	Insurer's Percent Reversed	Insurer's Percent Upheld
Partners National Health Plans of NC	1			
• Durable Medical Equipment	1	100.00	--	--
Total Percentage for Insurer		100.00	--	--
Principal Life Insurance Company	3			
• Mental Health/Substance Abuse	1	--	--	100.00
• Pharmacy	1	--	--	100.00
• Physician Services	1	--	--	100.00
Total Percentage for Insurer		--	--	100.00
Teachers' and State Employees' Comprehensive Major Medical Plan	39			
• Durable Medical Equipment	2	50.00	--	50.00
• Hospital Admission	2	--	--	100.00
• Hospital Length of Stay	1	100.00	--	--
• Lab, Imaging, Testing	1	100.00	--	--
• Mental Health / Substance Abuse	2	--	--	100.00
• Oncology	2	--	--	100.00
• Rehabilitation	2	100.00	--	--
• Skilled Nursing Services	9	44.44	--	55.56
• Surgical Services	16	31.25	--	68.75
• Transplant	2	50.00	--	50.00
Total Percentage for Insurer		38.46	--	61.54
United Healthcare Insurance Company	2			
• Durable Medical Equipment	1	100.00	--	--
• Lab, Imaging, Testing	1	--	--	100.00
Total Percentage for Insurer		50.00	--	50.00
UnitedHealthcare of NC, Inc.	4			
• Pharmacy	1	100.00	--	--
• Surgical Services	3	100.00	--	--
Total Percentage for Insurer		100.00	--	--
Wellpath Select, Inc.	5			
• Surgical Services	5	60.00	--	40.00
Total Percentage for Insurer		60.00	--	40.00
World Insurance Company	1			
• Surgical Services	1	100.00	--	--
Total Percentage for Insurer		100.00	--	--

VI. Activity by IRO

A. Summary by IRO

During the period of January 1, 2003 through December 31, 2003, 89 cases were assigned to an IRO for review. Table 8 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 the one request where an insurer reversed its own noncertification prior to the IRO assignment. All IROs were assigned cases during this reporting period.

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. Although Permedion's contract to perform IRO services for the HCR Program did not become effective until January 1, 2004, the case assigned to them was received on December 31, 2003, and determined to be eligible on January 7, 2004, thereby leaving Permedion eligible for IRO assignment.

**Table 8: IRO Activity Summary
January 1, 2003 – December 31, 2003**

IRO	Number Assigned	Upheld		Overturned	
		Number	Percent	Number	Percent
Carolina Center for Clinical Information	13	3	23.08	10	76.92
Hayes, Plus	25	19	76.00	6	24.00
IPRO	25	14	56.00	11	44.00
Maximus CHDR	24	11	45.83	13	54.17
Permedion	1	1	100.00	0	--
Prest & Associates	1	1	100.00	0	--
All Cases	89	49	55.06	40	44.94

B. Decision by Type of Service Requested and Insurer

The Department believes that public faith in the integrity of the external review process is absolutely essential. It is therefore 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 review 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 9 presents case outcomes by type of service for each IRO. One case that was reversed prior to IRO assignment is not reflected in this information. 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 9: IRO Decisions by Type of Service Requested
January 1, 2003 – December 31, 2003**

IRO and Type of Service	Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld
Carolina Center for Clinical Information	13		
• Home Health Nursing	1	--	100.00
• Hospital Length of Stay	1	100.00	--
• Lab, Imaging, Testing	1	100.00	--
• Mental Health/Substance Abuse	1	--	100.00
• Pharmacy	1	100.00	--
• Physician Services	1	--	100.00
• Surgical Services	7	100.00	--
Hayes, Plus	25		
• Durable Medical Equipment	2	50.00	50.00
• Home Health Nursing	1	--	100.00
• Hospital Admission	1	--	100.00
• Lab, Imaging, Testing	1	100.00	--
• Mental Health/Substance Abuse	2	--	100.00
• Pharmacy	1	100.00	--
• Physician Services	1	--	100.00
• Rehabilitation Services	1	100.00	--
• Skilled Nursing Facility	5	--	100.00
• Surgical Services	9	22.22	77.78
• Transplant	1	--	100.00
IPRO	25		
• Durable Medical Equipment	4	75.00	25.00
• Hospital Admission	1	--	100.00
• Hospital Length of Stay	1	--	100.00
• Lab, Imaging, Testing	1	--	100.00
• Oncology	2	--	100.00
• Pharmacy	2	--	100.00
• Skilled Nursing Facility	2	100.00	--
• Surgical Services	11	45.45	54.55
• Transplant	1	100.00	--
Maximus CHDR	24		
• Durable Medical Equipment	1	100.00	--
• Hospital Length of Stay	2	100.00	--
• Inpatient Rehabilitation	1	--	100.00
• Oncology	1	100.00	--
• Pharmacy	1	--	100.00
• Physician Services	3	--	100.00
• Rehabilitation Services	1	100.00	--
• Skilled Nursing Facility	2	100.00	--
• Surgical Services	12	50.00	50.00
Permedion	1		
• Surgical Services	1	--	100.00
Prest & Associates	1		
• Mental Health/Substance Abuse	1	--	100.00

Table 10 reports the outcomes for the Service Type for all IRO decisions. The data shows that surgical services represents the largest volume of accepted cases by service type, with IROs decisions for this service being evenly split between upheld and overturned cases.

**Table 10: Percentage of IRO Outcomes by General Service Type for all Insurers
January 1, 2003 – December 31, 2003**

Service Type	Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld
Durable Medical Equipment	7	71.43	28.57
Home Health Nursing	2	0.00	100.00
Hospital Admission	2	0.00	100.00
Hospital Length of Stay	4	75.00	25.00
Inpatient Rehabilitation	1	0.00	100.00
Lab, Imaging, Testing	3	66.67	33.33
Mental Health/Substance Abuse	4	0.00	100.00
Oncology	3	33.33	66.67
Pharmacy	5	40.00	60.00
Physician Services	5	0.00	100.00
Rehabilitation Services	2	100.00	0.00
Skilled Nursing	9	44.44	55.56
Surgical Services	40	50.00	50.00
Transplant	2	50.00	50.00

Table 11 shows each IRO's decisions by individual insurer and then for all insurers. The volume of cases reviewed in 2003 remains insufficient to note any discernable trends or draw any conclusions relating to any IRO's treatment of any individual insurer.

**Table 11: IRO Decisions by Insurer
January 1, 2003 – December 31, 2003**

IRO and Insurer	Number of Decisions	Percent Overturned	Percent Upheld
Carolina Center for Clinical Information			
• Celtic Insurance Company	1	100.00	--
• FirstCarolinaCare, Inc.	1	100.00	--
• GE Group Life Assurance Company	1	100.00	--
• Optimum Choice of the Carolinas	1	100.00	--
• New England Life Insurance Company	1	--	100.00
• Principal Life Insurance Company	2	--	100.00
• UnitedHealthcare of NC, Inc.	4	100.00	--
• Wellpath Select, Inc.	2	100.00	--
• All Plans	13	76.92	23.08
Hayes, Plus			
• Blue Cross Blue Shield of NC	5	40.00	60.00
• John Alden Life Insurance Company	1	--	100.00
• NC Healthchoice for Children	1	100.00	--
• North Carolina Medical Society Employees Benefit Trust (MEWA)	1	--	100.00
• Teachers' and State Employees' Comprehensive Major Medical Plan	17	17.65	82.35
• All Plans	25	24.00	76.00
IPRO			
• Blue Cross Blue Shield of NC	5	60.00	40.00
• CIGNA Healthcare of North Carolina, Inc.	2	50.00	50.00
• Connecticut General Life Insurance Company	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	12	41.67	58.33
• United Healthcare Insurance Company	1	--	100.00
• Wellpath Select, Inc.	2	50.00	50.00
• All Plans	25	44.00	56.00
Maximus CHDR			
• Blue Cross Blue Shield of NC	5	--	100.00
• CIGNA Healthcare of North Carolina, Inc.	7	57.14	42.86
• Teachers' and State Employees' Comprehensive Major Medical Plan	9	77.78	22.22
• United Healthcare Insurance Company	1	100.00	--
• Wellpath Select, Inc.	1	--	100.00
• World Insurance Company	1	100.00	--
• All Plans	24	54.17	45.83
Permedion			
• Teachers' and State Employees' Comprehensive Major Medical Plan	1	--	100.00
• All Plans	1	--	100.00
Prest & Associates			
• MAMSI Life and Health Insurance Company	1	--	100.00
• All Plans	1	--	100.00

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. In total, 110 surveys were sent and 63 consumers or authorized representative responded.

The outcomes of the cases of the responding parties were: 34 overturned, 27 upheld and 2 reversed by insurer. Most responders continue to report satisfaction with the HCR Program staff and information about the external review process. Of the 25 (40%) responders who reported difficulty understanding the reasoning and final decision by the IRO, narrative comments in these surveys suggests that the responder did not agree with the outcome, rather than had difficulty understanding the language or content of the determination. While 25 responders (40%) reported that the Healthcare Review Program did not help to resolve their problem, 51 responders (81%) reported that they would tell a friend about the External Review Program.

While not all responders received the decision they hoped for, the data suggests that responders are generally pleased with the services and information provided by the HCR staff, and that external review continues to be valued and an important consumer protection. The following chart breaks down the responses received.

Responses to HCR Program Consumer Satisfaction Survey

Question	Answers
<u>HCR Program</u>	
1. Where did you learn about the Independent External Review Program?	Insurer 31 NCDOI CSD 13 NCDOI Website 6 Word of Mouth 6 Other 7
2. Was the request form easy to use and understand?	Yes 54 No 5 N/A 2 No response 2
3. Was your telephone call answered promptly?	Yes 57 No 0 N/A 5 No response 1
4. Was your call handled in a courteous manner?	Yes 57 No 0 N/A 5 No response 1
5. Did the Department answer all your questions and help you get the information you were looking for?	Yes 54 No 3 N/A 5 No response 1
6. Were you able to reach a staff member during non-business hours?	Yes 13 No 5 N/A 44 No response 1
7. Did the correspondence you received from the Department give you adequate information about the External Review process?	Yes 55 No 5 N/A 0 No response 2
8. Did you receive information from the Department in the time frames you were promised?	Yes 61 No 0 N/A 1 No response 1
<u>IRO</u>	
9. Did you receive a decision from the IRO in the time frame you were promised?	Yes 60 No 1 N/A 1 No response 1
10. Did you have any difficulty understanding the reasoning and final decision made by the IRO?	Yes 25 No 37 N/A 1
<u>Problem Resolution</u>	
11. Did the Healthcare Review Program help to resolve your concern?	Yes 38 No 25
12. Did the Clinical Review Analyst help you understand the eligibility requirements for external review?	Yes 46 No 9 N/A 5 No response 3
13. Would you tell a friend about the External Review Program?	Yes 51 No 8 No response 4

VIII. Conclusion

North Carolina's law governing external review provides its citizens with the right to request an independent medical review of an insurer denial when the insurer's decision to deny reimbursement was based on a medical necessity determination. This law provides consumers with another option for resolving coverage disputes with their insurer using an efficient, cost-effective process.

The HCR Program Semiannual Report presents external review and consumer counseling data which documents the growth of the Program over the last 18 months as well as a reporting of activity and outcomes for calendar year 2003. While the quantity of data is still relatively small, and general conclusions cannot be made nor discernable trends reported, some overall observations can be reported based upon the data we have available.

The HCR Program has shown a sustained level of interest and activity from consumers who request external reviews or need assistance with issues involving their insurer's utilization review or internal appeal and grievance process. The Program's community outreach and education initiatives, designed to heighten consumer and provider awareness of external review services throughout the State, used a variety of media communications to reach North Carolinians. In the 18 months of the Program's operation, external review decisions that were overturned have resulted in \$542,377 worth of services being provided to consumers. Furthermore, consumer satisfaction surveys of the HCR Program and external review process indicate that while not all consumers are successful in winning their case, nearly all consumers are pleased with the services they receive from the HCR Program staff and would recommend the Program to others.

Over the last 18 months, the HCR Program has worked with five contracted IROs. One new IRO was added and became effective January 1, 2004. All IRO determinations were compliant with notice and time frame requirements as mandated under North Carolina law. Cases accepted for standard review were generally decided between 36 and 45 days. Expedited cases were decided in four days. While the HCR Program has collected data on the number and types of review decisions for each IRO, the small number of reviews relating to each type of service does not support using the data at this time to draw any conclusions about any IRO's tendency to decide a case one way or another. What can be noted is that, to date, requests that are of a surgical type reflect the largest percentage of accepted cases, and that the outcome of accepted surgical service cases shows 50% of the decisions upheld and 50 % overturned.

In reviewing the number of eligible requests by insurer for 2003, the Teachers' and State Employees' Comprehensive Major Medical Plan had the highest number of cases, with 39 such cases. Blue Cross Blue Shield of North Carolina had the second-largest number of accepted cases, with 15 such cases. Insurers continue to work with the HCR Program staff in a spirit of cooperation. All insurers who have had insured's request an external

review have provided the required eligibility information within the mandated time frame requirements.

North Carolina's External Review law is an important consumer protection, providing a way for consumers to resolve disputes with their insurer in an efficient and cost effective manner. Prior to the enactment of this law, a consumer receiving a noncertification decision from their insurer could only seek to win their appeal through the insurer's internal appeal and grievance process. Failing to win their appeal, other remedies required legal action. Now, consumers can request an external review and, if determined to be eligible, have their case reviewed by a clinical expert who has no relationship to the insurer. The decision issued by the IRO's clinical expert is binding to the insurer. Should the consumer not win their case through external review, other legal remedies still remain available to the insured. External review services are available to consumers at no charge.

The HCR Program will continue to monitor the external review data collected for discernable trends. While current numbers still remain relatively small, future data will identify trends and allow for general conclusions about specific clinical services, individual insurers and independent review organizations.