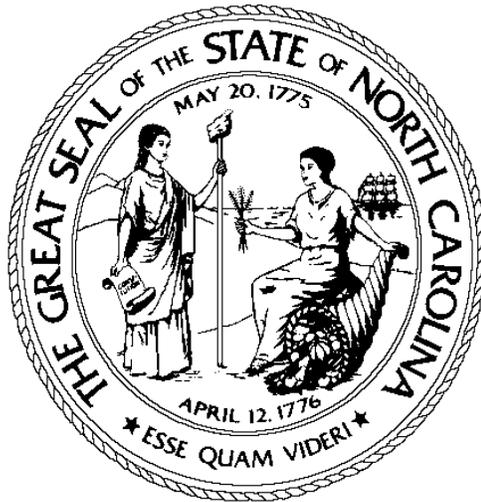


North Carolina Department of Insurance



Healthcare Review Program Semiannual Report

for the period of July 1, 2002 – June 30, 2004

James E. Long
Commissioner of Insurance

A REPORT ON EXTERNAL REVIEW REQUESTS IN NORTH CAROLINA

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Healthcare Review Program Semiannual Reports

Release I	July 1, 2002 – December 31, 2002
Release II	July 1, 2002 – June 30, 2003
Release III	July 1, 2002 – December 31, 2003
Release IV	July 1, 2002 - June 30, 2004

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

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Executive Summary

North Carolina's External Review Program provides 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.

The HCR Program became effective 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. Once a case is screened for eligibility and accepted by the Program, it is assigned to an Independent Review Organization (IRO) for review.

In the Program's first two years of operation (July 1, 2002 – June 30, 2004), 373 requests for external review were received. Of the requests received, 43 (11.5%) involved a re-submission of a request by individuals who were previously ineligible for an external review because their request was incomplete. Thus, 330 different individuals requested an external review. Of these requests, 142 were accepted during the Program's first two years.

During year one (July 1, 2002 – June 30, 2003), 162 requests were received. Requests increased by 30%, to 211, for year two (July 1, 2003 – June 30, 2004). Of the 142 cases that were accepted for review during this two year period, forty-five percent (45%) were decided in favor of the consumer, either due to the insurer reversing its own denial prior to IRO assignment (3 cases), or the IRO overturning the insurer's noncertification. An analysis of the request type of accepted cases for this two-year period showed that 15 cases (11%) involved decisions that services were cosmetic, 40 cases (28%) involved decisions that services were experimental / investigational, and 87 cases (61%) involved medical necessity determinations.

Of the cases accepted during the Program's first two years, IROs overturned 7 of the (47%) cosmetic cases, 13 of the (33%) experimental / investigational cases and 41 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. Gastric bypass surgery (13 cases) represents the largest number of accepted surgical cases, followed by vein surgery (10 cases).

For IRO decisions overturned in favor of the consumer between July 1, 2002 – June 30, 2004, the average amount of allowed charges assumed by the insurer was \$14,134. The average amount of allowed charges assumed by the insurer when they reversed their own noncertification was \$1,270. **The cumulative total of services provided to consumers as a result of external review is \$865,997.** Due to the prospective nature of one case overturned during 2003 - 2004, the cost of the allowed charges for this case has not yet been reported. 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 139 reviews performed was \$510.

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. Beginning in June, 2003, the HCR Program began an on-site auditing program to determine if IROs continue to satisfy statutory requirements as well as additional requirements established by law and contract. Two on-site audits have been completed and both IROs continued to meet all requirements. A third audit was scheduled but due to the IRO's decision to not extend its contract, the audit was cancelled.

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 North Carolina law. For Standard Requests, decisions by the clinical expert are required to be made within 45 days of the covered person's request. For an Expedited Request, a decision must be made within four days of the request. Since July 2002, all IRO decisions have been issued within the required time frames.

During the period of July 1, 2002 to June 30, 2004, 20 different insurers, plus the State Health Plan, had a total of 142 cases that were eligible for external review. With 55 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 (28) and CIGNA Healthcare of North Carolina, Inc. had 15 accepted cases. The remaining insurers had a small number of cases. While this reporting provides an accounting of the cases accepted for review, the case volume is too small to draw conclusions about insurers or how they compare to one another. In the previous report (Release III, July 1, 2002 – December 31, 2003), the Program provided data which compared insurers by

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. Due to insurer annual reporting requirements of member months data, the Program will not report on this activity until the next semiannual report, which will provide a comparison of data for calendar year 2003 and 2004.

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. For the period of July 1, 2002 through June 30, 2004, the HCR Program received 824 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 2700 calls have been received from consumers whose calls have been related to external review or consumer counseling assistance.

In the first two years, the HCR Program actively promoted 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. Future outreach activities will continue to focus on consumer awareness of external review services in targeted locations, and improved web-based forms and information, which is designed to be more "consumer friendly" and easy to use.

Since the HCR Program began, the staff has sought input from consumers as to how satisfied they were with the external review process and to determine which, if any, areas need improvement. A survey is mailed to each person whose case is accepted for review, once a decision is issued and the case is closed. In the first two years of the Program, 141 surveys were sent and 80 consumers or authorized representatives responded. Most responders report satisfaction with the HCR Program staff and information about the external review process. The data continues to suggest that external review is viewed to be a valued and important consumer protection. However, anecdotal comments and suggestions from consumers regarding the complexity of the Program and its related documents has prompted the Program staff to revise its consumer web-site information and related documents.

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 two years of operation (July 1, 2002 – June 30, 2004). Readers are cautioned that the number of requests for review and accepted cases still remains relatively small for statistical purposes. Therefore the validity of using the data for the purpose of identifying discernable trends or drawing conclusions about specific services or insurers still remains limited. However, some general observations are made from the data collected. 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 grows.

II. Background of the Healthcare Review Program

The HCR Program became effective July 1, 2002, as part of the North Carolina Patients' Bill of Rights legislation. 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 Organization (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 Analysts and an Administrative Assistant. The Program utilizes registered nurses with broad clinical, health plan utilization review experiences to process external review requests and to enhance the Program's Consumer Counseling services.

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

The HCR Program contracts with IROs to provide clinical review of cases. Initially, the HCR Program contracted with five IROs to provide these reviews. Four of the IROs were multi-specialty and one IRO is a single-service provider for mental health and substance abuse cases. Contracts between the Department and IROs are for a two-year period with an option to extend the contract for one year if mutually agreeable to both parties. All IROs completed their two-year contract. All five IROs were offered a one-year contract extension. Hayes Plus declined to extend its contract to perform external reviews as the IRO “determined that under the Department’s fee, administrative and conflict of interest standards continuing to conduct external reviews in North Carolina is not financially viable.” All other IROs extended their contract for an additional year, for the period July 1, 2004 through June 30, 2005.

In August, 2003, the Department issued a request for proposal, seeking additional IROs in order to reduce reliance on any one IRO and reduce limitations on assignment due to conflict of interest. One IRO responded and their proposal was reviewed by an evaluation committee that recommended acceptance of the proposal based on the IRO satisfying the minimum qualifications as set forth by statute. The Committee’s recommendation was accepted and the IRO (Permedion) became effective as a contracted IRO for the Department on January 1, 2004. As of July 1, 2004, the Department is contracted with five IROs, 4 multi-specialty and one single-service provider for mental health and substance abuse cases.

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 with 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

The IROs utilized by the Program are those companies that were determined via the solicitation process, 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. 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, two on-site audits have been completed, and it was determined that the IROs continued to meet the requirements under NCGS 58-50-87. A third on-site audit was scheduled, however the IRO elected to not extend its contract and the audit was cancelled.

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. Most consumers contact the HCR Program directly; however, some counseling is provided on a referral basis through the Department's Consumer Services Division. 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. Over the last two years, HCR Program activities focused on heightening consumer and provider awareness of external review services. 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. Two live noon-time TV interviews were done, with WRAL in Raleigh and WNCT in Greenville, NC. In January, 2004, a letter from the Commissioner of Insurance was mailed 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.

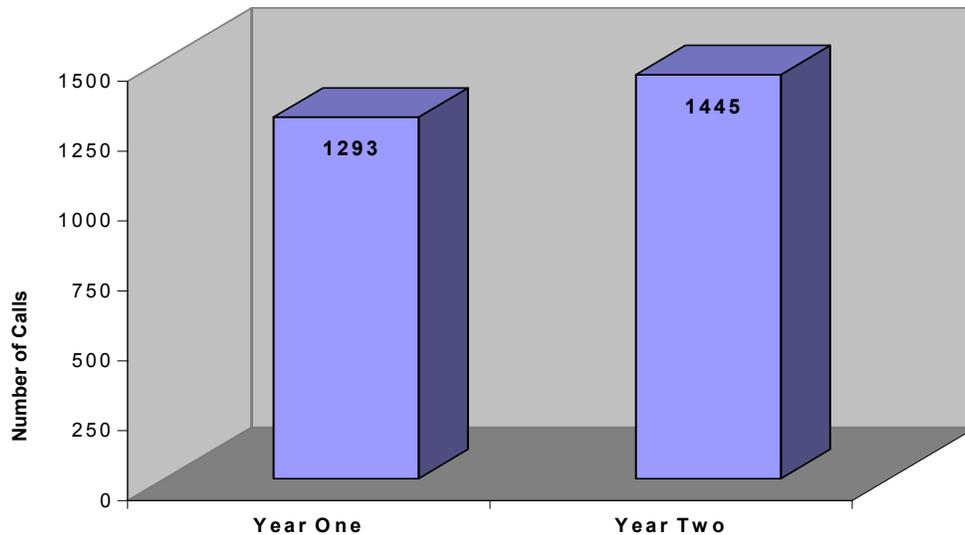
IV. Program Activity Data

A. Consumer Contacts

Consumer Telephone Calls

The HCR Program received 2,738 calls from consumers related to external review and consumer counseling services during the period of July 1, 2002 through June 30, 2004. Figure 1 identifies the number of calls the Program received for each year of operation since the Program began on July 1, 2002. The volume of calls increased by 11.8% from Year One to Year Two. The Program attributes this increase to its consumer outreach activities and the addition of a separate Consumer Counseling web page in May of 2003.

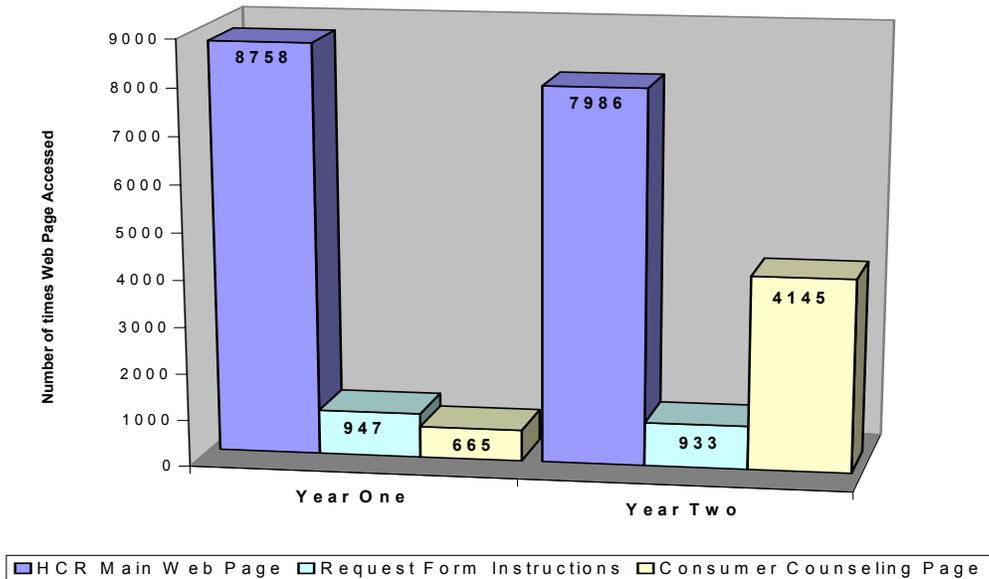
Figure 1: Comparison of External Review and Consumer Counseling Call Volume Received by the HCR Program by Year of Operation July 1, 2002 – June 30, 2004



Consumer Web Site Contacts

The data shown in Figure 2 represents the number of consumers who accessed different HCR Program websites for each operating year since the Program began. The data shows that a large number of consumers continue to access this website each year. The number of consumers accessing the Request Form Instructions remains constant for each year as well. Most significant is the number of consumers who are accessing the consumer counseling information, which was added to the website in May, 2003. The 665 consumers who accessed this website in Year One of operation did so in a two-month data collection period. The Year Two data shows that 52% of the consumers who accessed the main web page continued further to access the Consumer Counseling web page.

Figure 2: Comparison of HCR Program Web Site Page Access Activity by Year of Operation, July 1, 2002 – June 30, 2004

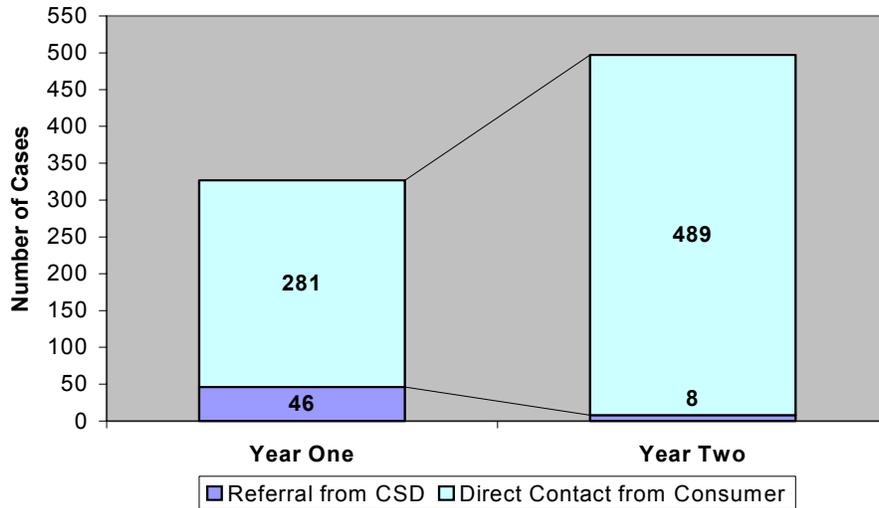


B. Consumer Counseling Activity (Utilization Review, Appeals & Grievances)

The HCR Program counseled 824 consumers during the period of July 1, 2002 through June 30, 2004. During the second year of HCR operations, the number of Consumer Counseling cases increased from 327 to 497 cases, realizing a 52% increase in Consumer Counseling activity. Figure 3 compares the volume of consumer cases by year of operation since July 1, 2002. As shown by the data, the addition of HCR Program contact information to the correspondence sent by Department’s Consumer Service Division (CSD) to consumers regarding appeal and grievance issues has enabled the consumer to directly contact the HCR Program staff.

Overall, consumers have shown a strong interest, and need for information, about appeals and grievance issues. Data reported for consumer calls, web site page usage and consumer counseling activity for the first two years of the Program indicates the need for this information, and the steady growth supports this conclusion.

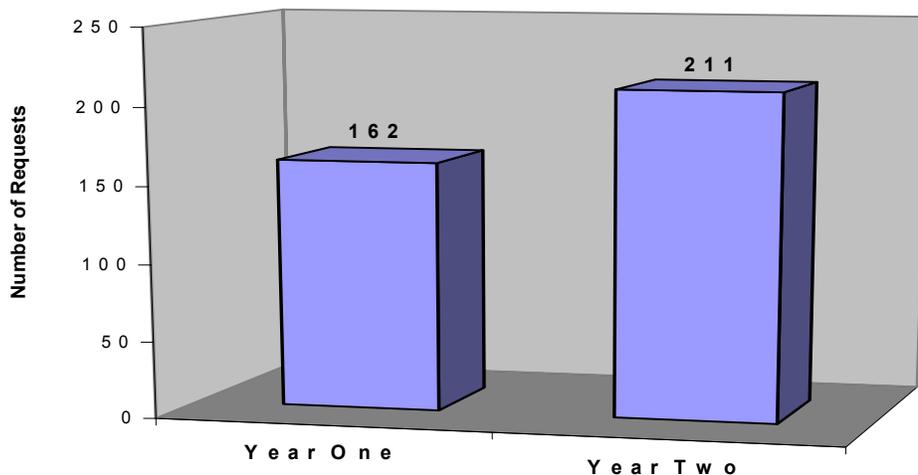
Figure 3: Comparison of Consumer Counseling Case Volume Received by the HCR Program July 1, 2002 – June 30, 2004



C. External Review Requests

During the first two full years of operation, the HCR Program received 373 requests for external review. Figure 4 compares the volume of requests for each year of operation since July 1, 2002. The Program saw a 30% increase in request activity in the second year of operation. The HCR Program expects the volume of requests to continue to increase as more consumers obtain the information needed to understand and complete the insurer’s internal appeal and grievance process, public awareness about the Program grows, and consumers seek out information and request external review services when needed.

Figure 4: Comparison of External Review Requests Received by the HCR Program by Year of Operation, July 1, 2002 – June 30, 2004



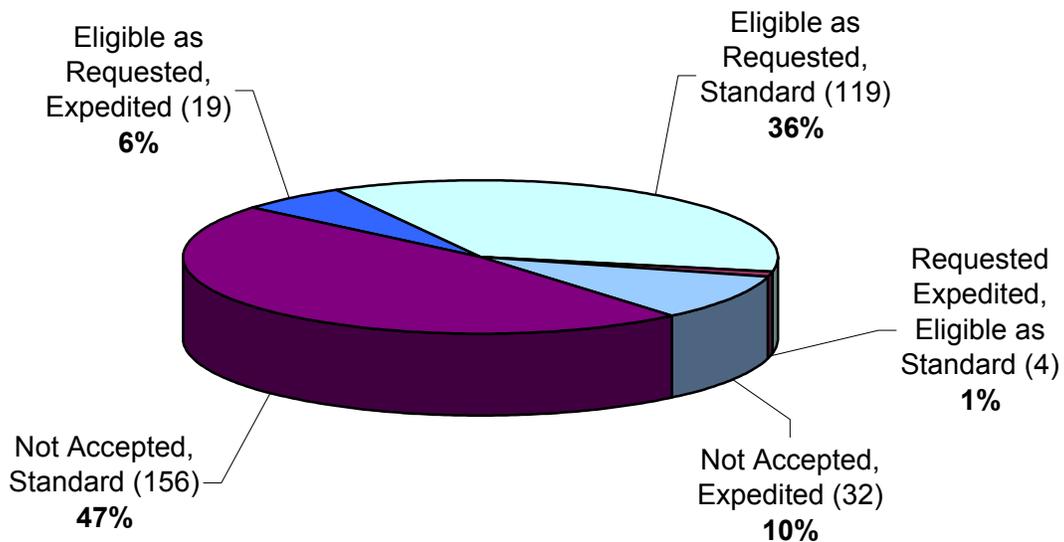
D. Eligibility Determinations on Requests for External Review

Of the 373 requests received during the entire operating period of July 1, 2002 – June 30, 2004, 43 (11.5%) involved re-submission of a request previously denied because it was incomplete. Therefore, 330 different individuals requested external review since the Program began.

The HCR Program determined that 142 (43%) of these requests were eligible for external review. The percentage of requests eligible for each operating year was 43% (65 of 150 separate requests in Year One, and 77 of 180 separate requests in Year Two).

Of the 142 cases determined to be eligible in the first two years, 123 cases were accepted to be reviewed on a standard basis, including 4 cases that were requested but were not eligible to be reviewed on an expedited basis. Nineteen cases were requested and accepted on an expedited basis. The information illustrated in Figure 5 shows the disposition of the 330 individuals' requests for external review received by the Program.

**Figure 5: Disposition of External Review Requests Received
July 1, 2002 – June 30, 2004**



The Program did not accept 57% of the requests it received 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 is situated in a state other than North Carolina.

Ineligibility refers to those cases that did not fulfill the statutory requirements for eligibility for an external review. Figure 6 shows the share of requests that were accepted, not accepted for eligibility reasons, and not accepted for jurisdiction reasons for the 330 individuals' requests received.

**Figure 6: Eligibility Determinations for Requests Received
July 1, 2002 – June 30, 2004**

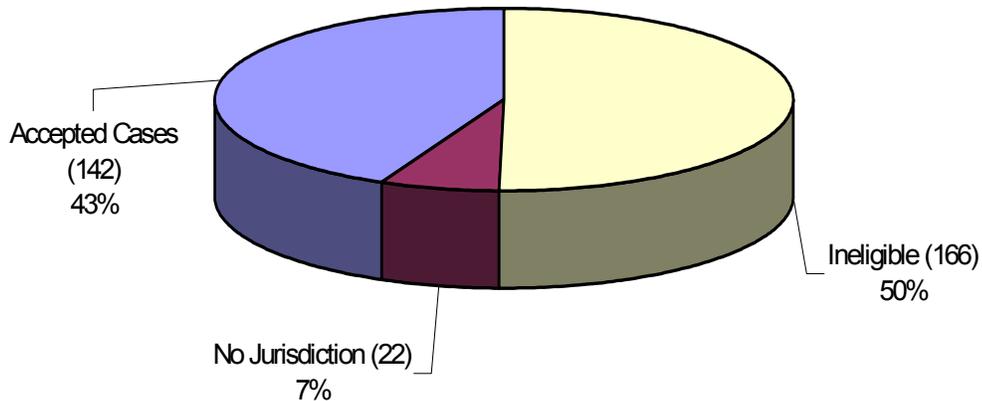


Table 1 shows the numbers of cases that were not accepted for review and the reasons for which they were not accepted for each year of operation. Requests that were submitted before the insurer's appeal process was exhausted and those cases involving issues other than a medical necessity determination,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

In both years, the percentage of cases not accepted for review was 57%. Analysis of this information provides insight that consumers may need additional information that will help increase a consumer's chance of submitting a successful request for external review. During the next year, the Main HCR web page and the Request Form, which are two areas that consumers access for information regarding external review, will be targeted for modification to provide information that is "consumer friendly" in reading and further clarifies the eligibility requirements for external review, thus reducing the number of consumer requests that are deemed ineligible.

**Table 1: Reasons for Non-Acceptance of an External Review Request
July 1, 2002 – June 30, 2004**

Reason for Non-acceptance	Number of Requests
INELIGIBLE	
Health Criteria Not Met for Expedited, not Eligible as Standard	11
Not a Medical Necessity Determination	42
Request Withdrawn	5
Service Excluded	20
No denial issued	1
Insurer's Expedited Appeal not requested prior to request	2
Not covered under health plan	1
Retrospective services-not eligible for expedited	3
Benefit Limitation	1
Denial Decision Pre-Dates Law	3
Past 60 Day Request Time Frame	13
Insurer Appeal Process not Exhausted	34
Insurance Type not Eligible for External Review	10
Request is Incomplete, no resubmission of request	20
Total Ineligible	166
NO JURISDICTION	
Contract Situs not in NC	4
Self-Funded	17
Medicare HMO	1
Total No Jurisdiction	22
Total Requests Not Accepted	188

E. Outcomes of Accepted Cases

Nearly one-half of all consumers whose case was accepted for external review received coverage for the disputed service as a result. Figure 7 shows the outcomes of all external reviews performed between July 1, 2002 and June 30, 2004.

**Figure 7: Outcomes of All Accepted Cases
July 1, 2002 – June 30, 2004**

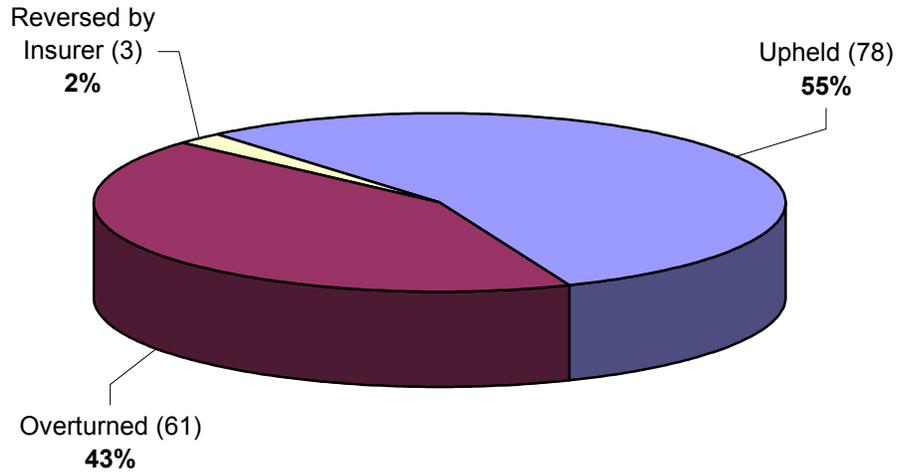
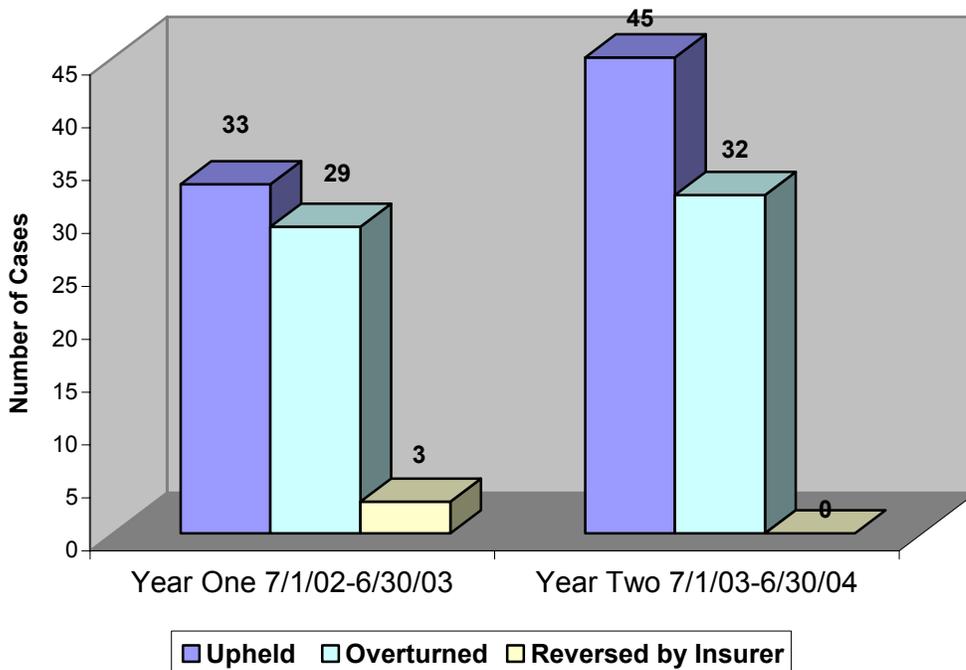


Figure 8 shows a comparison of outcomes by the type of review granted for each year of operation.

**Figure 8: Comparison of Case Outcome by Year of Operation,
July 1, 2002 – June 30, 2004**



The 142 cases that were accepted for review during the first two years of operation resulted in coverage for the disputed service for 45% of the consumers who requested external review, due either to the insurer reversing its own denial or the IRO overturning the insurer's noncertification. In 55% 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 69% 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, 58% 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
July 1, 2002 – June 30, 2004**

Type of Review	Number of Days to Reach Review Determination	Number of Cases
Expedited	0 - 1	2
	2 - 3	6
	4	11
Standard	< 5	1
	5 - 15	1
	16 - 25	23
	26 - 35	39
	36 - 45	59

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. 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. Insurers were not charged a rate for review on the three cases where the insurer reversed its own decision and the average cost to insurers for the remaining 139 reviews performed was \$510.

The amount of allowed charge assumed by the insurer in the three cases where the insurer reversed its own noncertification was \$1,270. The average amount of allowed charges assumed by the insurer for decisions that were overturned in favor of the consumer was \$14,134. From July 1, 2002 through the end of the first year of operation (June 30, 2003), external review decisions that were overturned resulted in \$274,831 worth of services being provided to consumers. The amount of allowed charges resulting from the second year of external review activity was \$591,166, more than double the charges captured in the first year of operation.

To date, the cumulative total of services provided to consumers as a result of external review since the Program commenced is \$865,997. Because of the prospective nature of one case that was overturned by the IRO, the cost of the allowed charges is not available for reporting.

Figure 9 shows the cost of the allowed charges for overturned or reversed services that the HCR Program captured each quarter, as well as the cumulative total of allowed charges for these services. Cumulative costs for the fourth quarter of 2002 will change with each reporting period due to the continuous service being provided as a result of an insurer's decision being overturned by an IRO. For simplicity in reporting, all allowed charges for that service (and any future service that is provided over a prolonged period of time) will be attributed to the date of the decision, as opposed to charges captured for that quarter.

**Figure 9: Quarterly and Cumulative Value of Allowed Charges for Overturned or Reversed Services,
July 1, 2002 – June 30, 2004**

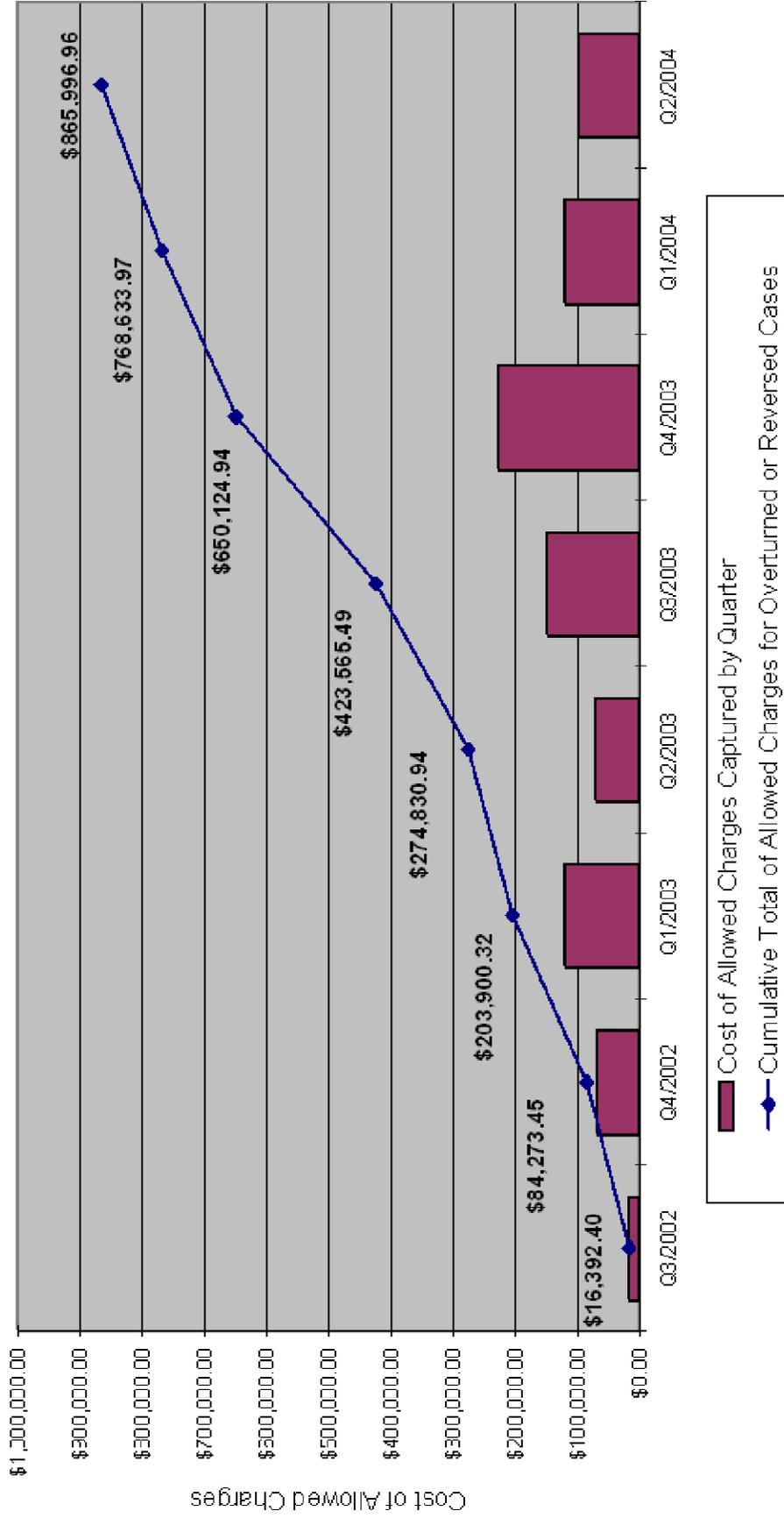


Table 3 shows the average total cost of the IRO review and cost of allowed charges for cases that were reversed by the insurer or overturned in the first two years of operation, by type of service requested. The last column shows the cumulative total of the allowed charges, by type of service.

Table 3: Cost of IRO Review, Average and Cumulative Allowed Charges by Type of Service Requested, July 1, 2002 – June 30, 2004

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	\$518	\$592	\$8,330	\$74,971
Emergency Treatment	450	450	1,096	1,096
Home Health Nursing	498	450	35,643	35,643
Hospital Length of Stay	795	300	788	788
Inpatient Mental Health	550	420	24,948	124,740
Inpatient Rehabilitation	450	0	0	0
Lab, Imaging, Testing	625	438	1,348	2,697
Mental Health Counseling	475	0	0	0
Oncology	795	675	20,757	41,515
Pharmacy	543	589	584	3,505
Physician Services	459	0	0	0
Rehabilitation Services	450	517	2,149	6,446
Skilled Nursing Facility	542	538	3,876	15,503
Surgical Services*	526	465	10,307	267,989
Transplant	615	738	145,552	291,103
All Cases	\$538	\$509	\$14,134	\$865,997

* Outstanding cost of allowed charges remain for prospective service.

V. Activity by Type of Service Requested

The HCR Program classifies accepted cases into general service-type categories. Table 4 gives the reader a listing of the types of specific services, along with the number of accepted cases for that service, that made up the general type of service category used for reporting. As the data collection advanced over a two-year period, the Program began to see separate and distinct categories that the requests would fall into from the type of service requested.

This reporting period has separated previous categories into more distinct service types, particularly as it relates to mental health services, to give the reader a clearer picture of the types of services that were denied. In this report, Inpatient Mental Health becomes a separate category and is no longer counted under the Hospital Length of Stay or Hospital Admission categories. This new category is primarily comprised of acute versus

residential mental health treatment. Oncology became a separate category in the previous reporting period, and is comprised of services such as chemotherapy and non-traditional surgical treatment for cancer.

Table 4: Type of General Service and Specific Services Requested for all Accepted Cases for External Review, July 1, 2002 – June 30, 2004

Type of General Service and Specific Services Requested			
Durable Medical Equipment (16)	Inpatient Mental Health (12)	Physician Services (8)	Surgical Services (59)
<ul style="list-style-type: none"> • Cranial Banding (10) • Glucose Monitoring (1) • Stair Lift (1) • Portable Hyperbaric Oxygen Chamber (2) • Leg Prosthesis (1) • Vest Airway Clearance System (1) 	<ul style="list-style-type: none"> • Admission, Acute Psych (1) • LOS, Acute Psych (4) • Admission, Residential Treatment (5) • LOS, Residential Treatment (1) • Partial Hospitalization Level (1) 	<ul style="list-style-type: none"> • Chelation Therapy (2) • Extracorporeal Shock Wave Therapy (3) • Chiropractics (2) • Intradiscal Electrothermal Therapy (1) 	<ul style="list-style-type: none"> • Gall Bladder (2) • Panniculectomy (6) • Hysterectomy (2) • Breast Reduction (9) • Gastric Bypass (13) • TMJ (5) • Electrothermal Arthroscopic Capsulorrhaphy (2) • Osteochondral Autograft Transfer (1) • Lumbar Laminectomy (1) • Vein Surgery (10) • Dermatocholasia (1) • Septoplasty (1) • In Utero Surgery (1) • Intrauterine Surgery (1) • Mole Removal (1) • Lipoma Removal (1) • Craniectomy (1) • Metal on Metal Hip Resurfacing (1)
Emergency Treatment (1)	Lab, Imaging, Testing (3)	Pharmacy (10)	
<ul style="list-style-type: none"> • Infectious Disease (1) 	<ul style="list-style-type: none"> • PET Scan (1) 	<ul style="list-style-type: none"> • Botox (3) • Synagis (1) • Non-steroidal Anti-inflammatory (3) • Triamcinolone (1) • Primaxin (2) 	
Home Health Nursing (3)	<ul style="list-style-type: none"> • Cardiac Arrhythmia Monitoring (1) • Polysomnogram (1) 	Skilled Nursing (11)	
<ul style="list-style-type: none"> • Private Duty Nursing (3) 			
Hospital LOS (2)	Oncology (5)		
<ul style="list-style-type: none"> • Cardiac (1) • Gastroenterology (1) 	<ul style="list-style-type: none"> • SIR-Spheres Therapy (3) • Renal Ablation (1) • Chemotherapy (1) 	<ul style="list-style-type: none"> • Skilled Nursing Facility (11) 	
Inpatient Rehabilitation (1)			
<ul style="list-style-type: none"> • Orthopedic (1) 	Rehabilitation Service (5)	Transplant (5)	
Mental Health Counseling (1)	<ul style="list-style-type: none"> • Speech Therapy (4) • Physical Therapy (1) 	<ul style="list-style-type: none"> • Stem Cell Transplant (5) 	
<ul style="list-style-type: none"> • Psychoanalysis (1) 			

Figure 10 shows the number of accepted cases by type of service requested. Surgical services continues to be the most frequent subject of accepted cases, representing 41% of the 142 accepted cases for review during the reporting period. Durable medical equipment and skilled nursing facility services place second and third for the service type receiving the most requests. All other services represent only a small share of the total accepted cases.

**Figure 10: Accepted Cases by Type of Service Requested
July 1, 2002 – June 30, 2004**

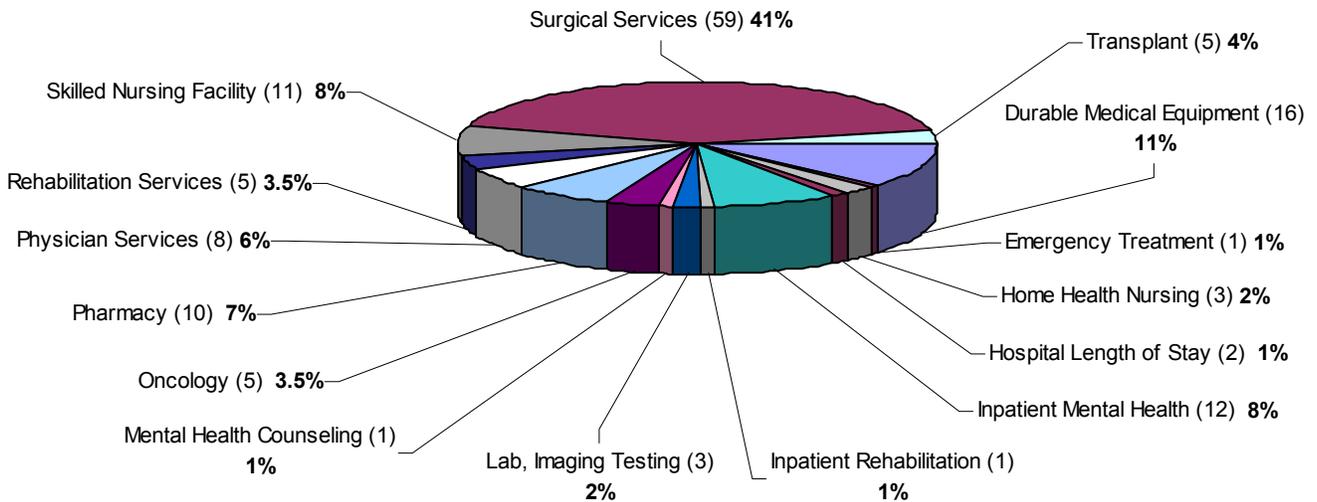


Table 5 shows the percentage share that each service type held for all accepted cases as well as for each case outcome. For surgical cases (the only service with a sizeable number of cases), the share of cases upheld and share of cases overturned are similar. The same is generally true for other service 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
July 1, 2002 – June 30, 2004**

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	11.28	14.75	0.00	8.97
Emergency Treatment	.70	1.64	0.00	0.00
Home Health Nursing	2.11	1.64	0.00	2.57
Hospital Length of Stay	1.41	1.64	0.00	1.28
Inpatient Mental Health	8.45	8.19	0.00	8.97
Inpatient Rehabilitation	.70	0.00	0.00	1.28
Lab, Imaging, Testing	2.11	3.28	0.00	1.28
Mental Health Counseling	.70	0.00	0.00	1.28
Oncology	3.52	3.28	0.00	3.85
Pharmacy	7.04	8.19	33.33	5.13
Physician Services	5.64	0.00	0.00	10.26
Rehabilitation Services	3.52	4.93	0.00	2.57
Skilled Nursing Services	7.75	6.56	0.00	8.97
Surgical Services	41.55	42.62	66.67	39.74
Transplant	3.52	3.28	0.00	3.85
Total	100%	100%	100%	100%

In previous reports on External Review Activity, data regarding the nature of the noncertification (medical necessity, experimental/investigation, or cosmetic) was referenced simply as an accounting of the number of requests that fell into each of the three categories. There was insufficient data to analyze outcomes as they relate to the nature of the noncertification. Because of the increasing types of services that are denied and the basis upon which the noncertification is issued, it is important for the reader to differentiate between a medical necessity denial and other types of noncertifications (i.e. cosmetic or experimental/investigational). Decisions made by IROs are considered by the nature of the noncertification, as well as the service requested. For example, an insurer may base its denial decision solely on the medical necessity of the procedure, evaluating whether the procedure meets its guidelines for appropriateness for the covered person's condition. However, noncertifications are also any situation where the insurer makes a decision about the covered person's condition to determine whether a requested treatment is experimental, investigational or cosmetic, and the extent of coverage is affected by that decision. A further breakdown of case outcomes as they relate to the service type and the nature of the noncertification is shown in Table 6.

Table 6: Outcomes of Accepted External Review Requests by Service Type and Denial Type, July 1, 2002 – June 30, 2004

Service Type	Medical Necessity			Experimental / Investigational			Cosmetic		
	Over-turned	Reversed	Upheld	Over-turned	Reversed	Upheld	Over-turned	Reversed	Upheld
Durable Medical Equipment	4	--	6	2	--	--	3	--	1
Emergency Treatment	1	--	--	--	--	--	--	--	--
Home Health Nursing	1	--	2	--	--	--	--	--	--
Hospital Length of Stay	1	--	1	--	--	--	--	--	--
Inpatient Mental Health	5	--	7	--	--	--	--	--	--
Inpatient Rehabilitation	--	--	1	--	--	--	--	--	--
Lab, Imaging, Testing	2	--	--	--	--	1	--	--	--
Mental Health Counseling	--	--	1	--	--	--	--	--	--
Oncology	--	--	--	2	--	3	--	--	--
Pharmacy	2	1	4	2	--	--	1	--	--
Physician Services	--	--	3	--	--	5	--	--	--
Rehabilitation Services	3	--	2	--	--	--	--	--	--
Skilled Nursing Services	4	--	7	--	--	--	--	--	--
Surgical Services	18	1	10	5	--	15	3	1	6
Transplant	--	--	--	2	--	3	--	--	--
Total	41	2	44	13	--	27	7	1	7

The data in Table 6 indicates that for denial decisions made on the basis of whether the requested service was medically necessity or cosmetic in nature, the outcomes are relatively equal. For decisions made by the insurer that the requested service is experimental or investigational, the outcome is twice as likely to be upheld by the IRO. Most of the service types have had decisions made strictly on the basis of medical necessity, however, the denials for the general service category of Oncology and Transplant (10 cases) have been made *only* on the basis that the requested service was experimental or investigational for the covered person's condition.

Despite the relatively small number of requests, the Program is beginning to see early trend development in the outcomes of the requests for external review as it relates to the *specific service* requested. Of the twelve cases accepted for inpatient mental health, the five that were overturned were related to inpatient acute psychiatric care, whereas five of the seven cases upheld involved a residential treatment facility. The HCR Program received 13 cases involving gastric bypass surgery. Six of seven cases (86%) overturned by the insurer involved a medical necessity determination as it relates to the overall service. Of the remaining upheld cases, five of six involved an experimental or investigational claim by the insurer involving the process by which the service is performed. Similar data is evident as it relates to vein surgery. The Program received 10 requests for external review for a denial relating to varicose vein surgery. Seven of the eight that were upheld involved a denial relating to the experimental or investigational method of performing the surgery.

Table 7 illustrates the outcomes of all accepted external review requests by the general service type and the type of review granted. Of the 142 eligible requests since the Program started, 19 have been granted to be reviewed on an expedited basis. Oncology and Pharmacy were the two types of services that were granted the most reviews on an expedited basis, each with 4 eligible requests. Oncology services were comprised of a renal ablation and three requests for SIR-Spheres therapy for liver cancer. The pharmacy service types that were granted expedited handling of the external review request involved Synagis for premature infant lung development and Botox injections for migraine pain. The three surgical procedures that were expeditiously decided either by the insurer by virtue of their own reversal, or by IRO decision involved In Utero surgery, a laparoscopic gall bladder surgery and an abdominal hysterectomy. Of all decisions made on an expedited basis, 42% were decided in favor of the covered person and 58% were decided in favor of the insurer.

The standard external review outcomes resulted in a positive outcome for 46% of eligible consumers requesting external review, 54% of the cases resulted in the IRO upholding the insurer's original noncertification.

**Table 7: Outcomes of Requests by Type of Service Requested by
Type of Review Granted, July 1, 2004 – June 30, 2004**

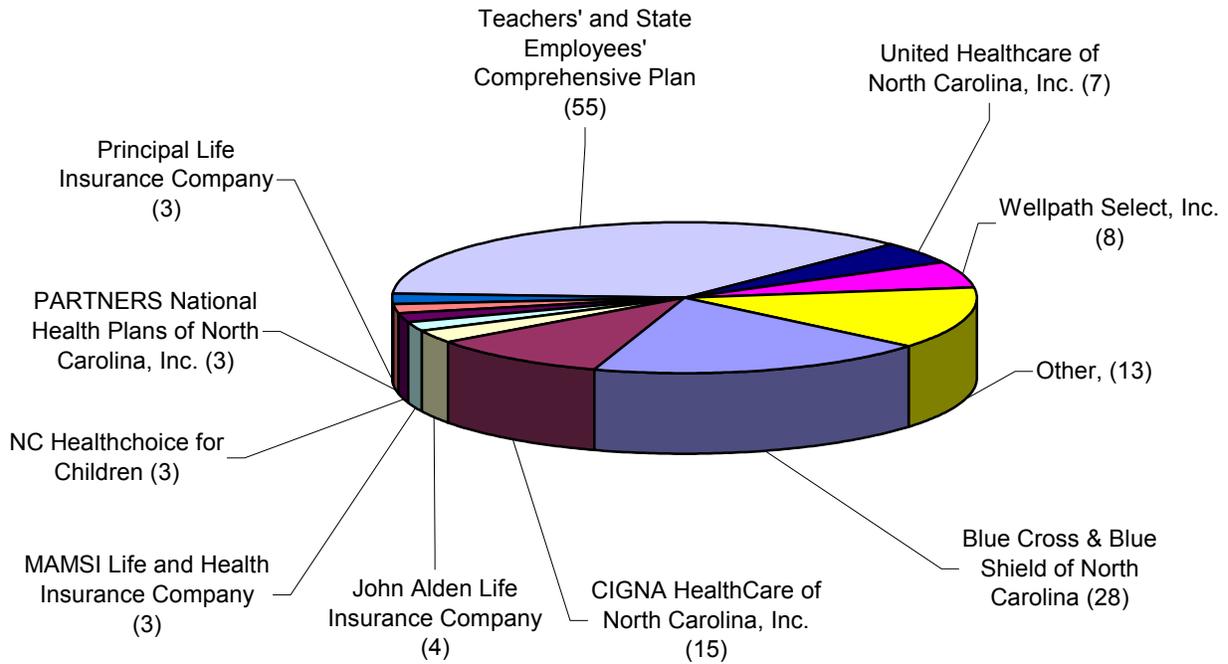
Service Type	Standard External Review			Expedited External Review		
	Overtured	Reversed	Upheld	Overtured	Reversed	Upheld
DME	9	0	7	0	0	0
Emergency Treatment	1	0	0	0	0	0
Home Health Nursing	1	0	0	0	0	2
Hospital Length of Stay	1	0	0	0	0	1
Inpatient Mental Health	5	0	7	0	0	0
Inpatient Rehabilitation	0	0	1	0	0	0
Lab, Imaging, Testing	1	0	1	1	0	0
Mental Health Counseling	0	0	1	0	0	0
Oncology	1	0	0	1	0	3
Pharmacy	3	0	3	2	1	1
Physician Services	0	0	8	0	0	0
Rehabilitation Services	3	0	2	0	0	0
Skilled Nursing Services	4	0	6	0	0	1
Surgical Services	25	1	30	1	1	1
Transplant	1	0	1	1	0	2
Total	55	1	67	6	2	11

A. Insurer and Type of Service Activity

During the period of July 1, 2002 through June 30, 2004, 20 different insurers plus the State Health Plan had a total of 142 cases that were eligible for external review. Nine insurers and the State Health Plan represented 91% of the insurers whose noncertifications resulted in External Review, while 11 insurers had only 1 or 2 noncertifications that resulted in external review over a two year period. Figure 11A shows the distribution of cases among those insurers that made up the majority of requests. The second pie graph (B) in Figure 11 shows the 11 insurers who had only 1-2 requests over the entire two year operation period. With 55 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 and consists of 39% of all requests. Blue Cross Blue Shield of North Carolina, the State's largest insurer, had the second-largest number of accepted cases (28) and CIGNA Healthcare of North Carolina, Inc. had 15 accepted cases.

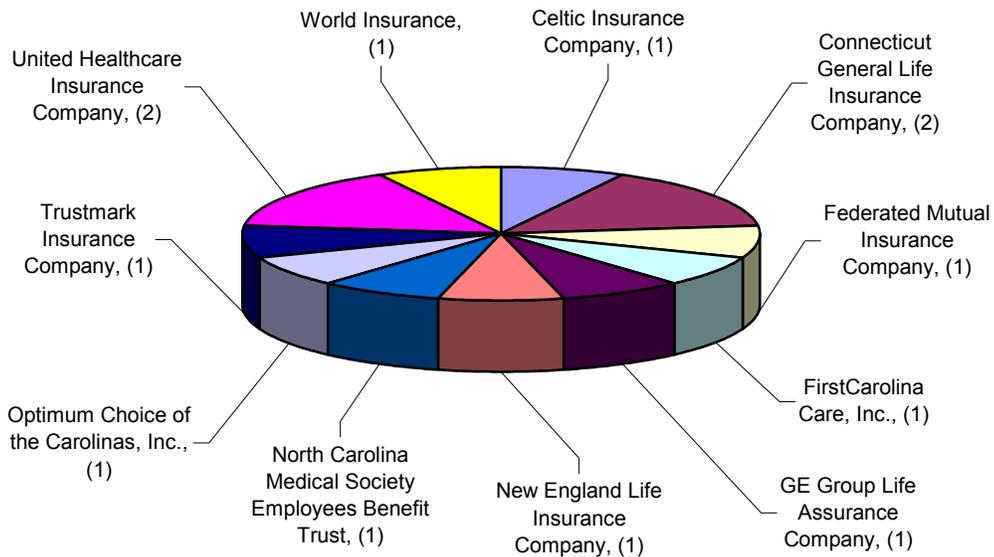
**Figure 11: Insurer's Share of Accepted External Review Requests
July 1, 2002 – June 30, 2004**

A. Insurers Comprising Majority of Cases



**Figure 11: Insurer's Share of Accepted External Review Requests
July 1, 2002 – June 30, 2004**

B. Other Insurers



HMOs are required to report “member months” data to the Department of Insurance on an annual basis. Insurers offering indemnity and PPO plans are not required to report member months. Prior analysis of member month 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 annual reporting requirement of this member month data, the Program is not able to make an analysis of requests per member months until the next report, which will entail an analysis of member month activity for the year 2004 as it compared to the year 2003.

Table 8 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 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 8: Accepted Case Activity by Insurer and Type of Service Requested, July 1, 2002 – June 30, 2004

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	28			
• Durable Medical Equipment	6	50.00	--	50.00
• Home Health Nursing	1	--	--	100.00
• Hospital Length of Stay	1	--	--	100.00
• Inpatient Mental Health	1	100.00	--	--
• Inpatient Rehabilitation	1	--	--	100.00
• Physician Services	2	--	--	100.00
• Surgical Services	16	31.25	--	67.75
Total Percentage for Insurer		32.14	--	67.86
CIGNA Healthcare of NC, Inc.	15			
• Durable Medical Equipment	1	--	--	100.00
• Inpatient Mental Health	1	100.00	--	--
• Oncology	1	100.00	--	--
• Pharmacy	4	50.00	25.00	25.00
• Physician Services	2	--	--	100.00
• Surgical Services	6	66.66	16.67	16.67
Total Percentage for Insurer		50.00	12.50	37.50
Celtic Insurance Company	1			
• Surgical Services	1	100.00	--	--
Total Percentage for Insurer		100.00	--	--
Connecticut General Life Insurance Company	2			
• Rehabilitation Services	1	--	--	100.00
• Pharmacy	1	--	--	100.00
Total Percentage for Insurer		--	--	100.00

Table 8: Accepted Case Activity by Insurer and Type of Service Requested, July 1, 2002 – June 30, 2004 (Cont'd.)

Insurer and Type of Service	Number of Accepted Cases	Insurer's Outcome		
		Insurer's Percent Overturned	Insurer's Percent Reversed	Insurer's Percent Upheld
Federated Mutual Insurance Company	1			
• Physician Services	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	4			
• Durable Medical Equipment	1	100.00	--	--
• Pharmacy	1	100.00	--	--
• Physician Services	1	--	--	100.00
• Rehabilitation Services	1	100.00	--	--
Total Percentage for Insurer		75.00	--	25.00
MAMSI Life and Health Insurance Company	3			
• Emergency Treatment	1	100.00	--	--
• Inpatient Mental Health	1	--	--	100.00
• Oncology	1	100.00	--	--
Total Percentage for Insurer		66.67	--	33.33
NC Healthchoice for Children	3			
• Pharmacy	1	100.00	--	--
• Rehabilitation Services	1	--	--	100.00
• Surgical Services	1	100.00	--	--
Total Percentage for Insurer		66.67	--	33.33
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	--	--
Partners National Health Plans of NC	3			
• Durable Medical Equipment	2	100.00	--	--
• Surgical Services	1	--	--	100.00
Total Percentage for Insurer		66.67	--	33.33

Table 8: Accepted Case Activity by Insurer and Type of Service Requested, July 1, 2002 – June 30, 2004 (Cont'd.)

Insurer and Type of Service	Number of Accepted Cases	Insurer's Outcome		
		Insurer's Percent Overturned	Insurer's Percent Reversed	Insurer's Percent Upheld
Principal Life Insurance Company	3			
• Inpatient Mental Health	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	55			
• Durable Medical Equipment	5	40.00	--	60.00
• Home Health Nursing	1	100.00	--	--
• Inpatient Mental Health	6	33.33	--	66.67
• Lab, Imaging, Testing	1	100.00	--	--
• Mental Health Counseling	1	--	--	100.00
• Oncology	3	--	--	100.00
• Physician Services	1	--	--	100.00
• Rehabilitation	2	100.00	--	--
• Skilled Nursing Services	11	36.36	--	63.64
• Surgical Services	20	25.00	--	75.00
• Transplant	4	50.00	--	50.00
Total Percentage for Insurer		61.81	--	38.19
Trustmark Insurance Company	1			
• Pharmacy	1	--	--	100.00
Total Percentage for Company		--	--	100.00
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.	7			
• Inpatient Mental Health	2	50.00	--	50.00
• Pharmacy	1	100.00	--	--
• Surgical Services	4	100.00	--	--
Total Percentage for Insurer		85.71	--	14.29
Wellpath Select, Inc.	8			
• Surgical Services	7	57.14	14.29	28.57
• Transplant	1	--	--	100.00
Total Percentage for Insurer		50.00	12.50	37.50
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 July 1, 2002 through June 30, 2004, 139 of the 142 accepted cases were assigned to an IRO for review, as 3 cases were reversed by the insurer prior to the case being assigned to an IRO for review. Table 9 shows the number of cases assigned to each IRO, along with the number and percentages of types of review decisions for each IRO. 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 9: IRO Activity Summary
July 1, 2002 – June 30, 2004**

IRO	Number Assigned	Overturned		Upheld	
		Number	Percent	Number	Percent
Carolina Center for Clinical Information	17	13	76.47	4	23.53
Hayes Plus	36	7	19.44	29	80.56
IPRO	39	19	48.72	20	51.28
Maximus CHDR	38	19	50.00	19	50.00
Permedion	8	3	37.50	5	62.50
Prest & Associates	1	0	0.00	1	100.00
All Cases	139	61	43.88	78	59.09

All IROs except Permedion began their contracted service with the Healthcare Review Program on July 1, 2002, which constituted a two-year agreement with an option to renew the contract for one additional year. Hayes Plus chose to not extend their contract for an additional year, and therefore, their contract with the Program ended on June 30, 2004.

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 not possible to expect the same decision to be made for similar cases. The Program audits 100% of IRO determinations to assure that each review was conducted in accordance with statutory requirements. However, large discrepancies of outcomes for similar services between different IROs would provide cause for the Program to further investigate the outcome patterns.

Table 10 presents case outcomes by type of service for each IRO. The number of cases for any IRO is still too small to identify trends or make any evaluative statements.

**Table 10: IRO Decisions by Type of Service Requested
July 1, 2002 – June 30, 2004**

IRO and Type of Service	Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld
Carolina Center for Clinical Information	17		
• Home Health Nursing	1	--	100.00
• Hospital Length of Stay	1	100.00	--
• Inpatient Mental Health	2	50.00	50.00
• Lab, Imaging, Testing	1	100.00	--
• Pharmacy	2	50.00	50.00
• Physician Services	1	--	100.00
• Surgical Services	9	100.00	--
Hayes Plus	36		
• Durable Medical Equipment	5	20.00	80.00
• Home Health Nursing	1	--	100.00
• Inpatient Mental Health	3	--	100.00
• Lab, Imaging, Testing	1	100.00	--
• Mental Health Counseling	1	--	100.00
• Pharmacy	1	100.00	--
• Physician Services	2	--	100.00
• Rehabilitation Services	1	100.00	--
• Skilled Nursing Facility	5	--	100.00
• Surgical Services	14	21.43	78.57
• Transplant	2	--	100.00
I PRO	39		
• Durable Medical Equipment	7	85.71	14.29
• Hospital Length of Stay	1	--	100.00
• Inpatient Mental Health	1	--	100.00
• Lab, Imaging, Testing	1	--	100.00
• Oncology	3	--	100.00
• Pharmacy	4	50.00	50.00
• Physician Services	1	--	100.00
• Rehabilitation Services	1	100.00	--
• Skilled Nursing Facility	4	50.00	50.00
• Surgical Services	14	50.00	50.00
• Transplant	2	50.00	50.00

**Table 10: IRO Decisions by Type of Service Requested
July 1, 2002 – June 30, 2004 (Cont'd.)**

IRO and Type of Service	Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld
Maximus CHDR	38		
• Durable Medical Equipment	2	50.00	50.00
• Emergency Treatment	1	100.00	--
• Home Health Nursing	1	100.00	--
• Inpatient Mental Health	4	100.00	--
• Inpatient Rehabilitation	1	--	100.00
• Oncology	2	100.00	--
• Pharmacy	1	--	100.00
• Physician Services	4	--	100.00
• Rehabilitation Services	3	33.33	66.67
• Skilled Nursing Facility	2	100.00	--
• Surgical Services	17	41.18	58.82
Permedion	8		
• Durable Medical Equipment	2	50.00	50.00
• Inpatient Mental Health	1	--	100.00
• Pharmacy	1	100.00	--
• Surgical Services	3	--	100.00
• Transplant	1	100.00	--
Prest & Associates	1		
• Inpatient Mental Health	1	--	100.00

Table 11 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 all IRO decisions for this service being somewhat evenly split between upheld and overturned cases.

Table 11: Percentage of IRO Outcomes by General Service Type for all Insurers, July 1, 2002 – June 30, 2004

Service Type	Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld
Durable Medical Equipment	16	56.25	43.75
Emergency Treatment	1	100.00	--
Home Health Nursing	3	33.33	66.67
Hospital Length of Stay	2	50.00	50.00
Inpatient Mental Health	12	41.67	58.33
Inpatient Rehabilitation	1	--	100.00
Lab, Imaging, Testing	3	66.67	33.33
Mental Health Counseling	1	--	100.00
Oncology	5	40.00	60.00
Pharmacy	9	55.56	44.44
Physician Services	8	--	100.00
Rehabilitation Services	5	60.00	40.00
Skilled Nursing Facility	11	36.36	63.64
Surgical Services	57	45.61	54.39
Transplant	5	40.00	60.00

Table 12 shows the outcomes of each IRO's decisions as it relates to the nature of the noncertification.

Table 12: IRO Decisions by Nature of Noncertification July 1, 2002 – June 30, 2004

Name of IRO	Number of Decisions	Medical Necessity		Experimental Investigational		Cosmetic	
		Overturned	Upheld	Overturned	Upheld	Overturned	Upheld
Carolina Center for Clinical Information	17	9	3	2	1	2	0
Hayes Plus	36	5	18	2	9	0	2
IPRO	39	11	9	4	10	4	1
Maximus, CHDR	38	15	10	3	6	1	3
Permedion	8	1	3	2	1	0	1
Prest & Associates	1	0	1	0	0	0	0
Total	139	41	44	13	27	7	7

Table 13 shows each IRO's decisions by individual insurer. The number of cases for any IRO is still too small to identify trends or make any evaluative statements.

**Table 13: IRO Decisions by Insurer
July 1, 2002 – June 30, 2004**

IRO and Insurer	Number of Decisions	Percent Overturned	Percent Upheld
Carolina Center for Clinical Information	17		
• Celtic Insurance Company	1	100.00	--
• FirstCarolinaCare, Inc.	1	100.00	--
• GE Group Life Assurance Company	1	100.00	--
• New England Life Insurance Company	1	--	100.00
• Optimum Choice of the Carolinas	1	100.00	--
• Principal Life Insurance Company	2	--	100.00
• Trustmark Insurance Company	1	--	100.00
• UnitedHealthcare of NC, Inc.	6	100.00	--
• Wellpath Select, Inc.	3	100.00	--
Hayes Plus	36		
• Blue Cross Blue Shield of NC	11	27.27	72.73
• 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	22	13.64	86.36
IPRO	39		
• Blue Cross Blue Shield of NC	9	55.56	44.44
• CIGNA Healthcare of North Carolina, Inc.	3	66.67	33.33
• Connecticut General Life Insurance Company	1	--	100.00
• John Alden Life Insurance Company	3	100.00	--
• NC Healthchoice for Children	1	100.00	--
• Partners National Health Plans of NC, Inc.	2	100.00	--
• Principal Life Insurance Company	1	--	100.00
• Teachers' and State Employees' Comprehensive Major Medical Plan	15	33.33	66.67
• United Healthcare Insurance Company	1	--	100.00
• Wellpath Select, Inc.	3	33.33	66.67

**Table 13: IRO Decisions by Insurer
July 1, 2002 – June 30, 2004 (Cont'd)**

IRO and Insurer	Number of Decisions	Percent Overturned	Percent Upheld
Maximus CHDR	38		
• Blue Cross Blue Shield of NC	7	14.29	85.71
• CIGNA Healthcare of North Carolina, Inc.	8	62.50	37.50
• Connecticut General Life Insurance Company	1	--	100.00
• Federated Mutual Insurance Company	1	--	100.00
• MAMSI Life and Health Insurance Company	2	100.00	--
• NC Healthchoice for Children	1	--	100.00
• PARTNERS National Health Plans of North Carolina, Inc.	1	--	100.00
• Teachers' and State Employees' Comprehensive Major Medical Plan	14	64.29	35.71
• United Healthcare Insurance Company	1	100.00	--
• Wellpath Select, Inc.	1	--	100.00
• World Insurance Company	1	100.00	--
Permedion	8		
• Blue Cross Blue Shield of North Carolina	1	--	100.00
• CIGNA HealthCare of North Carolina, Inc.	2	50.00	50.00
• Teachers' and State Employees' Comprehensive Major Medical Plan	4	50.00	50.00
• UnitedHealthcare of North Carolina, Inc.	1	--	100.00
Prest & Associates	1		
• MAMSI Life and Health Insurance Company	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, 141 surveys were sent and 80 consumers or authorized representative responded.

The outcomes of the cases of the responding parties were: 44 overturned, 34 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 responders whose decision was overturned, 100% stated they would tell a friend about external review. While this number is be expected, what is relevant is that 62% of the responders (21 out of 34) whose decision was upheld, would also tell a friend about external review. This data continues to suggest that external review is viewed to be a valued and important consumer protection.

Overall, responders are generally pleased with the customer service they receive while contacting the Healthcare Review Program. Specific responses received regarding the complexity of the program and its documents were considered in the Program's decision to revise its website and consumer documents.

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	38
	NCDOI CSD	16
	NCDOI Website	8
	Word of Mouth	8
	Other	9
2. Was the request form easy to use and understand?	Yes	69
	No	7
	N/A	2
	No response	2
3. Was your telephone call answered promptly?	Yes	72
	No	0
	N/A	7
	No response	1
4. Was your call handled in a courteous manner?	Yes	73
	No	0
	N/A	6
	No response	1
5. Did the Department answer all your questions and help you get the information you were looking for?	Yes	70
	No	3
	N/A	6
	No response	1
6. Were you able to reach a staff member during non-business hours?	Yes	17
	No	7
	N/A	55
	No response	1
7. Did the correspondence you received from the Department give you adequate information about the External Review process?	Yes	71
	No	6
	N/A	0
	No response	3
8. Did you receive information from the Department in the time frames you were promised?	Yes	78
	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	77
	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	29
	No	50
	N/A	1
<u>Problem Resolution</u>		
11. Did the Healthcare Review Program help to resolve your concern?	Yes	49
	No	30
	No response	1
12. Did the Clinical Review Analyst help you understand the eligibility requirements for external review?	Yes	58
	No	10
	N/A	8
	No response	4
13. Would you tell a friend about the External Review Program?	Yes	67
	No	9
	No response	4

VIII. Conclusion

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

The HCR Program Semiannual Report presents external review and consumer counseling data which documents the growth of the Program during its first two years. While the quantity of data is still relatively small, and general conclusions cannot be made not discernable trends reported, some overall observations can be reported based upon the data we have available.

In its first two years of operation, 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 appeals and grievance process. The HCR Program counseled 327 consumers during the first year. Requests increased by 52%, to 497, in the second year of operation. For consumers requesting an external review, the Program received 162 requests in the first year. Requests increased by 30%, to 211, for the second year of operation. Of the 142 cases that were accepted for external review in the first two years of operation, 64 cases (45%) resulted in coverage for consumers that had previously been denied. To date, the cumulative total of services provided to consumers as a result of external review since the Program commenced is \$865,996.

In the Program's first two years, all IRO determinations have been issued in compliance with statutory requirements. Additionally, on-site auditing of two IROs found that both organizations continued to meet the minimum qualifications set forth in statute as well as contractual terms and requirements.

Insurers subject to North Carolina's External Review law are required to provide notice of external review rights to covered persons in their noncertification decisions and notices of decision on appeals and grievances. 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 eligibility determinations can be made. The HCR Program's interaction with the insurer community over the last two years has been positive. Insurers have complied with time frame requirements in providing information, been accessible for case discussion, and in general, were timely in payment for IRO services.

Since July 1, 2002, the HCR Program has used a consumer satisfaction survey tool to understand how satisfied consumers were with the external review process and to determine which areas needed improvement. The survey is mailed to the consumer or authorized representative at the completion of each accepted case. During this two-year

period, 141 surveys were sent and 80 (57%) were completed and returned. The data indicates that external review is viewed to be a valued and important consumer protection. Furthermore, in addition to the fact that all of those responders whose decision was overturned would tell a friend about the Program, 21 of the 34 (62%) responders whose decision was upheld would also tell a friend about external review.

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. Over the last two years, the HCR Program has sought opportunities to heighten consumer and provider awareness of external review services. Success of the Program's community outreach activities is evident in the steady growth of external review requests and consumer counseling activities.