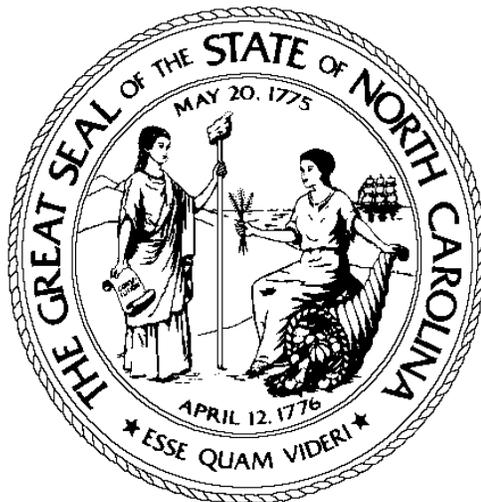


# North Carolina Department of Insurance



Healthcare Review Program Semiannual Report  
for the period of January 1, 2003 – December 31, 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
Release V	January 1, 2003 – December 31, 2004

All Healthcare Review Program Semiannual Reports are available on the NC Department of Insurance web site at: [www.ncdoi.com](http://www.ncdoi.com)

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## **Executive Summary**

North Carolina's External Review law 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 Healthcare Review Program ("HCR Program" or "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 calendar years of operation (January 1, 2003 – December 31, 2004), 421 requests for external review were received. In 2003, the Program received 220 requests. In 2004, the number of requests decreased by 8.6%, to 201. Of these requests received, 66 (15.6%) involved a re-submission of a request by individuals who were previously ineligible for an external review because their request was incomplete. Thus, 355 different individuals requested an external review. Of these requests, 167 were accepted during this two year period.

Of the 167 cases that were accepted, 43% were decided in favor of the consumer, either due to the insurer reversing its own denial prior to IRO assignment (1 case), or the IRO overturning the insurer's noncertification. An analysis of the request type of accepted cases for this two-year period showed that 22 cases (13%) involved decisions that services were cosmetic, 52 cases (31%) involved decisions that services were experimental / investigational, and 92 cases (56%) involved medical necessity determinations.

Of the cases accepted during the Program's first two calendar years, IROs overturned 13 (59%) of the cosmetic cases, 18 (35%) of the experimental / investigational cases and 40 (43%) of the medical necessity cases. In 2003, surgical services represented the largest percentage of cases accepted (45.05%) and overturned (50%). In 2004, surgical cases remained the largest percentage of accepted cases (28.57%), but decreased in total percentage of overturned cases (26.67%). In 2003, durable medical equipment (DME) represented 7.68% of accepted cases and 12.50 % of overturned cases. In 2004, the percentage share of cases accepted increased (18.18%) as did the percentage of overturned cases (26.67%). Gastric bypass surgery (13 cases) represents the largest number of

accepted surgical cases, followed by vein surgery (12 cases). For DME, cranial banding (16 cases) represents the largest number of accepted cases.

For IRO decisions overturned in favor of the consumer between July 1, 2002 and December 31, 2004, the average amount of allowed charges assumed by the insurer was \$12,635. The average amount of allowed charges assumed by the insurer when they reversed their own noncertification was \$1,270. **Since July 1, 2002, the cumulative total of services provided to consumers as a result of external review is \$947,592.** Due to the prospective nature of seven cases 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 185 reviews performed was \$534.

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. Three on-site audits have been completed and all IROs continued to meet statutory and contract requirements. A fourth audit was scheduled but due to the IRO's decision to not extend its contract, the audit was cancelled. Due to the small volume of cases assigned to Prest & Associates, an on-site audit was not performed.

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 January 1, 2003 to December 31, 2004, 24 different insurers, plus the State Health Plan, had a total of 167 cases that were eligible for external review. With 75 accepted cases during this two year period, the State Health Plan continues as the health plan that has experienced the highest number of cases accepted for external review. A comparison of accepted cases by year for State Health Plan shows that 39 cases were accepted in 2003 and 36 cases in 2004. Blue Cross & Blue Shield of North Carolina, the

State's largest insurer, had the second-largest number of accepted cases (35) during this two year period, with 15 cases in 2003 and 20 cases in 2004. 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. A comparison of insurers who reported total member months data for 2004 shows that the rate of external review activity for all HMOs required to report data has decreased from 2003, with insurers having less than one case per 100,000 members.

The HCR Program also provides counseling to consumers who have questions or need assistance with issues involving their insurer's utilization review or internal appeal and grievance process. Consumers receive counseling from a staff of professional nurses who understand the clinical aspects of cases as well. For the period of January 1, 2003 through December 31, 2004, the HCR Program received 931 requests for assistance from consumers. A comparison of consumer counseling case volume by year shows a 35% increase in activity between 2003 and 2004. During this two year period, more than 2800 calls have been received from consumers whose calls have been related to external review or consumer counseling assistance.

The HCR Program has 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 consumers, physicians and office practice administrators, hospital administration, publications and TV interviews. In January, 2004, a letter from the Commissioner of Insurance was sent 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. Additionally, the HCR Program sought to expand its consumer awareness campaign of external review services by displaying External Review signage (poster size) in the patient waiting area of doctor's offices and hospitals. A letter from the Commissioner, along with two posters and a brochure about the Program, was sent to physician practice administrators and hospital business managers throughout the State. Finally, changes were made to the format on both the main HCR Program web page and the Consumer Counseling page to facilitate ease of use and provide additional information about services available through the Program. The online External Review request form and web page underwent revisions to become more "user friendly", and clarify eligibility requirements for external review.

Since the HCR Program began, the staff has sought input from consumers regarding their satisfaction 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. The data collected continues to suggest that external review is viewed to be a valued and important consumer protection.

## **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 comparative analysis of the HCR Program's external review activities and consumer contact with the HCR Program for the Program's first two calendar years of operation (January 1, 2003 – December 31, 2004). 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. External review and consumer counseling activities for the first six months of the Program (July 1, 2002 – December 31, 2002) have been addressed in previous semiannual report releases.

In reviewing this report, 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. North Carolina General Statutes 58-50-75 through 58-50-95, known as the Health Benefit Plan External Review Law, governs the independent external review process. North Carolina's external review rights assure covered persons the opportunity for an independent review of an appeal decision or second-level grievance review decision upholding a health plan's noncertification, subject to certain eligibility requirements.

Requests for external review are made directly to the Department and screened for eligibility by HCR Program staff, but the actual medical reviews are conducted by 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 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 five (5) IROs to provide clinical review of cases. IROs are subject to many statutory requirements regarding the organizations' structure and operations, the reviewers that they use, and their handling of individual cases. The HCR Program engages in a variety of activities to provide appropriate monitoring, ensuring compliance with statutory and contract requirements.

### **III. Program Activities**

#### **A. External Review**

The HCR Program staff is responsible for receiving requests for external review. In most cases, external review is available only after appeals made directly to a health plan have failed to secure coverage. A covered person or person acting on their behalf, including their health care provider, may request an external review of a health plan's decision 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. Three on-site audits have been completed and all IROs continued to meet statutory and contract requirements. A fourth audit was scheduled but due to the IRO's decision to not extend its contract, the audit was cancelled. Due to the small volume of cases assigned to Prest & Associates, an on-site audit was not performed.

### **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 Program Services**

The HCR Program actively promotes 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, consumers remain unaware of the availability of this service. Strategies used to inform and educate consumers and providers have included health fairs, group presentations, publications, TV interviews and direct mailings to physicians. In 2004, the HCR Program sought to expand its consumer awareness campaign of external review services by displaying External Review signage (poster size) in the patient waiting area of doctor's offices and hospitals. A letter from the Commissioner, along with two posters and a brochure about the Program, was sent to physician practice administrators and hospital business managers throughout the State. Also, changes were made to the format on both the main HCR Program web page and the Consumer Counseling page to facilitate ease of use and provide additional information about services available through the Program. The online External Review request form and web page underwent revisions to become more "user friendly", and clarify eligibility requirements for external review.

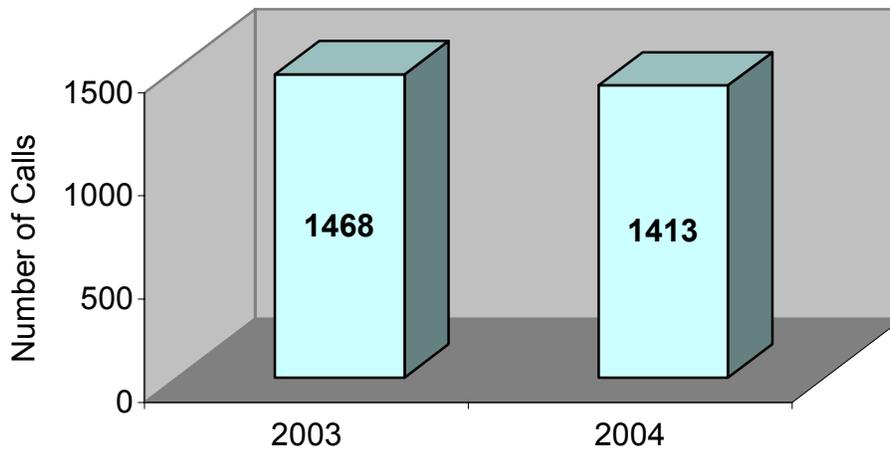
## IV. Program Activity Data

### A. Consumer Contacts

#### Consumer Telephone Calls

The Healthcare Review Program received 2,881 calls from consumers related to external review and consumer counseling services during the period of January 1, 2003 – December 31, 2004. The number of calls the Program received from year to year has remained constant. Consumer telephone calls include questions pertaining to external review service, as well as those from consumers and providers seeking assistance, information and counseling relating to utilization review, an insurer's appeals and grievance process or external review. Figure 1 demonstrates the sustained phone activity experienced by the Program during the first two full calendar years of operation.

**Figure 1: Comparison of External Review and Consumer Counseling Call Volume Received by the HCR Program by Calendar Year January 1, 2003 – December 31, 2004**



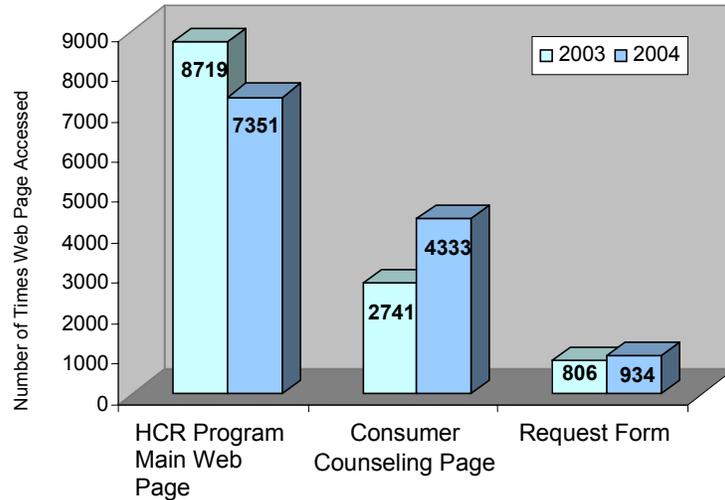
#### Consumer Web Site Contacts

Another measure of the HCR Program's continued success in reaching consumers is demonstrated in the data that tracks web page access. The data in Figure 2 shows that a large number of consumers continue to access the main HCR Program website each year. Consumers continue to seek additional information relating to appeals and grievances on the consumer counseling page, which was added to the website in May, 2003. Since this page was added, an average of 354 individuals have accessed this site each month.

In October 2004, several changes were made to the format on both the main HCR Program web page and the Consumer Counseling page to facilitate ease of use and provide additional information about services available through the HCR Program. Additionally, the online External Review request form and web page underwent revisions

to become more “user friendly” and to clarify eligibility requirements for external review in hopes of reducing the number of consumer requests that are deemed ineligible. As shown in Figure 2, the number of consumers accessing the online Request Form in 2004 increased by 15.8% over 2003.

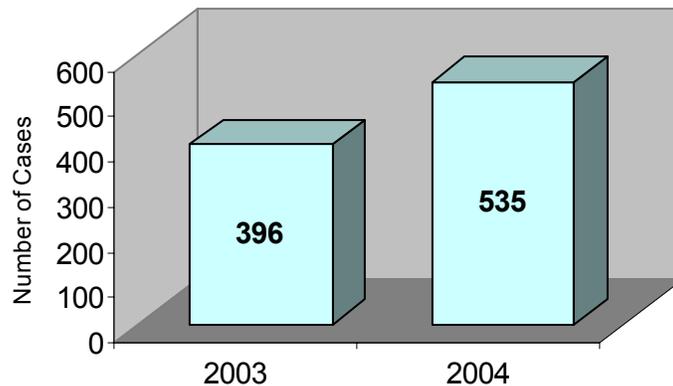
**Figure 2: Comparison of HCR Program Web Site Page Access Activity by Calendar Year, January 1, 2003 – December 31, 2004**



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

The HCR Program counseled 931 consumers during the period of January 1, 2003 – December 31, 2004. During 2004, the number of consumer counseling cases increased from 396 cases in 2003 to 535 in 2004, realizing a 35% increase in consumer counseling activity. Figure 3 compares the volume of consumer cases by full calendar year of operation.

**Figure 3: Comparison of Consumer Counseling Case Volume Received by the HCR Program by Calendar Year, January 1, 2003 – December 31, 2004**



Consumers continue to show a strong need for information about appeals and grievance issues. In 2004, 298 (55.7%) consumer callers contacted the HCR Program after they had received a denial from their insurance company (initial, first-level appeal, or second-level grievance), seeking information about how to proceed with the next step in the appeal process. Program staff provided education and suggestions regarding the insurer's appeal and grievance process, brochure information and explanations regarding what the consumer can expect from the appeal process and how external review related to the consumer's specific issue. Overall, consumers report that they are pleased with the information they receive and state they are better prepared to initiate the insurer's appeal process after speaking with the Program staff.

The remainder of calls received by the Program related to the following issues:

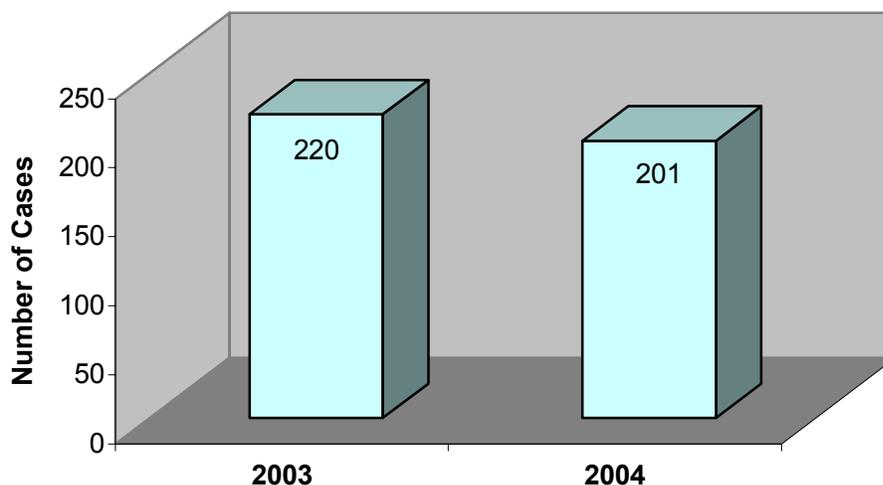
- Denials made by self-funded employer plans regulated under ERISA.
- Insurance coverage.
- Dental Plan denials.
- Insurers not regulated under North Carolina law.
- Insurer's claim payment.
- Network Access.

The Program's staff was able to provide these consumers with the appropriate resources where their concerns could be addressed. Callers were referred to the Department's Consumer Service Division, the Department's Managed Care & Health Benefits Division, the Managed Care Patient Assistance Program, the US Department of Labor, Medicare, other state's Department of Insurance, Tri-Care and the Office of Personnel Management as appropriate, for those issues not subject to North Carolina's utilization review laws, appeals and grievances or external review. Callers often express appreciation in the assistance the Program provides in navigating them to the appropriate resources.

### **C. External Review Requests**

During the period of January 1, 2003 - December 31, 2004, the HCR Program received 421 requests for external review. Figure 4 compares the volume of requests for each year. The Program saw a small decrease in request activity in 2004. With more than 200 requests per year, the HCR Program expects the volume of requests to remain steady as consumers and providers 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 Calendar Year, January 1, 2003 – December 31, 2004**



**D. Eligibility Determinations on Requests for External Review**

Eligibility of requests received is considered on the basis of individuals who requested review rather than each separate request. Because consumers may submit an incomplete request for external review and subsequently submit a completed request, counting all incomplete requests as ineligible does not accurately reflect the number of requesters who were denied an external review.

Of the 421 requests received during 2003 and 2004, 66 (15.6%) involved re-submission of a request previously denied because it was incomplete. Therefore, eligibility determinations were made on 355 different individuals requesting external review during this two-year period. In 2003, 46 individuals submitted an incomplete request. Of those 46, 36 (78.2%) individuals subsequently resubmitted a complete request which was accepted for external review. Similarly in 2004, of 41 individuals whose request was originally incomplete, 30 (73.1%) resubmitted a complete request that was accepted for external review.

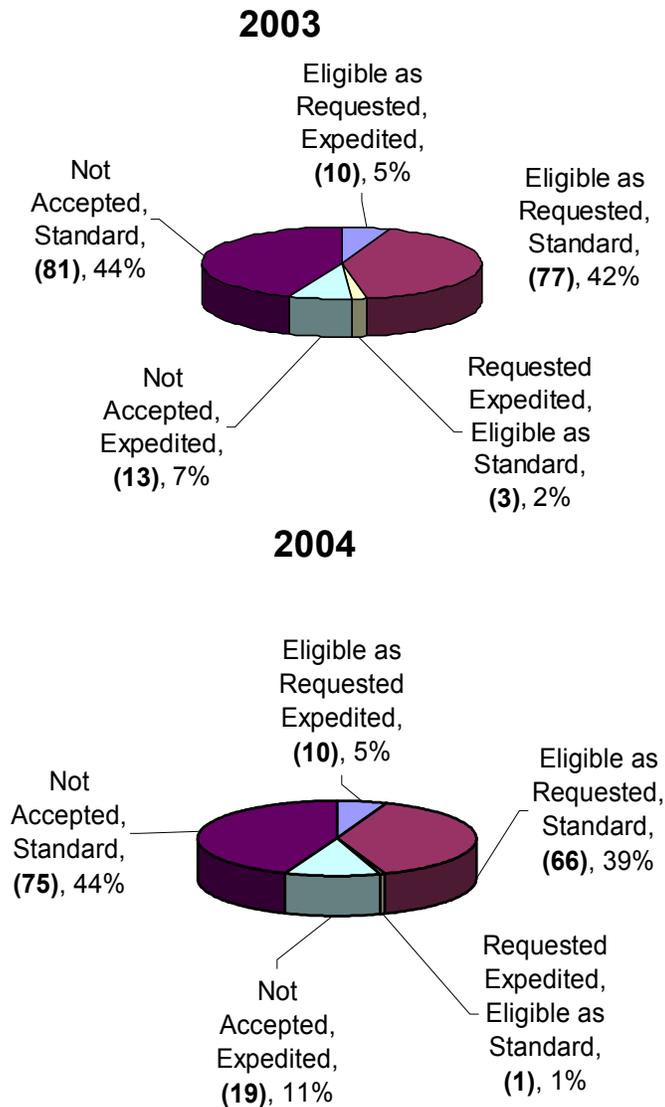
Based upon the 355 individual's requests made during 2003 and 2004, 167 (47%) of these requests were ineligible for external review. The percentage of requests eligible for each operating year was 49% (90 of 184) in 2003 and 45% (77 of 171) in 2004.

Figure 5 shows the disposition of requests for external review by calendar year. The overall percentage of eligible reviews has increased marginally from the previous reporting period (July 1, 2002 – June 30, 2004) where only 43% of requests were eligible for external review.

Conversely, the percentage of requests that were denied external review has dropped. For the years 2003 and 2004, 52.9% of requests received were not eligible to be accepted for external review. This is decreased from the previous reporting periods (July 1, 2002 – June 30, 2004) where 57% of requests were deemed ineligible.

In 2003, the HCR Program received 161 requests for standard review and accepted 80 (49.7%) cases (including 3 expedited requests that were accepted for standard review). Twenty three (23) expedited cases were received and 10 (43%) cases were accepted. In 2004, the Program received 143 requests for standard review and accepted 68 (47.5%) cases (including one expedited request that was accepted for standard review), and 28 expedited requests were received and 10 (35.7%) were accepted.

**Figure 5: Comparison of Disposition of External Review Requests Received by Calendar Year, January 1, 2003 – December 31, 2004**



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, Medicare or those policies whose contract is situated in a state other than North Carolina. “Ineligibility” refers to those cases that did not fulfill the statutory requirements for eligibility for an external review.

Figure 6 shows the share of requests that were accepted, not accepted for eligibility reasons, and not accepted for jurisdiction reasons for the 355 individuals’ requests received for the years 2003 and 2004. The outcomes for eligibility determinations are very similar for each year.

**Figure 6: Comparison of Eligibility Determinations for Requests Received by Calendar Year, January 1, 2003 – December 31, 2004**

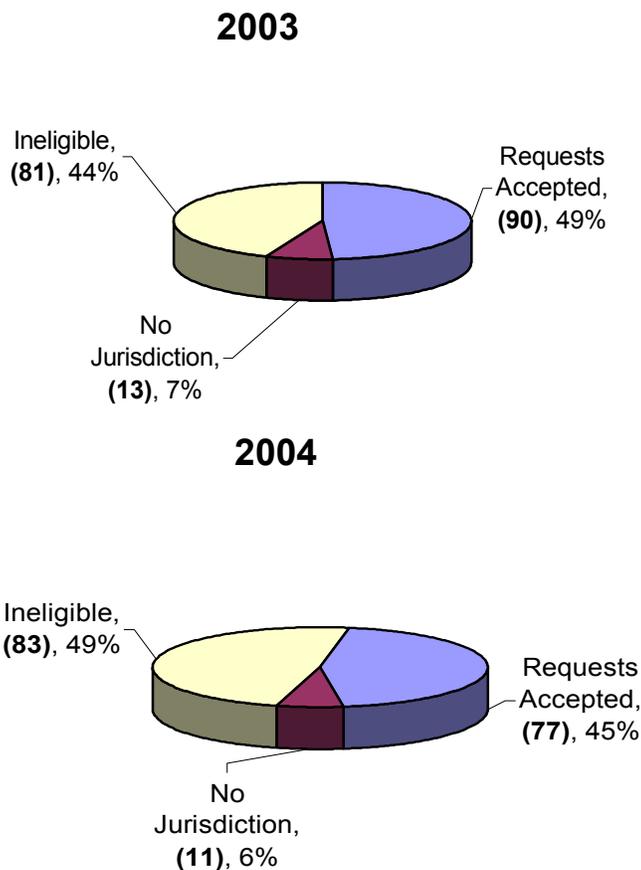


Table 1 shows the numbers of cases that were not accepted for review and the reasons for which they were not accepted for each year of operation. For both years, non-accepted requests due to “ineligible” reasons rather than “no jurisdiction” reasons continue to make up the largest numbers for external review requests to be deemed ineligible.

Consumers who received a denial from their insurance company that did not involve a noncertification, or had not exhausted their insurer’s appeal process prior to requesting an external review represent the largest number of requests that were not accepted. Consumers requesting an external review for services that are specifically excluded make up the third largest reason why a request was not accepted for external review.

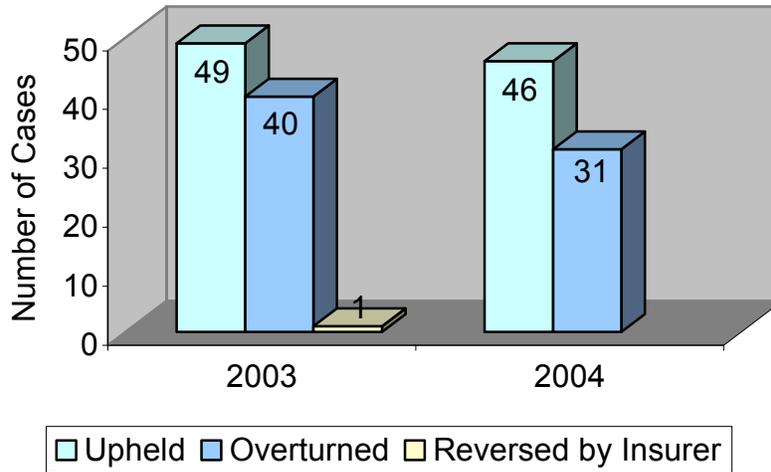
**Table 1: Reasons for Non-Acceptance of an External Review Request  
January 1, 2003 – December 31, 2004**

Reason for Non-acceptance	Number of Requests	
	2003	2004
<b>INELIGIBLE</b>		
Health Criteria not Met for Expedited, Not Eligible as Standard	8	4
Not a Medical Necessity Determination	18	20
Request Withdrawn	1	4
Service Excluded	14	8
No Denial Issued	0	2
Insurer’s Expedited Appeal not Requested Prior to Request	0	1
Not Covered under Health Plan	0	2
Retrospective Services-not Eligible for Expedited	0	2
Denial Decision Pre-Dates Law	1	0
Past 60 Day Request Time Frame	7	6
Insurer Appeal Process not Exhausted	17	18
Insurance Type not Eligible for External Review	5	5
Request is Incomplete, no Resubmission of Request	10	11
<b>Total Ineligible</b>	<b>81</b>	<b>83</b>
<b>NO JURISDICTION</b>		
Contract Situs not in NC	3	1
Self-Funded	9	10
Medicare HMO	1	0
<b>Total No Jurisdiction</b>	<b>13</b>	<b>11</b>
<b>Total Requests Not Accepted</b>	<b>94</b>	<b>94</b>

**E. Outcomes of Accepted Cases**

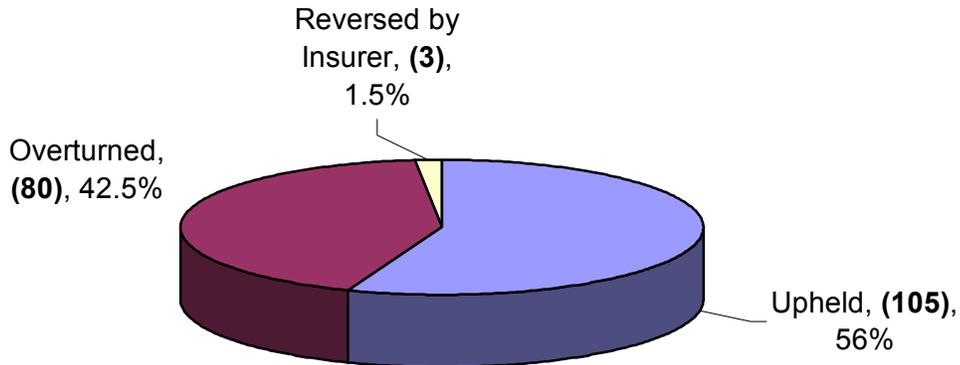
The HCR Program accepted fewer cases for external review in 2004 than it did in 2003. Of the 77 cases accepted in 2004, 40.25% resulted in the insurer’s decision being overturned, compared to 2003, where 45.5% of requests were overturned in favor of the consumer. Figure 7 shows the outcomes of external reviews performed, compared by calendar year.

**Figure 7: Comparison of Case Outcomes by Calendar Year  
January 1, 2003 – December 31, 2004**



The HCR Program became effective July 1, 2002. During the two years and six months of operation, 188 cases were accepted for review, resulting in coverage for the disputed service for 44% of the consumers who requested external review, due either to the insurer reversing its own denial or the IRO overturning the insurer’s noncertification, as shown in Figure 8.

**Figure 8: Percentage of Outcomes for All Accepted Cases,  
July 1, 2002 – December 31, 2004**

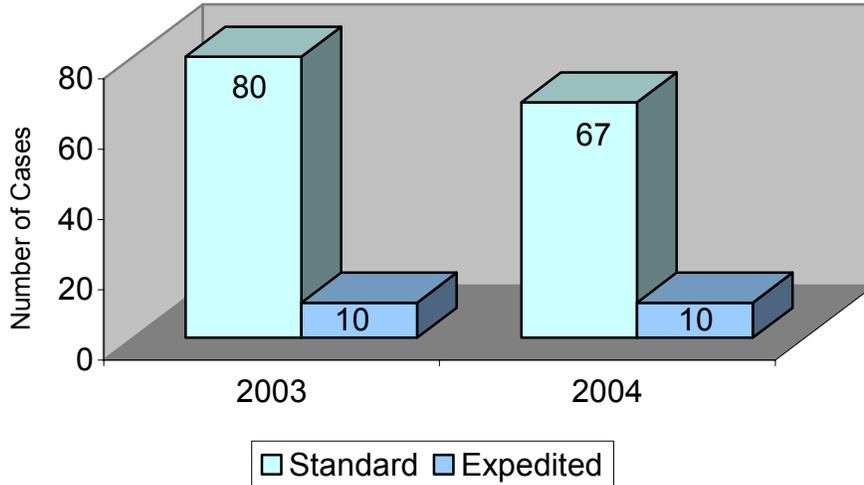


**F. Types of External Review Requested**

The HCR Program continues to receive and accept significantly more cases to be processed on a standard basis versus an expedited basis. In order to be eligible for expedited processing, a contracted medical consultant with no association with the insurer must advise that the time frame required to complete the insurer’s internal appeal

or a standard external review is likely to seriously jeopardize the patient’s life, health or ability to regain maximum function. Figure 9 shows a comparison of cases accepted by type of review by calendar year.

**Figure 9: Comparison of External Review Cases Accepted by Type of Review by Calendar Year, January 1, 2003 – December 31, 2004**



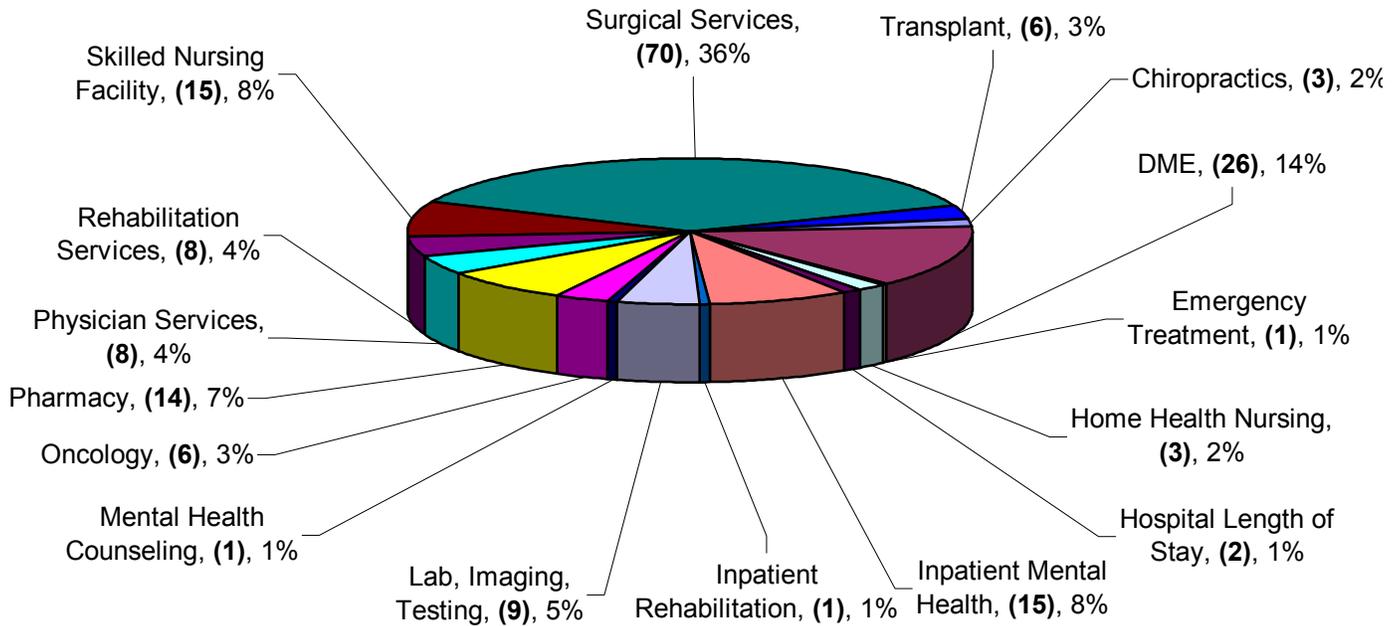
**G. Average Time to Process Accepted Cases**

When a case is assigned to an IRO for a determination, the IRO must render a decision within the time frames mandated under North Carolina law. For a standard review, the decision must be rendered by the 45<sup>th</sup> calendar day following the date of the HCR Program’s receipt of the request. For an expedited request, the IRO has until the 4<sup>th</sup> calendar day following the HCR Program’s receipt of the request. Most cases accepted on a standard basis are completed between the 36<sup>th</sup> and 45<sup>th</sup> day. Most cases accepted on an expedited basis are completed between the 3<sup>rd</sup> and 4<sup>th</sup> day. In no case was the mandated deadline for a decision not met.

**V. Activity by Type of Service Requested**

The HCR Program classifies accepted cases into general service-type categories. In order to give the reader a full picture of the types of service that are the subject of external review, the discussion of activity by type of service will first encompass cumulative activity and then compare activity by calendar year where comparison is relevant. Figure 10 shows the number of accepted cases by type of service requested. Surgical service continues to be the largest share of accepted cases, representing 36% of the 188 accepted cases for review during the reporting period. Durable medical equipment (DME) has the second largest share of requests (14%) and inpatient mental health services has tied with skilled nursing services for the third largest share of activity (8% each). All other services represent a smaller share of the total accepted cases.

**Figure 10: Accepted Cases by Type of Service Requested  
July 1, 2002 – December 31, 2004**



The HCR Program reports primarily on the basis of the general service-type categories. Information on specific service types is also kept by the Program to analyze activity and identify trends. Table 2 gives the reader a listing of the 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 data collection for the HCR Program has evolved, final areas of categorization have been developed. "Chiropractics" has become its own general type of service, moving from "Physician Services" to give the reader a clearer concept of the type of service.

**Table 2: Type of General Service and Specific Services Requested  
for all Accepted Cases for External Review, July 1, 2002 – December 31, 2004**

<b>Type of General Service and Specific Services Requested</b>				
<b>Durable Medical Equipment (DME) (26)</b>	<b>Inpatient Mental Health (15)</b>	<b>Rehabilitation Service (8)</b>	<b>Surgical Services (70)</b>	
<ul style="list-style-type: none"> <li>• Cranial Banding (16)</li> <li>• Glucose Monitoring (1)</li> <li>• Stair Lift (1)</li> <li>• Portable Hyperbaric Oxygen Chamber (2)</li> <li>• Leg Prosthesis (2)</li> <li>• Vest Airway Clearance System (1)</li> <li>• Bone Growth Stimulator (1)</li> <li>• Anodyne Therapy (1)</li> <li>• Nocturnal Enuresis Alarm (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Admit, Acute Psych (1)</li> <li>• LOS, Acute Psych (6)</li> <li>• Admission, Residential (6)</li> <li>• LOS, Residential Treatment (1)</li> <li>• Partial Hospitalization Level (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Speech Therapy (6)</li> <li>• Physical Therapy (1)</li> <li>• Biofeedback (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Gall Bladder (2)</li> <li>• Panniculectomy (7)</li> <li>• Hysterectomy (2)</li> <li>• Breast Reduction (10)</li> <li>• Gastric Bypass (13)</li> <li>• TMJ/Orthognothic Surgery (9)</li> <li>• Electrothermal Arthroscopic Capsulorrhaphy (2)</li> <li>• Osteochondral Autograft Transfer (1)</li> <li>• Lumbar Laminectomy(1)</li> <li>• Vein Surgery (12)</li> <li>• Dermatocholasia (1)</li> <li>• Septoplasty (1)</li> <li>• In Utero Surgery (1)</li> <li>• Intrauterine Surgery (1)</li> <li>• Mole Removal (1)</li> <li>• Lipoma Removal (1)</li> <li>• Craniectomy (1)</li> <li>• Metal on Metal Hip Resurfacing (2)</li> <li>• Tonsillectomy (1)</li> <li>• Meniscal Allograph Procedure (1)</li> </ul>	
		<b>Transplant (6)</b>		<ul style="list-style-type: none"> <li>• Stem Cell Transplant (5)</li> <li>• Corneal Transplant (1)</li> </ul>
		<b>Chiropractics (3)</b>		<b>Lab, Imaging, Testing (9)</b>
<ul style="list-style-type: none"> <li>• Chiropractic Services (3)</li> </ul>	<ul style="list-style-type: none"> <li>• PET Scan (2)</li> <li>• Cardiac Arrhythmia/Risk Assessment (2)</li> <li>• Polysomnogram (1)</li> <li>• Electrogastrogram (1)</li> <li>• Gastroenterological testing (1)</li> <li>• Capsule Endoscopy (1)</li> <li>• Mycotoxin Blood Test (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Botox (3)</li> <li>• Synagis (1)</li> <li>• Non-steroidal Anti-Inflammatory (3)</li> <li>• Growth Hormone (1)</li> <li>• Remicade (1)</li> <li>• Steroid Injection (1)</li> <li>• IV Antibiotics-Lyme (2)</li> <li>• Chelation Therapy (2)</li> </ul>		
<b>Emergency Treatment (1)</b>			<ul style="list-style-type: none"> <li>• Infectious Disease (1)</li> </ul>	
<b>Hospital LOS (2)</b>			<ul style="list-style-type: none"> <li>• Cardiac (1)</li> <li>• Gastroenterology (1)</li> </ul>	
<b>Home Health Nursing (3)</b>			<b>Oncology (6)</b>	<b>Physician Services (8)</b>
<ul style="list-style-type: none"> <li>• Private Duty Nursing (3)</li> </ul>			<ul style="list-style-type: none"> <li>• SIR-Spheres Therapy (3)</li> <li>• Renal Ablation (1)</li> <li>• Chemotherapy (1)</li> <li>• Mammosite Radiation (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Insulin Potentiation (1)</li> <li>• Extracorporeal Shock Wave Therapy (3)</li> <li>• Intradiscal Electrothermal Therapy (1)</li> <li>• Laser/Dermatology (2)</li> <li>• Facial Pain Treatment (1)</li> </ul>
<b>Inpatient Rehabilitation (1)</b>	<ul style="list-style-type: none"> <li>• Orthopedic (1)</li> </ul>			
<b>Mental Health Counseling (1)</b>	<b>Skilled Nursing Facility (15)</b>			
<ul style="list-style-type: none"> <li>• Psychoanalysis (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Skilled Nursing Facility (15)</li> </ul>			

In an analysis of activity of accepted cases and outcomes by calendar year, the Program has noted some changes. In 2003, 57% of the DME cases accepted for review were for DOC bands (cranial banding), of which 50% ended in an overturned decision by the IRO. In 2004, again 57% of the DME cases accepted involved the use of DOC bands; however, the overturned rate increased to 75%. In 2003, three of the six Pharmacy requests received involved the use of Botox injections. In 2004, there were no requests involving the use of Botox.

For surgical service, ten requests involving varicose vein surgery were accepted in 2003. All but one decision was upheld by the IRO. In 2004, only 2 cases involving varicose vein surgery were accepted, both of which had decisions upheld by the IRO. Nine requests for gastric bypass surgery were accepted in 2003. Six of these were overturned by the IRO and all six related to the necessity for the procedure. The three that were upheld related to the method in which the procedure was done. By 2004, only 4 requests relating to gastric bypass surgery were accepted. Three were upheld by the IRO for the same reason seen in 2003—the method by which the procedure was done was considered to be experimental. The one case that was overturned related to the necessity of the procedure. Requests relating to orthognothic surgery were similar in both years. Three requests were received in 2003 which were all overturned by the IRO and four requests were received in 2004 which were all overturned.

Table 3 shows the percentage share that each service type held for all accepted cases as well as for each case outcome by calendar year. For surgical cases (the only service with a sizeable number of cases), the percentage of overall cases decreased in 2004 from 45.05% to 28.57%. In 2003, surgical services represented 50% of all cases overturned for that year. In 2004, surgical services represented only 25.81% of overturned cases with DME representing another 25.81% of all overturned cases. It is important to remember that the numbers of cases for each service type remains small, comprised of differing specific services and therefore, not credible for making generalizations about frequency of case outcomes.

**Table 3: Comparison of Percentage Share of Review Activity by Type of Service Requested  
January 1, 2003 – December 31, 2004**

Type of Service	2003				2004		
	Percent of All Accepted Cases 2003	Outcome of Accepted Cases			Percent of All Accepted Cases 2004	Outcome of Accepted Cases	
		Percent of All Cases Overturned	Percent of All Cases Reversed	Percent of All Cases Upheld		Percent of All Cases Overturned	Percent of All Cases Upheld
Chiropractics	1.10	0.00	0.00	2.04	2.60	0.00	4.35
DME	7.68	12.50	0.00	4.09	18.18	25.81	13.04
Emergency Treatment	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Home Health Nursing	2.18	0.00	0.00	4.09	0.00	0.00	0.00
Hospital Length of Stay	2.18	2.50	0.00	2.04	0.00	0.00	0.00
Inpatient Mental Health	7.68	5.00	0.00	10.20	9.09	9.67	8.69
Inpatient Rehabilitation	1.10	0.00	0.00	2.04	0.00	0.00	0.00
Lab, Imaging, Testing	3.29	5.00	0.00	2.04	7.80	6.45	8.69
Mental Health Counseling	1.10	0.00	0.00	2.04	0.00	0.00	0.00
Oncology	3.29	2.50	0.00	4.09	3.89	3.23	4.35
Pharmacy	6.59	5.00	0.00	8.16	7.80	16.12	2.17
Physician Services	3.29	0.00	0.00	6.12	6.49	6.45	6.53
Rehabilitation Services	3.29	5.00	0.00	0.00	5.19	3.23	6.53
Skilled Nursing Services	10.00	10.00	0.00	10.20	6.49	0.00	10.86
Surgical Services	45.05	50.00	100.00	40.81	28.57	25.81	30.44
Transplant	2.18	2.50	0.00	2.04	3.90	3.23	4.35
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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

The data in Table 4 shows that there were services where decisions were made solely on the basis of medical necessity. Those service types were chiropractics, home health nursing, hospital length of stay, inpatient mental health, inpatient rehabilitation, mental health counseling, and skilled nursing services. Other service types, such as oncology, had denial decisions based solely on the insurer's claim that the cancer treatment was experimental or investigational for that condition. Other types of service, such as DME, pharmacy, physician services and surgical services had denials made on the basis of medical necessity, experimental nature or cosmetic nature of the treatment.

Overall, in 2003 outcomes for medical necessity and cosmetic denials were split evenly between overturned and upheld. In 2004, cosmetic outcomes remained relatively even between overturned and upheld. Medical necessity denials were almost twice as likely to be upheld in 2004. In both years, outcomes for cases denied due to the experimental or investigational nature of the treatment for the condition were exactly or almost twice as likely to be upheld as overturned. The number of cases available for analysis remains small and cannot be relied upon to make any generalizations relating to outcomes at this point.

**Table 4: Comparison of Outcomes of Accepted External Review Requests by Service Type and Denial Type by Calendar Year, January 1, 2003 – December 31, 2004**

Service Type	2003						2004					
	Medical Necessity		Experimental / Investigational		Cosmetic		Medical Necessity		Experimental / Investigational		Cosmetic	
	Overtured	Upheld	Overtured	Upheld	Overtured	Upheld	Overtured	Upheld	Overtured	Upheld	Overtured	Upheld
Chiropractics	--	1	--	--	--	--	--	2	--	--	--	--
DME	2	2	1	--	2	--	1	2	1	2	6	2
Home Health Nursing	--	2	--	--	--	--	--	--	--	--	--	--
Hospital Length of Stay	1	1	--	--	--	--	--	--	--	--	--	--
Inpatient Mental Health	2	5	--	--	--	--	3	4	--	--	--	--
Inpatient Rehabilitation	--	1	--	--	--	--	--	--	--	--	--	--
Lab, Imaging, Testing	2	--	--	1	--	--	--	2	2	2	--	--
Mental Health Counseling	--	1	--	--	--	--	--	--	--	--	--	--
Oncology	--	--	1	2	--	--	--	--	1	2	--	--
Pharmacy	--	3	2	1	--	--	2	1	2	--	1	--
Physician Services	--	1	--	2	--	--	1	--	--	2	1	1
Rehabilitation Services	2	--	--	--	--	--	--	2	1	1	--	--
Skilled Nursing Services	4	5	--	--	--	--	--	5	--	--	--	--
Surgical Services	12	5	5	13	3	2	8	6	--	4	--	4
Transplant	--	--	1	1	--	--	--	1	1	1	--	--
<b>Total</b>	<b>25</b>	<b>27</b>	<b>10</b>	<b>20</b>	<b>5</b>	<b>2</b>	<b>15</b>	<b>25</b>	<b>8</b>	<b>14</b>	<b>8</b>	<b>7</b>

Table 5 compares the outcomes of all accepted external review requests by the general service type and the type of review granted by calendar year. Cases are accepted for expedited handling when, on the advise of a contracted medical professional, the time frame for either completing the insurer's internal appeal process or a standard external review, would likely seriously jeopardize the patient's life, health or ability to regain maximum function. During 2003, 11.1% of accepted cases were processed on an expedited basis. Of these cases, the circumstances related to: private duty home health nursing for paralyzed patients, inpatient hospital length of stay, concurrent PET scans in conjunction with cancer treatment, SIR-Spheres therapy for treatment of liver cancer, renal ablation for treatment of liver cancer, Botox injections for treatment of migraine headaches, and in vitro surgery. There are too few cases to identify any trends in outcomes.

During 2004, 12.9% of cases were approved to be handled on an expedited basis. These cases involved the following circumstances: application of a bone growth stimulator to be applied during surgery, SIR-Spheres therapy, Mammosite radiation therapy, Synergis injection for premature infant lung development, discharge from skilled nursing facility, tonsillectomy and stem cell transplant.

For each year, 30% of expedited cases were decided in favor of the patient, with 70% being decided in favor of the insurer. Of all standard external review outcomes in 2003, 47.5% of those resulted in a positive outcome for the consumer. In 2004, 41.7% of standard external reviews were decided in favor of consumers. There are insufficient numbers of cases to identify any trends in outcomes or to make any assumptions or generalizations relating to outcomes and types of service.

**Table 5: Comparison of Outcomes of Requests by Type of Service Requested by Type of Review Granted by Calendar Year, January 1, 2003 – December 31, 2004**

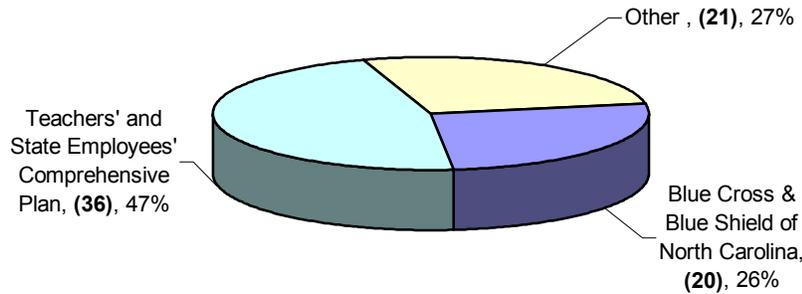
Service Type	2003						2004					
	Standard Review			Expedited Review			Standard Review			Expedited Review		
	Overtuned	Reverse	Upheld	Overtuned	Reverse	Upheld	Overtuned	Reverse	Upheld	Overtuned	Reverse	Upheld
Chiropractics	--	--	1	--	--	--	--	--	2	--	--	--
DME	5	--	2	--	--	--	8	--	5	--	--	1
Home Health Nursing	--	--	--	--	--	2	--	--	--	--	--	--
Hospital Length of Stay	1	--	--	--	--	1	--	--	--	--	--	--
Inpatient Mental Health	2	--	5	--	--	--	3	--	4	--	--	--
Inpatient Rehabilitation	--	--	1	--	--	--	--	--	--	--	--	--
Lab, Imaging, Testing	1	--	1	1	--	--	2	--	4	--	--	--
Mental Health Counseling	--	--	1	--	--	--	--	--	--	--	--	--
Oncology	--	--	--	1	--	2	1	--	--	--	--	2
Pharmacy	1	--	3	1	--	1	4	--	1	1	--	--
Physician Services	--	--	3	--	--	--	2	--	3	--	--	--
Rehabilitation Services	2	--	--	--	--	--	1	--	3	--	--	--
Skilled Nursing Services	4	--	5	--	--	--	--	--	2	--	--	3
Surgical Services	20	1	19	--	--	1	7	--	14	1	--	--
Transplant	1	--	1	--	--	--	--	--	1	1	--	1
<b>Total</b>	<b>37</b>	<b>1</b>	<b>42</b>	<b>3</b>	<b>0</b>	<b>7</b>	<b>28</b>	<b>0</b>	<b>39</b>	<b>3</b>	<b>0</b>	<b>7</b>

**A. Insurer and Type of Service Activity**

During 2004, State Health Plan and Blue Cross & Blue Shield of North Carolina comprised 73% of external review activity. Thirteen other insurers made up the additional 27% of the activity. The percentage share of insurer activity is depicted in Figure 11 (A) and (B).

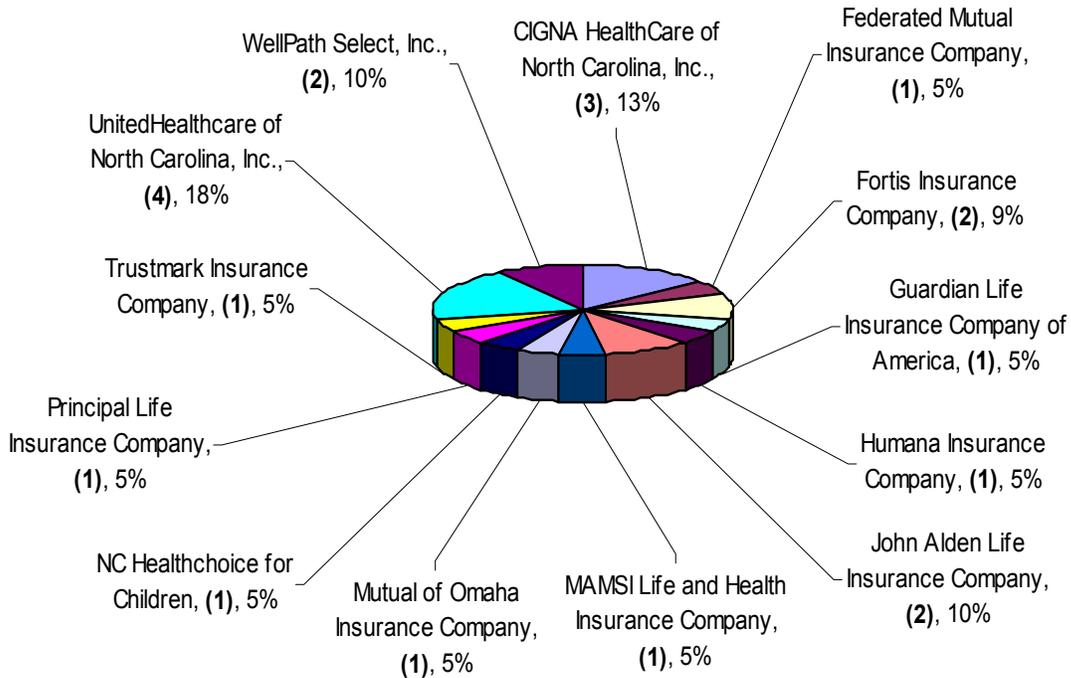
**Figure 11: Insurer's Share of Accepted External Review Requests  
January 1, 2004 – December 31, 2004**

**A. Insurers Comprising Majority of Cases**



**Figure 11: Insurer's Share of Accepted External Review Requests  
January 1, 2004 – December 31, 2004**

**B. Other Insurers**



With 36 accepted cases during 2004, the State Health Plan remains the health plan that experiences the highest number of requests for external review within the Healthcare Review Program. Blue Cross & Blue Shield of North Carolina, the state's largest insurer, had the second largest number with 20 accepted cases.

The rate of cases accepted for external review involving any specific insurer must be compared to the number of covered members per month in order to have meaning for prevalence of activity. HMOs are required to report "member months" data to the Department of Insurance on an annual basis. Insurers offering indemnity and PPO plans are not required to report member months. Member month data for the State Health Plan and the NC Healthplan for Children is reported to the Program upon request.

Table 6 compares the 2003 rate of external review activity per 100,000 members to that activity of 2004. Analysis of health plans with member month data shows that the rate of external review activity for all HMOs required to report data has decreased from 2003. There are no HMOs who have a case rate of more than one per 100,000 member months.

The State Health Plan and the NC Healthchoice for Children remain constant in their prevalence of cases accepted. Both health plans have a rate of less than 1 case per 100,000 members for both years of activity.

For indemnity or PPO plans, the volume of external review cases is very small. Blue Cross & Blue Shield of North Carolina does not report the member month data for its non-HMO business; however its non-HMO external review activity for 2004 was sixteen cases. No other PPO or indemnity plan experienced more than two external review cases during 2004.

In comparing activity between 2003 and 2004, the Program is seeing similar data. A small number of large healthplans comprise the most cases for external review, while a large number of smaller healthplans make up less than 30% of activity. The rate of external review cases per member month for both years is small. Overall, there are still too few cases of external review to make any assumptions regarding insurers and external review activity.

**Table 6: Comparison of Accepted Case Activity by Insurer by Member Months by Calendar Year, January 1, 2003 – December 31, 2004**

Insurer	2003			2004		
	Number of Accepted Cases	Number of Member Months	Number of Cases per 100,000 Member Months	Number of Accepted Cases	Number of Member Months	Number of Cases per 100,000 Member Months
Blue Cross & Blue Shield of North Carolina (HMO)	6	2,158,617	0.28	4	1,791,103	0.22
Blue Cross & Blue Shield of North Carolina (Non-HMO)	9	NR	N/A	16	NR	N/A
CIGNA HealthCare of North Carolina, Inc.	10	1,573,647	0.64	2	1,087,330	0.18
Celtic Insurance Company	1	NR	N/A	0	N/A	N/A
Connecticut General Life Insurance Co.	1	NR	N/A	0	N/A	N/A
Federated Mutual Insurance Company	0	N/A	N/A	1	NR	N/A
FirstCarolinaCare, Inc.	1	93,382	1.07	0	120,316	N/A
Fortis Insurance Company	0	N/A	N/A	1	NR	N/A
Guardian Life Insurance Company of America	0	N/A	N/A	1	NR	N/A
GE Group Life Assurance Company	1	NR	N/A	0	N/A	N/A
Humana Insurance Company	0	N/A	N/A	1	N/R	N/A
John Alden Life Insurance Company	1	NR	N/A	2	NR	N/A
MAMSI Life and Health Insurance Company	1	NR	N/A	1	NR	N/A
Mutual of Omaha Insurance Company	0	N/A	N/A	1	NR	N/A
NC Healthchoice for Children	1	1,243,429	0.08	1	1,471,703	0.06
New England Life Insurance Company	1	NR	N/A	0	N/A	N/A
North Carolina Medical Society Employees Benefit Trust (MEWA)	1	NR	N/A	0	N/A	N/A
Optimum Choice of the Carolinas	1	172,470	0.58	0	135,814	N/A
PARTNERS National Health Plans of North Carolina	1	327,782	0.31	0	N/A	N/A
Principal Life Insurance Company	3	NR	N/A	1	NR	N/A
Teachers' and State Employees' Comprehensive Plan	39	6,742,967	0.58	36	6,275,459	0.57
Trustmark Insurance Company	0	N/A	N/A	1	NR	N/A
UnitedHealthcare of North Carolina, Inc.	4	2,980,756	0.13	3	2,870,681	0.10
United HealthCare Insurance Company	2	NR	N/A	0	N/A	N/A
WellPath Select, Inc.	5	739,089	0.68	2	768,012	0.26
World Insurance Company	1	NR	N/A	0	N/A	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 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. For insurers with the largest number of requests (SHP and Blue Cross & Blue Shield of North Carolina) the percentage of cases overturned by the IRO and the percentage of cases upheld by the IRO are remarkably similar from 2003 to 2004. 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: Comparison of Accepted Case Activity by Insurer and Type of Service Requested by Calendar Year, January 1, 2003 – December 31, 2004**

Insurer and Type of Service	2003				2004			
	Number of Accepted Cases	Insurer's Outcome			Number of Accepted Cases	Insurer's Outcome		
		Percent Overturned	Percent Reversed	Percent Upheld		Percent Overturned	Percent Reversed	Percent Upheld
<b>Blue Cross &amp; Blue Shield of North Carolina</b>	<b>15</b>				<b>20</b>			
• DME	2	100.00	--	--	2	50.00	--	50.00
• Home Health Nursing	1	--	--	100.00	NA	--	--	--
• Hospital Length of Stay	1	--	--	100.00	NA	--	--	--
• Inpatient Mental Health	NA	--	--	--	1	100.00	--	--
• Inpatient Rehabilitation	1	--	--	100.00	NA	--	--	--
• Lab, Imaging, Testing	NA	--	--	--	3	--	--	100.00
• Pharmacy	1	--	--	100.00	1	100.00	--	--
• Physician Services	NA	--	--	--	4	25.00	--	75.00
• Surgical Services	9	33.33	--	66.67	9	33.33	--	66.67
<b>Total Percentage for Insurer</b>		<b>33.33</b>	<b>--</b>	<b>66.67</b>		<b>35.00</b>	<b>--</b>	<b>65.00</b>
<b>CIGNA HealthCare of North Carolina, Inc.</b>	<b>10</b>				<b>3</b>			
• DME	1	--	--	100.00	NA	--	--	--
• Inpatient Mental Health	1	100.00	--	--	NA	--	--	--
• Oncology	1	100.00	--	--	NA	--	--	--
• Pharmacy	1	--	--	100.00	2	100.00	--	--
• Physician Services	2	--	--	100.00	NA	--	--	--
• Surgical Services	4	75.00	25.00		1	--	--	100.00
<b>Total Percentage for Insurer</b>		<b>50.00</b>	<b>10.00</b>	<b>40.00</b>		<b>66.67</b>	<b>--</b>	<b>33.33</b>
<b>Celtic Insurance Company</b>	<b>1</b>				<b>NA</b>			
• Surgical Services	1	100.00	--	--	NA	--	--	--
<b>Total Percentage for Insurer</b>		<b>100.00</b>	<b>--</b>	<b>--</b>		<b>--</b>	<b>--</b>	<b>--</b>
<b>Connecticut General Life Insurance Company</b>	<b>1</b>				<b>NA</b>			
• Pharmacy	1	100.00	--	--	NA	--	--	--
<b>Total Percentage for Insurer</b>		<b>100.00</b>	<b>--</b>	<b>--</b>		<b>--</b>	<b>--</b>	<b>--</b>

**Table 7: Comparison of Accepted Case Activity by Insurer and Type of Service Requested by Calendar Year, January 1, 2003 – December 31, 2004 (Cont'd.)**

Insurer and Type of Service	2003				2004			
	Number of Accepted Cases	Insurer's Outcome			Number of Accepted Cases	Insurer's Outcome		
		Percent Overturned	Percent Reversed	Percent Upheld		Percent Overturned	Percent Reversed	Percent Upheld
<b>Federated Mutual Insurance Company</b>	<b>NA</b>				<b>1</b>			
• Chiropractics	NA	--	--	--	1	--	--	100.00
<b>Total Percentage for Insurer</b>		--	--	--		--	--	<b>100.00</b>
<b>FirstCarolinaCare, Inc.</b>	<b>1</b>				<b>NA</b>			
• Surgical Services	1	100.00	--	--	NA	--	--	--
<b>Total Percentage for Insurer</b>		<b>100.00</b>	--	--		--	--	--
<b>Fortis Insurance Company</b>	<b>NA</b>				<b>2</b>			
• Lab, Imaging, Testing	NA	--	--	--	1	100.00	--	--
• Surgical Services	NA	--	--	--	1	--	--	100.00
<b>Total Percentage for Insurer</b>		--	--	--		<b>50.00</b>	--	<b>50.00</b>
<b>GE Group Life Assurance Company</b>	<b>1</b>				<b>NA</b>			
• Lab, Imaging, Testing	1	100.00	--	--	NA	--	--	--
<b>Total Percentage for Insurer</b>		<b>100.00</b>	--	--		--	--	--
<b>Guardian Life Insurance Company of America</b>	<b>NA</b>				<b>1</b>			
• Inpatient Mental Health	NA	--	--	--	1	100.00	--	--
<b>Total Percentage for Insurer</b>		--	--	--		<b>100.00</b>	--	--
<b>Humana Insurance Company</b>	<b>NA</b>				<b>1</b>			
• Chiropractics	NA	--	--	--	1	--	--	100.00
<b>Total Percentage for Insurer</b>		--	--	--		--	--	<b>100.00</b>
<b>John Alden Life Insurance Company</b>	<b>1</b>				<b>2</b>			
• Chiropractics	1	--	--	100.00	NA	--	--	--
• DME	NA	--	--	--	1	100.00	--	--
• Pharmacy	NA	--	--	--	1	100.00	--	--
<b>Total Percentage for Insurer</b>		--	--	<b>100.00</b>		<b>100.00</b>	--	--
<b>MAMSI Life and Health Insurance Company</b>	<b>1</b>				<b>1</b>			
• Inpatient Mental Health	1	--	--	100.00	NA	--	--	--
• Oncology	NA	--	--	--	1	100.00	--	--
<b>Total Percentage for Insurer</b>		--	--	<b>100.00</b>		<b>100.00</b>	--	--

**Table 7: Comparison of Accepted Case Activity by Insurer and Type of Service Requested by Calendar Year, January 1, 2003 – December 31, 2004 (Cont'd.)**

Insurer and Type of Service	2003				2004			
	Number of Accepted Cases	Insurer's Outcome			Number of Accepted Cases	Insurer's Outcome		
		Percent Overturned	Percent Reversed	Percent Upheld		Percent Overturned	Percent Reversed	Percent Upheld
<b>Mutual of Omaha Insurance Company</b>	<b>NA</b>				<b>1</b>			
• Surgical Services	NA	--	--	--	1	--	--	100.00
<b>Total Percentage for Insurer</b>		--	--	--		--	--	<b>100.00</b>
<b>NC Healthchoice for Children</b>	<b>1</b>				<b>1</b>			
• Pharmacy	1	100.00	--	--	NA	--	--	--
• Rehabilitation Services	NA	--	--	--	1	--	--	100.00
<b>Total Percentage for Insurer</b>		<b>100.00</b>	--	--		--	--	<b>100.00</b>
<b>New England Life Insurance Company</b>	<b>1</b>				<b>NA</b>			
• Home Health Nursing	1	--	--	100.00	NA	--	--	--
<b>Total Percentage for Insurer</b>		--	--	<b>100.00</b>		--	--	--
<b>North Carolina Medical Society Employees Benefit Trust (MEWA)</b>	<b>1</b>				<b>NA</b>			
• Surgical Services	-	--	--	100.00	NA	--	--	--
<b>Total Percentage for Insurer</b>		--	--	<b>100.00</b>		--	--	--
<b>Optimum Choice of the Carolinas, Inc.</b>	<b>1</b>				<b>NA</b>			
• Hospital Length of Stay	1	100.00	--	--	NA	--	--	--
<b>Total Percentage for Insurer</b>		<b>100.00</b>	--	--		--	--	--
<b>PARTNERS National Health Plans of North Carolina</b>	<b>1</b>				<b>NA</b>			
• DME	1	100.00	--	--	NA	--	--	--
<b>Total Percentage for Insurer</b>		<b>100.00</b>	--	--		--	--	--
<b>Principal Life Insurance Company</b>	<b>3</b>				<b>1</b>			
• Inpatient Mental Health	1	--	--	100.00	NA	--	--	--
• Pharmacy	1	--	--	100.00	NA	--	--	--
• Physician Services	1	--	--	100.00	NA	--	--	--
• Rehabilitation Services	NA	--	--	--	1	--	--	100.00
<b>Total Percentage for Insurer</b>		--	--	<b>100.00</b>		--	--	<b>100.00</b>

**Table 7: Comparison of Accepted Case Activity by Insurer and Type of Service Requested by Calendar Year, January 1, 2003 – December 31, 2004 (Cont'd.)**

Insurer and Type of Service	2003				2004			
	Number of Accepted Cases	Insurer's Outcome			Number of Accepted Cases	Insurer's Outcome		
		Percent Overturned	Percent Reversed	Percent Upheld		Percent Overturned	Percent Reversed	Percent Upheld
<b>Teachers' and State Employees' Comprehensive Plan</b>	<b>39</b>				<b>36</b>			
• DME	2	50.00	--	50.00	11	54.55	--	45.45
• Inpatient Mental Health	4	25.00	--	75.00	3	33.33	--	66.67
• Lab, Imaging, Testing	1	100.00	--	--	1	--	--	100.00
• Mental Health Counseling	1	--	--	100.00	NA	--	--	--
• Oncology	2	--	--	100.00	2	--	--	100.00
• Pharmacy	NA	--	--	--	1	100.00	--	--
• Physician Services	NA	--	--	--	1	100.00	--	--
• Rehabilitation Services	2	100.00	--	--	2	50.00	--	50.00
• Skilled Nursing Facility	9	44.44	--	55.56	5	--	--	100.00
• Surgical Services	16	31.25	--	68.75	7	42.86	--	57.14
• Transplant	2	50.00	--	50.00	3	33.33	--	66.67
<b>Total Percentage for Insurer</b>		<b>38.46</b>	--	<b>61.54</b>		<b>38.89</b>	--	<b>61.11</b>
<b>Trustmark Insurance Company</b>	<b>NA</b>				<b>1</b>			
• Pharmacy	NA	--	--	--	1	--	--	100.00
<b>Total Percentage for Insurer</b>		--	--	--		--	--	<b>100.00</b>
<b>United HealthCare Insurance Company</b>	<b>1</b>				<b>NA</b>			
• DME	1	100.00	--	--	NA	--	--	--
• Lab, Imaging, Testing	1	--	--	100.00	NA	--	--	--
<b>Total Percentage for Insurer</b>		<b>50.00</b>	--	<b>50.00</b>		--	--	--
<b>UnitedHealthcare of North Carolina, Inc.</b>	<b>4</b>				<b>4</b>			
• Inpatient Mental Health	NA	--	--	--	1	--	--	100.00
• Lab, Imaging, Testing	NA	--	--	--	1	100.00	--	--
• Pharmacy	1	100.00	--	--	NA	--	--	--
• Surgical Services	3	100.00	--	--	2	50.00	--	50.00
<b>Total Percentage for Insurer</b>		<b>100.00</b>	--	--		<b>50.00</b>	--	<b>50.00</b>
<b>WellPath Select, Inc.</b>	<b>5</b>				<b>2</b>			
• Inpatient Mental Health	NA	--	--	--	1	--	--	100.00
• Surgical Services	5	60.00	--	40.00	1	100.00	--	--
<b>Total Percentage for Insurer</b>		<b>60.00</b>	--	<b>40.00</b>		<b>50.00</b>	--	<b>50.00</b>
<b>World Insurance Company</b>	<b>1</b>				<b>NA</b>			
• Surgical Services	1	100.00	--	--	NA	--	--	--
<b>Total Percentage for Insurer</b>		<b>100.00</b>	--	--		--	--	--

## VI. Activity by IRO

### A. Summary by IRO

During the period of January 1, 2003 – December 31, 2004, IROs rendered 166 external review decisions for consumers. These cases encompass a variety of insurers, noncertification reasons and specific types of services. Table 8 compares the number of cases assigned to each IRO with the number and percentage of their review decisions, by calendar year. 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. The contract for Hayes Plus expired on June 30, 2004 when the IRO declined to extend their contract for one additional year. Permedion's contract became effective January 1, 2004.

The data in Table 8 shows that the number of cases assigned to Carolina Center for Clinical Information decreased in 2004 by 46%, a result of conflict of interest screening for case assignment, and a smaller volume of accepted cases by the Program during the year. The percentage of review decisions upheld by Hayes Plus in 2004 (January 1 – June 30<sup>th</sup>) increased slightly in comparison to review decisions for 2003. The number and percentage of types of review decisions for Maximus CHDR and IPRO remained relatively constant for both years. In 2004, Permedion's percentage of overturned decisions was 36.8%. Prest & Associates did not have a large enough volume to analyze.

**Table 8: Comparison of IRO Activity Summary by Calendar Year, January 1, 2003 – December 31, 2004**

IRO	2003					2004				
	Number Assigned	Overturned		Upheld		Number Assigned	Overturned		Upheld	
		#	%	#	%		#	%	#	%
Carolina Center for Clinical Information	13	10	76.92	3	23.08	7	3	42.86	4	57.14
Hayes Plus	25	6	24.00	19	76.00	6	1	16.67	5	83.33
IPRO	25	11	44.00	14	56.00	22	9	40.91	13	59.09
Maximus CHDR	24	13	54.17	11	45.83	22	11	50.00	11	50.00
Permedion	1	0	0.00	1	100.00	19	7	36.84	12	63.16
Prest & Associates	1	0	0.00	1	100.00	1	0	0.00	1	100.00
<b>All Cases</b>	<b>89</b>	<b>40</b>	<b>44.94</b>	<b>49</b>	<b>55.06</b>	<b>77</b>	<b>31</b>	<b>40.26</b>	<b>46</b>	<b>59.74</b>

## 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 services. Large discrepancies of outcomes for similar services between different IROs would provide cause for the Program to further investigate the outcome patterns.

Table 9 presents the percentage of case outcomes by the general type of service for each IRO. The table shows how each IRO decided on the cases categorized by the general types of services for each case. Table 10 reports the outcomes for the Service Type for all IRO decisions. This enables the reader to compare an individual IRO's percentage of outcomes to those of all IROs for that same general type of service.

**Table 9: Comparison of IRO Decisions by Type of Service Requested by Calendar Year, January 1, 2003 – December 31, 2004**

IRO and Type of Service	2003			2004		
	Number of Decisions	Outcomes		Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld		Percent Overturned	Percent Upheld
<b>Carolina Center for Clinical Information</b>						
• Chiropractics	--	--	--	1	--	100.00
• Home Health Nursing	1	--	100.00	--	--	--
• Hospital Length of Stay	1	100.00	--	--	--	--
• Inpatient Mental Health	1	100.00	--	1	--	100.00
• Lab, Imaging, Testing	1	100.00	--	1	100.00	--
• Pharmacy	1	--	100.00	1	--	100.00
• Physician Services	1	--	100.00	--	--	--
• Rehabilitation Services	--	--	--	1	--	100.00
• Surgical Services	7	100.00	--	2	50.00	50.00
<b>Hayes Plus</b>						
• Chiropractics	1	--	100.00	--	--	--
• DME	2	50.00	50.00	--	--	--
• Home Health Nursing	1	--	100.00	--	--	--
• Inpatient Mental Health	2	--	100.00	1	--	100.00
• Lab, Imaging, Testing	1	100.00	--	--	--	--
• Mental Health Counseling	1	--	100.00	--	--	--
• Pharmacy	1	100.00	--	--	--	--
• Rehabilitation Services	1	100.00	--	--	--	--
• Skilled Nursing Facility	5	--	100.00	--	--	--
• Surgical Services	9	22.22	77.78	4	25.00	75.00
• Transplant	1	--	100.00	1	--	100.00

**Table 9: Comparison of IRO Decisions by Type of Service Requested by  
Calendar Year, January 1, 2003 – December 31, 2004 (Cont'd.)**

IRO and Type of Service	2003			2004		
	Number of Decisions	Outcomes		Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld		Percent Overturned	Percent Upheld
<b>IPRO</b>						
• DME	4	75.00	25.00	6	66.67	33.33
• Hospital Length of Stay	1	--	100.00	--	--	--
• Inpatient Mental Health	1	--	100.00	--	--	--
• Lab, Imaging, Testing	1	--	100.00	1	--	100.00
• Oncology	2	--	100.00	1	--	100.00
• Pharmacy	2	--	100.00	2	100.00	--
• Skilled Nursing Facility	2	100.00	--	4	--	100.00
• Surgical Services	11	45.45	54.55	5	40.00	60.00
• Transplant	1	100.00	--	1	--	100.00
<b>Maximus CHDR</b>						
• Chiropractics	--			1	--	100.00
• DME	1	100.00	--	4	50.00	50.00
• Inpatient Mental Health	2	100.00	--	2	100.00	--
• Inpatient Rehabilitation	1	--	100.00	--	--	--
• Lab, Imaging, Testing	--	--	--	2	50.00	50.00
• Oncology	1	100.00	--	1	100.00	--
• Pharmacy	2	--	100.00	1	100.00	--
• Physician Services	2	--	100.00	--	--	--
• Rehabilitation Services	1	100.00	--	3	33.33	66.67
• Skilled Nursing Facility	2	100.00	--	--	--	--
• Surgical Services	12	50.00	50.00	7	42.86	57.14
<b>Permedion</b>						
• DME	--	--	--	4	50.00	50.00
• Inpatient Mental Health	--	--	--	2	--	100.00
• Lab, Imaging, Testing	--	--	--	1	--	100.00
• Oncology	--	--	--	1	--	100.00
• Pharmacy	--	--	--	2	100.00	--
• Physician Services	--	--	--	3	33.33	66.67
• Skilled Nursing Facility	--	--	--	1	--	100.00
• Surgical Services	1	--	100.00	4	25.00	75.00
• Transplant	--	--	--	1	100.00	--
<b>Prest &amp; Associates</b>						
• Inpatient Mental Health	1	--	100.00	1	--	100.00

**Table 10: Comparison of All IRO Outcomes (Percentages) by General Service Type for all Insurers by Calendar Year, January 1, 2003 – December 31, 2004**

Service Type	2003			2004		
	Number of Decisions	Outcomes		Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld		Percent Overturned	Percent Upheld
Chiropractics	1	--	100.00	2	--	100.00
DME	7	71.43	28.57	14	57.14	42.86
Home Health						
Nursing	2	--	100.00	--	--	--
Hospital Length of Stay	2	50.00	50.00	--	--	--
Inpatient Mental Health	7	28.57	71.43	7	42.86	57.14
Inpatient Rehabilitation	1	--	100.00	--	--	--
Lab, Imaging, Testing	3	66.67	33.33	6	33.33	66.67
Mental Health Counseling	1	--	100.00	--	--	--
Oncology	3	--	100.00	3	33.33	66.67
Pharmacy	6	33.33	66.67	6	83.33	16.67
Physician Services	3	--	100.00	5	40.00	60.00
Rehabilitation Services	2	100.00	--	4	25.00	75.00
Skilled Nursing Facility	9	44.44	55.56	5	--	100.00
Surgical Services	40	50.00	50.00	22	36.36	63.64
Transplant	2	50.00	50.00	3	33.33	66.67

Table 11 shows the outcomes of each IRO's decisions as it relates to the nature of the noncertification. For both years of operation, the majority of cases received for external review related to the insurer's decision that the service was not medically necessary. The insurer's decision that the requested treatment was experimental or investigational for the patient's condition was the second largest type of denial that IROs reviewed. In both years, the outcome for these types of denials was twice as likely to be upheld by the IRO regardless of the IRO assigned.

An IRO is assigned a case on the basis of an alphabetical rotation that is required by law, plus on the basis that no conflict of interest is identified. The nature of the denial has no bearing on the assignment to an IRO. Each IRO, except for Permedion and Prest & Associates, received a fair distribution of each type of noncertification (medical necessity, experimental/investigational, cosmetic). The data remains insufficient in numbers to draw any meaningful conclusions relating the outcomes by specific IROs and the type of denial that is reviewed.

**Table 11: Comparison of IRO Decisions by Nature of Noncertification by Calendar Year,  
January 1, 2003 – December 31, 2004**

Name of IRO	2003							2004						
	Number of Decisions	Medical Necessity		Experimental / Investigational		Cosmetic		Number of Decisions	Medical Necessity		Experimental / Investigational		Cosmetic	
		Overturn	Upheld	Overturn	Upheld	Overturn	Upheld		Overturn	Upheld	Overturn	Upheld	Overturn	Upheld
Carolina Center for Clinical Information	13	6	2	2	1	2	0	7	2	2	1	2	0	0
Hayes Plus	25	4	12	2	7	0	0	6	1	3	0	1	0	1
IPRO	25	5	7	4	6	2	1	22	4	6	0	4	5	3
Maximus, CHDR	24	10	5	2	5	1	1	22	5	7	4	3	2	1
Permedion	1	0	0	0	1	0	0	19	3	6	3	4	1	2
Prest & Associates	1	0	1	0	0	0	0	1	0	1	0	0	0	0
<b>Total</b>	<b>89</b>	<b>25</b>	<b>27</b>	<b>10</b>	<b>20</b>	<b>5</b>	<b>2</b>	<b>77</b>	<b>15</b>	<b>25</b>	<b>8</b>	<b>14</b>	<b>8</b>	<b>7</b>
<b>Percentage</b>		<b>58.4%</b>		<b>33.7%</b>		<b>7.9%</b>			<b>52%</b>		<b>28.5%</b>		<b>19.5%</b>	

**Note:** Permedion became effective as a contracted IRO on January 1, 2004. The IRO was assigned a case in January, 2004 that was received and accepted by the Program in December, 2003.

Table 12 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 12: Comparison of IRO Decisions by Insurer by Calendar Year,  
January 1, 2003 – December 31, 2004**

IRO and Insurer	2003			2004		
	Number of Decisions	% Overturn	% Upheld	Number of Decisions	% Overturn	% Upheld
<b>Carolina Center for Clinical Information</b>	<b>13</b>			<b>7</b>		
• Celtic Insurance Company	1	100.00	--	NA	--	--
• FirstCarolinaCare, Inc.	1	100.00	--	NA	--	--
• Guardian Life Insurance Company of America	NA	--	--	1	100.00	--
• GE Group Life Assurance Company	1	100.00	--	NA	--	--
• Humana Insurance Company	NA	--	--	1	--	100.00
• New England Life Insurance Company	1	--	100.00	NA	--	--
• Optimum Choice of the Carolinas	1	100.00	--	NA	--	--
• Principal Life Insurance Company	2	--	100.00	1	--	100.00
• Trustmark Insurance Company	NA	--	--	1	--	100.00
• UnitedHealthcare of North Carolina, Inc.	4	100.00	--	3	66.67	33.33
• WellPath Select, Inc.	2	100.00	--	NA	--	--
<b>Hayes Plus</b>	<b>25</b>			<b>6</b>		
• Blue Cross & Blue Shield of North Carolina	5	40.00	60.00	2	50.00	50.00
• John Alden Life Insurance Company	1	--	100.00	NA	--	--
• NC Healthchoice for Children	1	100.00	--	NA	--	--
• North Carolina Medical Society Employees Benefit Trust (MEWA)	1	--	100.00	NA	--	--
• Teachers' and State Employees' Comprehensive Plan	17	17.65	82.35	4	--	100.00
<b>IPRO</b>	<b>25</b>			<b>22</b>		
• Blue Cross & Blue Shield of North Carolina	5	60.00	40.00	8	37.50	62.50
• CIGNA HealthCare of North Carolina, Inc.	2	50.00	50.00	1	100.00	--
• Connecticut General Life Insurance Company	1	--	100.00	NA	--	--
• Fortis Insurance Company	NA	--	--	1	--	100.00
• John Alden Life Insurance Company	NA	--	--	2	100.00	--
• PARTNERS National Health Plans of North Carolina, Inc.	1	100.00	--	NA	--	--
• Principal Life Insurance Company	1	--	100.00	NA	--	--
• Teachers' and State Employees' Comprehensive Plan	12	41.67	58.33	10	30.00	70.00
• United HealthCare Insurance Company	1	--	100.00	NA	--	--
• WellPath Select, Inc.	2	50.00	50.00	NA	--	--

**Table 12: Comparison of IRO Decisions by Insurer by Calendar Year,  
January 1, 2003 – December 31, 2004 (Cont'd)**

IRO and Insurer	2003			2004		
	Number of Decisions	% Overturn	% Upheld	Number of Decisions	% Overturn	% Upheld
<b>Maximus CHDR</b>	<b>24</b>			<b>22</b>		
• Blue Cross & Blue Shield of North Carolina	5	--	100.00	5	40.00	60.00
• CIGNA HealthCare of North Carolina, Inc.	7	57.14	42.86	NA	--	--
• Federated Mutual Insurance Company	NA	--	--	1	--	100.00
• Fortis Insurance Company	NA	--	--	1	100.00	--
• MAMSI Life and Health Insurance Company	NA	--	--	1	100.00	--
• NC Healthchoice for Children	NA	--	--	1	--	100.00
• Teachers' and State Employees' Comprehensive Plan	9	77.78	22.22	12	50.00	50.00
• United HealthCare Insurance Company	1	100.00	--	NA	--	--
• WellPath Select, Inc.	1	--	100.00	1	100.00	--
• World Insurance Company	1	100.00	--	NA	--	--
<b>Permedion</b>	<b>1</b>			<b>19</b>		
• Blue Cross & Blue Shield of North Carolina	NA	--	--	5	20.00	80.00
• CIGNA HealthCare of North Carolina, Inc.	NA	--	--	2	50.00	50.00
• Mutual of Omaha Insurance Company	NA	--	--	1	--	100.00
• Teachers' and State Employees' Comprehensive Plan	1	--	100.00	10	50.00	50.00
• UnitedHealthcare of North Carolina, Inc.	NA	--	--	1	--	100.00
<b>Prest &amp; Associates</b>	<b>1</b>			<b>1</b>		
• MAMSI Life and Health Insurance Company	1	--	100.00	NA	--	--
• WellPath Select, Inc.	NA	--	--	1	--	100.00

## VII. Cost of External Review 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 185 reviews performed was \$534.

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 \$12,635. The costs of allowed charges from cases that have been reversed by the insurer or overturned by an IRO for each year are:

2002-	\$89,726.06
2003-	\$565,851.49
2004-	\$292,014.48

**To date, the cumulative total of services provided to consumers as a result of external review since the Program commenced is \$947,592. Because of the prospective nature of seven (7) cases that were overturned by the IRO, the cost of the allowed charges for those cases are not available for reporting at this time.**

Figure 12 shows the cost of the allowed charges for overturned or reversed services that the HCR Program captured each year, as well as the cumulative total of allowed charges for these services. Cumulative costs for 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.

**Figure 12: Yearly and Cumulative Value of Allowed Charges for Overturned or Reversed Services, July 1, 2002 – December 31, 2004**

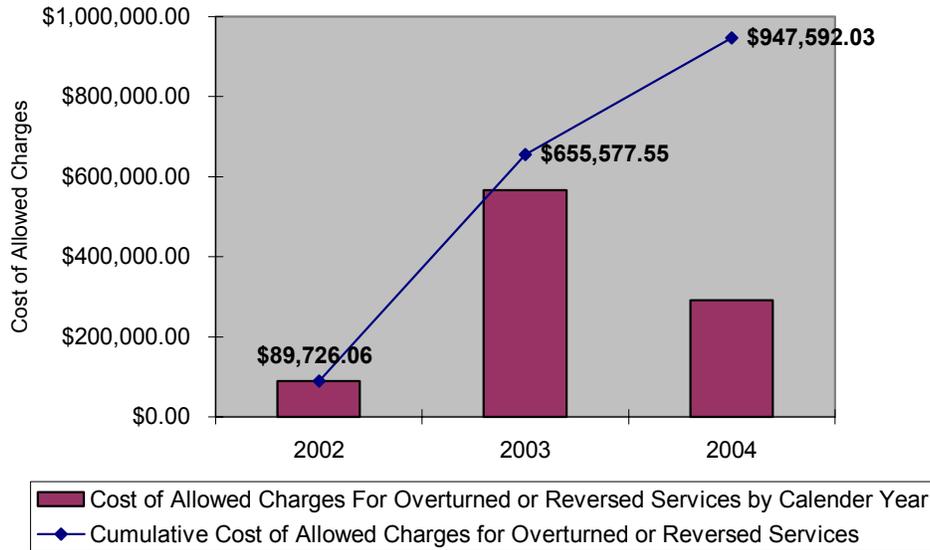


Table 13 shows the average total cost of the IRO review and cost of allowed charges for cases that were reversed by the insurer or overturned (average and cumulative) since the Program began operations, by type of service requested.

**Table 13: Cost of IRO Review, Average and Cumulative Allowed Charges by Type of Service Requested, July 1, 2002 – December 31, 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	
Chiropractics	\$408	\$0	\$0	\$0
DME	559	583	5,971	89,571
Emergency Treatment	0	450	1,096	1,096
Home Health Nursing	498	450	41,096	41,096
Hospital Length of Stay	795	300	788	788
Inpatient Mental Health	594	400	28,406	170,435
Inpatient Rehabilitation	450	0	0	0
Lab, Imaging, Testing*	560	406	967	3,867
Mental Health Counseling	475	0	0	0
Oncology	809	675	20,757	41,515
Pharmacy*	516	578	584	3,505
Physician Services	521	638	632	1,264
Rehabilitation Services	413	500	2,149	6,446
Skilled Nursing Facility	608	538	3,876	15,503
Surgical Services*	525	490	10,050	281,403
Transplant	618	738	145,552	291,104
<b>All Cases</b>	<b>\$552</b>	<b>\$518</b>	<b>\$12,635</b>	<b>\$947,592</b>

\* Outstanding cost of allowed charges remains for prospective service.

## VIII. HCR Program Evaluation

The HCR Program continues to utilize its consumer satisfaction survey with all accepted cases in order to obtain feedback from consumers regarding the external review experience. A consumer satisfaction survey is mailed to the consumer or authorized representative at the completion of each accepted case. In total, 188 surveys were sent and 97 consumers or authorized representative responded. The outcomes of the cases of the responding parties were: 56 overturned, 38 upheld and 3 reversed by insurer.

In addition to questions regarding the service the HCR Program Staff provided and the IRO decision, the survey asks for consumer comments and “Would you tell a friend about external review?.” Overall, responders are generally pleased with the customer service they receive while contacting the Healthcare Review Program. Most responders report satisfaction with the HCR Program staff and information about the external review process. Comments from consumers regarding the difficulty they experienced with filling out the request form properly due to its complexity, led to complete revisions to clarify and simplify the request form.

Despite the number of respondents whose decision was upheld, a large percentage of consumers responded that they “would tell a friend” about external review. Of the responders whose decision was overturned, 98.21% stated they would tell a friend about external review. While this number is to be expected, what is relevant is that 63.15% of the responders, whose decision was upheld, would also tell a friend about external review. As shown in Table 14, 84.5% of individuals who went through the external review process stated they would tell a friend about external review, suggesting that external review is viewed to be a valued and important consumer protection.

**Table 14: Consumer Satisfaction Survey Analysis**

Outcome of External Review	Number of Surveys Sent	Number of Surveys Received	Percentage of Respondents	Number of Respondents “would tell a friend”	Percentage of Respondents “would tell a friend”
Overtuned	79	56	70.8%	55	98.21%
Upheld	106	38	35.84%	24	63.15%
Reversed	3	3	100%	3	100%
<b>Total:</b>	<b>188</b>	<b>97</b>	<b>51.59%</b>	<b>82</b>	<b>84.5%</b>

## **IX. Conclusion**

The Department of Insurance established the Healthcare Review Program to administer North Carolina's External Review Law. External Review is a medical review process, independent of all affected parties, to determine if a health care service is medically necessary. Requests for review are made to the Healthcare Review Program, but the external reviews are performed by independent review organizations (IROs). The decision by the IRO is binding on both the insured and covered person, except to the extent that the covered person has remedies under State or Federal law. Since the Program's inception on July 1, 2002, 188 requests for external review have been accepted, resulting in coverage for the disputed service for 44% of the consumers who requested an external review, and the cumulative total of services provided to consumers as a result of external review is \$947,592.

During this reporting period (January 1, 2003 – December 31, 2004), the volume of external review requests decreased slightly in 2004 (201 requests) compared to 2003 (220 requests), however the volume of consumer counseling cases increased substantially by 35%, to 535 case in 2004 compared to 396 cases in 2003. Call volume from consumers has remained steady, and the number of consumers accessing online web-based HCR Program consumer counseling information and the External Review Request Form increased significantly in 2004. Of the 167 external review cases accepted during this reporting period, 43% were decided in favor of the consumer, either due to the insurer reversing its own denial prior to IRO assignment, or the IRO overturning the insurer's noncertification.

The HCR Program has worked with six contracted IROs. Hayes Plus chose to not extend its contract beyond the term of the agreement (June 30, 2004). The contract with Permedion became effective January 1, 2004. The Program has found all IROs to be accessible, responsive, and compliant with statutory requirements. On-site auditing of three IROs found those organizations continuing to meet the minimum qualifications as 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.

The HCR Program has used a variety of strategies to inform and educate consumers and providers on a statewide basis of the availability of external review and consumer counseling services. It is hoped that consumers and providers who receive this information will have a heightened level of awareness about external review services and

will encourage friends, patients and colleagues to further seek out information on internal appeals issues and to request external review services when needed.

The HCR Program uses a consumer satisfaction survey to obtain feedback from consumers regarding their external review experience. Consumers whose request was accepted receive a survey after the case has been closed. To date, 188 surveys have been sent and 97 consumers or authorized representative responded. Responders report being generally pleased with the customer services they receive from the HCR Program staff and information about the external review process, and would tell a friend about the Program.

The HCR Program works closely and in mutual cooperation with insurers, providers, consumer groups and professional organizations in educating and implementing external review services. Improvements to the Program have been made based on experiences from staff, and suggestions from consumers and insurers. In the end the Healthcare Review Program operates efficiently to provide external review services to the citizens of North Carolina.