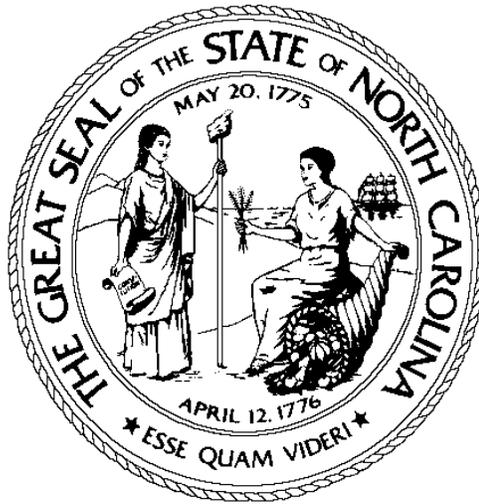


# North Carolina Department of Insurance



Healthcare Review Program Semiannual Report  
for the period of January 1, 2004 – December 31, 2005

**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
Release VI	January 1, 2005 – June 30, 2005
Release VII	January 1, 2004 – December 31, 2005

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 last two calendar years of operation (January 1, 2004 – December 31, 2005), 492 requests for external review were received. In 2004, the Program received 201 requests. In 2005, the number of requests increased by 44.8 percent, to 291. Of the 492 requests received, 94 (19.1%) involved a re-submission of a request by individuals who were previously ineligible for an external review because their request was incomplete. Thus, 398 different individuals requested an external review during this two-year period. Of these requests, 184 were accepted during this two-year period.

Of the 184 cases that were accepted, 41.8 percent were decided in favor of the consumer, either due to the insurer reversing its own denial prior to IRO assignment (8 cases) or after assignment of the IRO (1 case), or the IRO overturning the insurer's noncertification (68 cases). An analysis of the type of accepted cases that were reviewed by an IRO for this two-year period showed that 29 cases (16.5%) involved decisions for services that were cosmetic, 54 cases (31%) involved decisions that services were experimental/investigational, and 92 cases (52.5%) involved medical necessity determinations. Of the cases accepted during the Program's last two calendar years, IROs overturned 13 (45%) of the cosmetic cases, 17 (31%) of the experimental/investigational cases and 38 (41%) of the medical necessity cases.

In 2004, surgical services represented the largest percentage of accepted cases (28.5%) but tied with durable medical equipment (DME) cases for the largest percentage of overturned cases (25.8%). Mammoplasty represented the largest number of accepted cases (6 cases) followed by Gastric Bypass Surgery and TMJ, each with four (4) cases. In 2005, the trend continued with surgical services representing the largest percentage of accepted cases (35.51%) and overturned cases (29.72%). The largest number of accepted surgical cases included TMJ (10 cases), Orthopedic/Musculoskeletal (7 cases) and Vein Surgery (6 cases). Other noted changes include

a growing increase in the number of all mental health cases (inpatient and outpatient). In 2002, there was one (1) mental health case accepted for external review. In 2003 – eight (8) cases were reviewed, in 2004 – seven (7) cases and in 2005 – 20 cases. In 2005, 40 percent of the mental health cases were generated by one (1) provider. The remainder of the cases were from a variety of different service types.

For IRO decisions overturned in favor of the consumer between July 1, 2002 and December 31, 2005, the average amount of allowed charges assumed by the insurer was \$14,374. In 2004, no insurers reversed their decision prior to the case being assigned to an IRO. In 2005, nine (9) insurers reversed their decision prior to IRO issuing a decision. The average amount of allowed charges assumed by the insurer in the nine (9) cases where the insurer reversed its own noncertification was \$11,383. **Since July 1, 2002, the cumulative total of services provided to consumers as a result of external review is \$1,753,628.** Due to the prospective nature of five (5) cases overturned by the IRO, the cost of the allowed charges for these services has not yet been reported. The IRO charges for reviewing cases are per case fees which range from \$450 to \$895, depending on the IRO assigned and whether the review was conducted under a standard or expedited time frame. The average cost to insurers for the 98 reviews performed by an IRO during 2005 was \$588. However, the average cost for all IRO reviews since the Program began is \$553.

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 (NCGS) § 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 (4) days of the request. Since July 2002, all IRO decisions have been issued within the required time frames. The HCR Program is responsible for monitoring IRO compliance with statutory requirements on an ongoing basis. The HCR Program audits 100 percent 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.

During the period of January 1, 2004 to December 31, 2005, 18 different insurers, plus the State Health Plan and CHIP had a total of 184 cases that were eligible for external review. With 84 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 36 cases were accepted in 2004 and 48 cases in 2005. Blue Cross & Blue Shield of North Carolina, the State's largest insurer, had the second-largest number of accepted cases during this two-year period, with 20 cases in 2004 and 20 cases in 2005. UnitedHealthcare of North Carolina, Inc. had the third-largest number of

accepted cases with four (4) cases in 2004 and 20 cases in 2005. 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 2005 shows that the rate of external review activity for all HMOs required to report data has remained relatively unchanged from 2004, with insurers still having less than one (1) case per 100,000 members.

During the 2005 Legislative Session, the North Carolina General Assembly made several changes to North Carolina's External Review Law in response to consumer requests. Effective October 1, 2005, a covered person or the covered person's representative who made a request for external review and whose case is accepted, shall be sent a copy of the same information sent by the insurer to the IRO in considering the case. The insurer is required to send the information to the covered person or the covered person's representative, by the same time and same means, as was sent to the IRO. Other changes benefiting consumers include changing the timeframes for processing an expedited external review request from four (4) calendar days to business days.

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, 2004 through December 31, 2005, the HCR Program received 908 requests for assistance from consumers. A comparison of consumer counseling case volume by year shows a decline in the number of consumer counseling cases in 2005 (373 cases) compared to 2004 (535 cases). However, during this same period, the volume of consumer call activity increased by 6.7 percent in 2005 with 1,508 calls compared to 2004 with 1,413 calls. Similarly, the volume of external review requests increased in 2005 by 44.8 percent with 291 requests compared to 2004 with 201 requests.

The HCR Program continues to promote consumer and provider awareness of external review services through a comprehensive community outreach and education program. While insurers' are statutorily required to notify consumers of their right to external review, many consumers remain unaware of the Program and do not avail themselves of this service. During this two year period, community outreach and education activities have included participation in health fairs, speaking engagements to consumers, physicians and office practice administrators, hospital administration, publications and radio 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 and two (2) External Review Posters to be displayed in patient lobby areas. In November, 2005, an electronic notice about External Review Services was sent to State Agencies, private sector businesses and allied health providers. The response to that consumer outreach initiative was very positive with the Program receiving the largest number of External Review Requests in December, 2005, since the Program began.

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 North Carolina General Statutes (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 last two calendar years of operation (January 1, 2004 – December 31, 2005). 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. Previous HCR Program reports provide a detailed summary and analysis of Program activities since July 1, 2002.

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. NCGS § 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 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, two (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 two (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 within 60 days of receiving a decision. Upon receipt, requests are reviewed to determine eligibility and completeness. Cases accepted for review are assigned to an IRO. The IROs assign clinical experts to review each case, issuing a determination as to whether an insurer's denial should be upheld or overturned. Decisions are required to be made within 45 days of the request for a standard review. Cases accepted for expedited review require a decision to be rendered within 4 business 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 percent 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. The HCR Program also conducts on-site compliance audits of contacted IROs to determine if the IRO continues to satisfy requirements regarding its handling of individual cases and policies and procedures, as well as fulfill its obligation to provide an adequate network of disinterested reviewers to review cases assigned.

### **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 and a copy of that same information to the covered person or the covered person's representative. The insurer is required to send the information to the covered person or the covered person's representative by the same time and same means as was sent to the IRO.

When a case is decided in favor of the covered person, the 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 three (3) business days in the case of a standard review decision and one (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 Department's HCR Program contracts with IROs to provide independent medical review of insurer's denial of coverage. As set forth in NCGS § 58-50-92 Funding of external review, the insurer against which a request for a standard or expedited external review is filed shall reimburse the Department for the fees charged by the organization in conducting the external review, including work actually performed by the organization for a case that was terminated due to an insurer's decision to reconsider a request and reverse its noncertification decision, prior to the insurer notifying the organization of the reversal, or when a review is terminated because the insurer failed to provide information to the review organization.

The HCR Program acts as the liaison between insurers and IROs for invoicing and payment of IRO services. As the contracting entity with the IROs, it is the responsibility of the Department

to insure that IROs are paid in a timely manner for their services. Over the course of the last two (2) years, the HCR Program identified a growing trend of late payment for IRO services by some insurers. Those insurers were contacted and a plan to correct the problem was developed and implemented. Payment from insurers is now received in compliance with the expected payment due date. Compliance with payment timeframes by all insurers is monitored and reported on a weekly basis by the HCR Program Administrative Assistant and reported to the HCR Program Director.

Overall, 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. 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, radio 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. In November,

2005, an electronic notice about External Review Services was e-mailed to State Agencies, North Carolina Public Schools, State Universities and Community Colleges, Chambers of Commerce and allied health providers. Recipients of the electronic notice were asked to forward the message on to their employees, staff and colleagues. In December, 2005, HCR Program received the largest number of requests for external review from consumers since the Program began on July 1, 2002.

Other initiative during 2004 – 2005 included making changes 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.

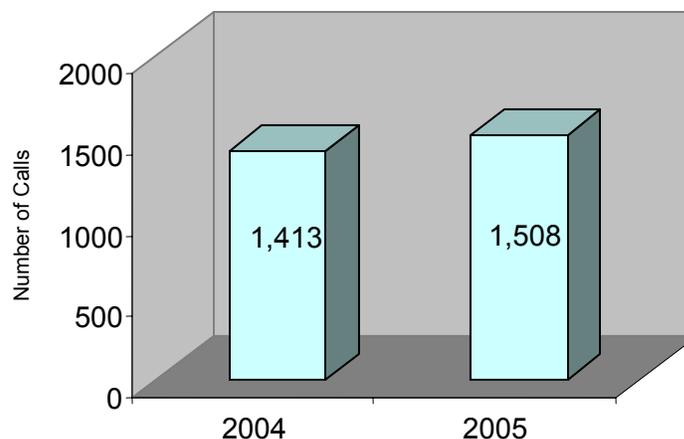
#### **IV. Program Activity Data**

##### **A. Consumer Contacts**

###### **Consumer Telephone Calls**

The HCR Program received 2,921 calls from consumers related to external review and consumer counseling services during the period of January 1, 2004 – December 31, 2005. Figure 1 shows the volume of calls received by year. During 2004, the Program received 1,413 calls. The volume of consumer calls increased by 6.7 percent to 1,508 during 2005. 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. Overall, the number of calls remains constant, identifying a continued need for consumer information.

**Figure 1: Comparison of External Review and Consumer Counseling Call Volume Received by the HCR Program by Calendar Year, January 1, 2004 – December 31, 2005**

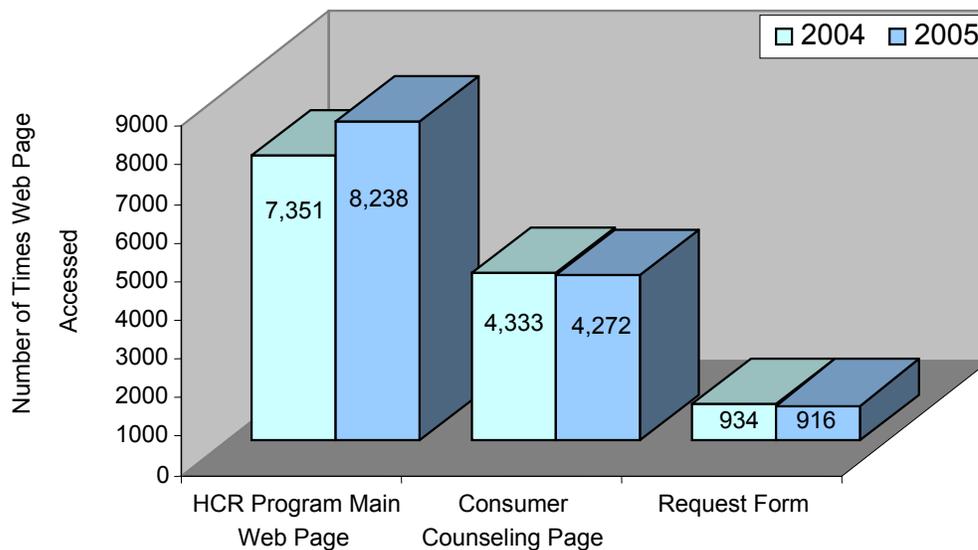


## Consumer Web Site Contacts

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.

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 remains constant from year to year.

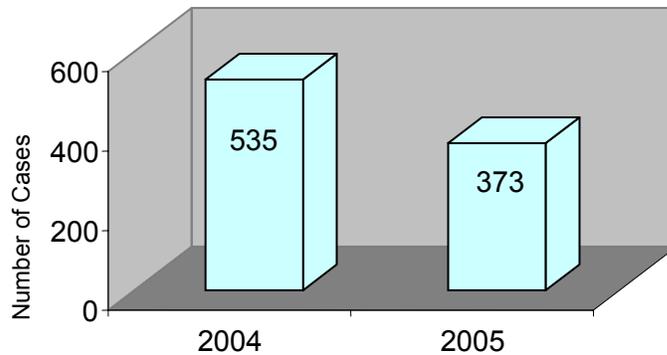
**Figure 2: Comparison of HCR Program Web Site Page Access Activity by Calendar Year, January 1, 2004 – December 31, 2005**



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

The HCR Program counseled 908 consumers during the period of January 1, 2004 – December 31, 2005. As shown in Figure 3, the volume of consumer counseling cases in 2004 was 535 cases. In 2005, the volume of consumer counseling case activity declined by 30 percent to 373 cases.

**Figure 3: Comparison of Consumer Counseling Case Volume Received by the HCR Program by Calendar Year, January 1, 2004 – December 31, 2005**



Consumers continue to show a strong need for information about appeals and grievance issues. In 2004, of the 535 consumer counseling cases, 298 (55.7%) consumers 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 or external review. While 2005 saw a decrease in the volume of case activity (373), a higher percentage of those cases (251 cases or 67.3%) contacted HCR Program staff seeking counseling on a denial issue. 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 consumer counseling cases received by the Program related to the following issues:

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

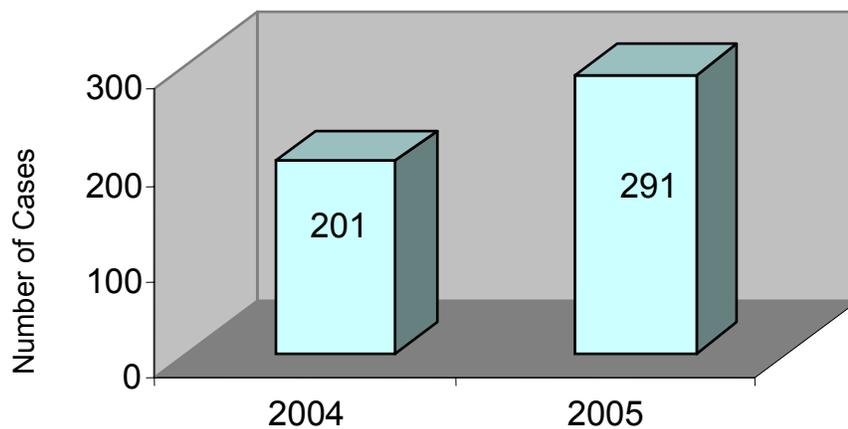
The Program's staff was able to provide these consumers with the appropriate resources where their concerns could be addressed. Callers were referred to the Department's Consumer Services Division, the Managed Care Patient Assistance Program, the US Department of Labor, Medicare, other state's Department 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. Consumers frequently express appreciation in the assistance the Program's staff provides in navigating them to the appropriate resources.

### C. External Review Requests

During the period of January 1, 2004 - December 31, 2005, the HCR Program received 492 requests for external review. Figure 4 compares the volume of requests for each year. The Program saw a 44.8 percent increase in external review requests received as compared to those received in 2004. The HCR Program attributes the increase in the volume of requests to ongoing community outreach efforts to educate consumers and providers about the program, as well as the counseling given to consumers early in the appeal process.

**Figure 4: Comparison of External Review Requests Received by the HCR Program by Calendar Year, January 1, 2004 – December 31, 2005**



### 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.

In 2004, 30 of 41 individuals who submitted an incomplete request, subsequently resubmitted and had their request accepted for external review. There were four (4) individuals whose resubmitted requests were ultimately deemed ineligible. Therefore, 167 different individuals requested external review in 2004.

In 2005, the Program saw growth in the number of "Incomplete" requests. Of 291 requests received in 2005, 85 were deemed to be incomplete. Of those requestors, 43 requestors resubmitted a request that was eligible for external review. Seventeen additional resubmitted requests were deemed ineligible. Thus, 231 individuals requested external review in 2005.

Table 1 explains how the Program considers “Incomplete” requests, as it relates to the number of individuals who request external review. The data also shows that the number of true “incomplete” requests that are not resubmitted correlate with an increase in the number of providers who request external review.

**Table 1: Disposition of Incomplete Requests Made to the HCR Program by Calendar Year, January 1, 2004 – December 31, 2005**

<b>Disposition of Incomplete Request</b>	<b>2004</b>	<b>2005</b>
Resubmitted—Accepted for External Review	<b>30</b>	<b>43</b>
Resubmitted—Not Accepted Due to:		
* Service excluded	0	1
* No medical necessity determination	1	2
* Self insured	0	2
* Situs of contract not NC	0	1
* Past required time frame	1	4
* Request withdrawn	0	1
* Internal appeals not exhausted	1	5
* No denial issued	0	1
* Expedited criteria not met	1	0
<b>Subtotal:</b>	<b>4</b>	<b>17</b>
Never Resubmitted, Request Made by:		
* Provider	1	12
* Consumer	5	11
* Authorized representative	1	2
<b>Subtotal:</b>	<b>7</b>	<b>25</b>
<b>Grand Total of Incomplete Requests:</b>	<b>41</b>	<b>85</b>

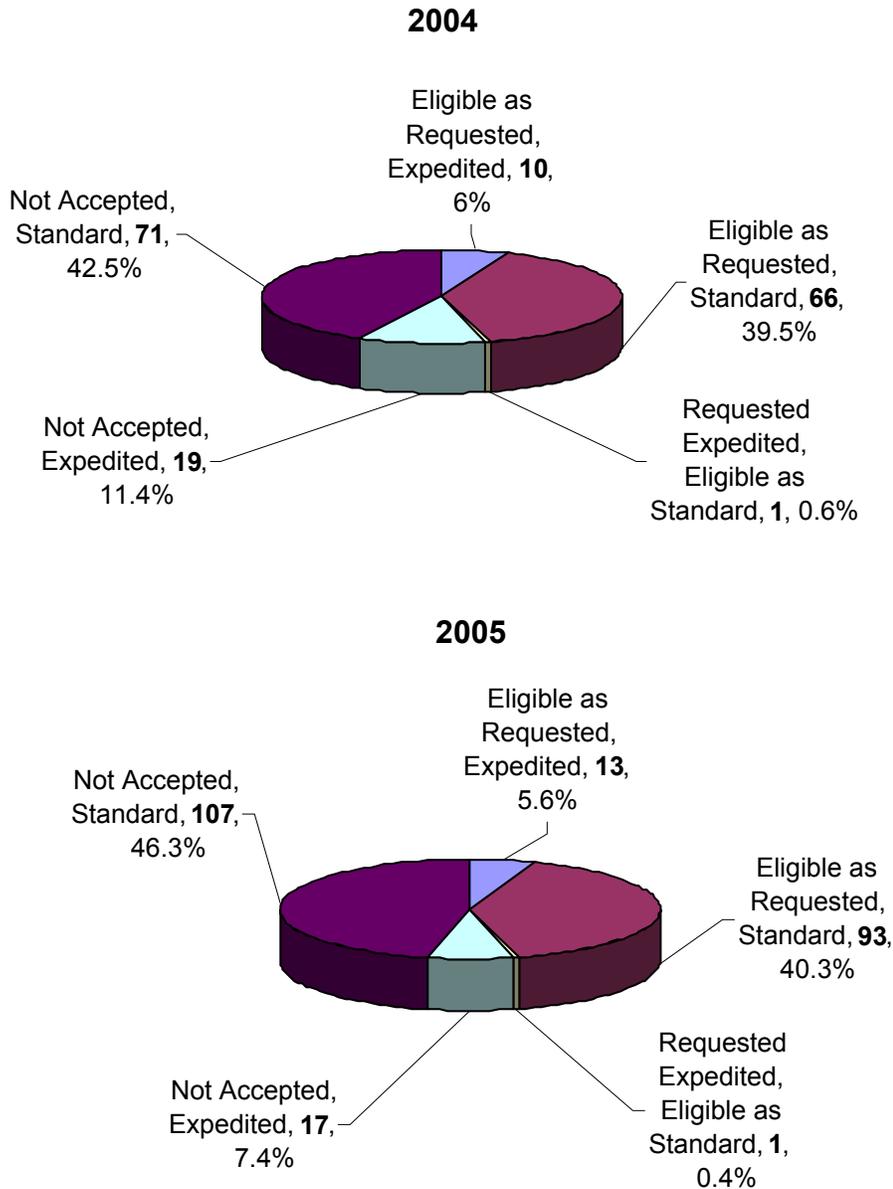
Of the 492 requests received during 2004 and 2005, 94 (19.1%) involved re-submission of a request previously denied because it was incomplete. Therefore, eligibility determinations were made on 398 different individuals requesting external review during this two-year period. Based upon the 398 individual’s requests made during 2004 and 2005, 214 (53.7%) of these requests were ineligible for external review. The percentage of requests eligible for each operating year was 46.1 percent (77 of 167) in 2004 and 46.3 percent (107 of 231) in 2005.

Figure 5 shows the disposition of requests for external review by calendar year. The overall percentage of eligible reviews has remained constant in 2004 and 2005, as has the percentage of requests that were determined to be ineligible for review.

In 2004, the Program received 138 requests for standard review and accepted 67 (48.5%) cases (including one (1) expedited request that was accepted for standard review), and 29 expedited requests were received and 10 (34.5%) were accepted. In 2005, the Program received 201 requests for standard review and accepted 94 (46.8%), including one (1) case originally

requested as expedited, but eligible as standard. The Program received 30 requests for expedited external review and accepted 13 (43.3%).

**Figure 5: Comparison of Disposition of External Review Requests Received by Calendar Year, January 1, 2004 – December 31, 2005**



The reason why a case would not be accepted falls into two (2) 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 2004 and 2005. 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, 2004 – December 31, 2005**

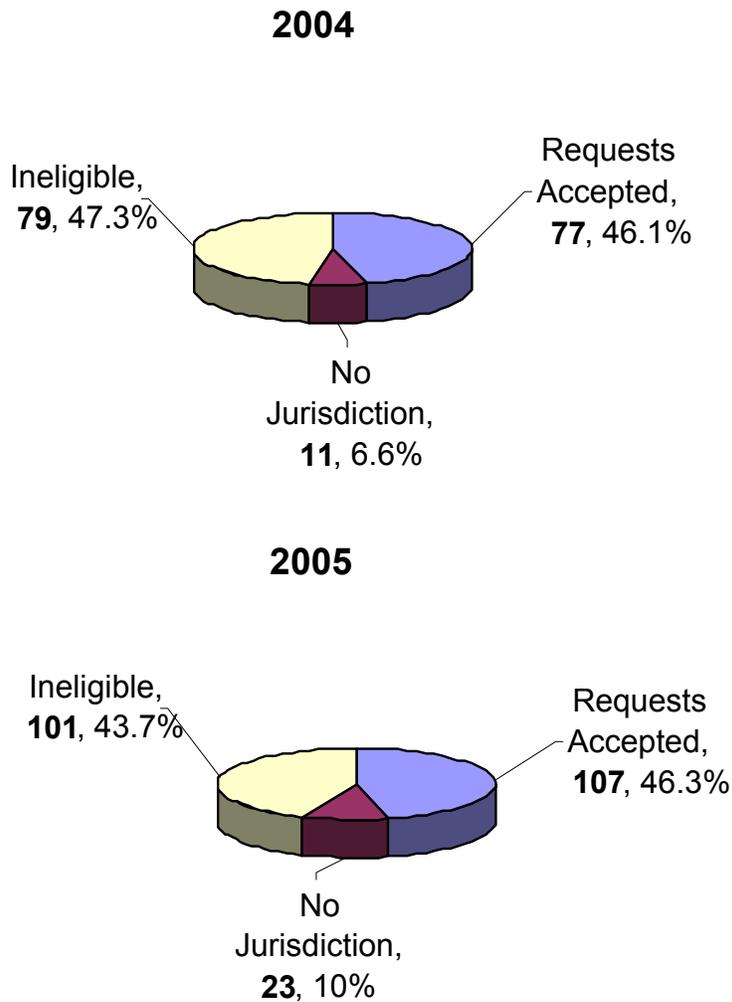


Table 2 shows the numbers of cases that were not accepted for review and the reasons for which they were not accepted for each year of operation. For both years, non-accepted requests due to “ineligible” reasons rather than “no jurisdiction” reasons continue to make up the largest numbers for external 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. Incomplete requests represented a significantly higher percentage of requests not accepted in 2005 at 20.1 percent, up from 7.8 percent in 2004. The increase in the percentage of incomplete requests in 2005 reflects the number of providers who submitted an incomplete external review request on behalf of a consumer, but then never

resubmitted a completed request (Table 1). The HCR Program staff contacts all consumers and providers (when contact information is available) who have submitted an incomplete request to instruct them on the process and requirements for submitting a complete request.

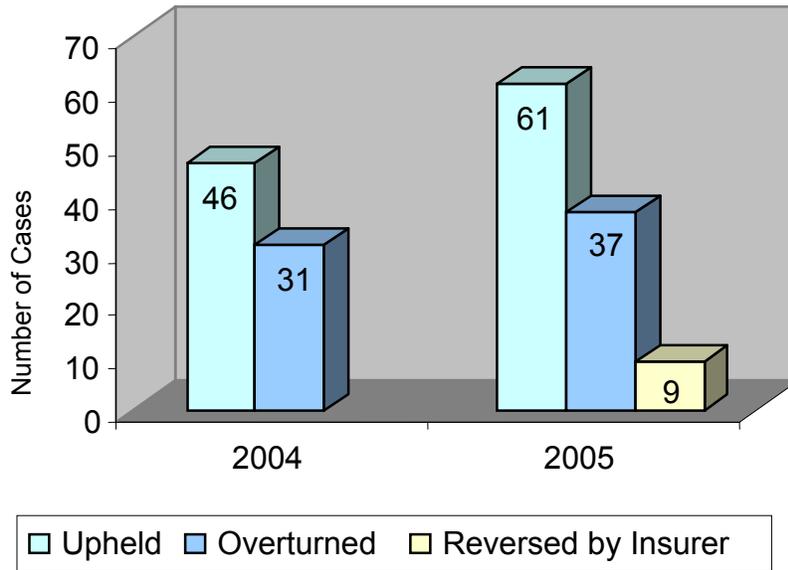
**Table 2: Reasons for Non-Acceptance of an External Review Request, January 1, 2004 – December 31, 2005**

Reason for Non-Acceptance	Number of Requests	
	2004	2005
<b>INELIGIBLE</b>		
Health Criteria Not Met for Expedited, Not Eligible as Standard	4	3
Not a Medical Necessity Determination	20	25
Request Withdrawn	4	3
Service Excluded	8	8
No Denial Issued	2	6
Insurer's Expedited Appeal Not Requested Prior to Request	0	1
Not Covered Under Health Plan	2	0
Retrospective Services - Not Eligible for Expedited	2	1
Past 60 Day Request Time Frame	6	5
Insurer Appeal Process Not Exhausted	19	22
Insurance Type Not Eligible for External Review	5	2
Request is Incomplete, No Resubmission of Request	7	25
<b>Total Ineligible</b>	<b>79</b>	<b>101</b>
<b>NO JURISDICTION</b>		
Contract Situs Not in NC	1	7
Self-Funded	10	14
Medicare HMO	0	2
<b>Total No Jurisdiction</b>	<b>11</b>	<b>23</b>
<b>Total Requests Not Accepted</b>	<b>90</b>	<b>124</b>

#### **E. Outcomes of Accepted Cases**

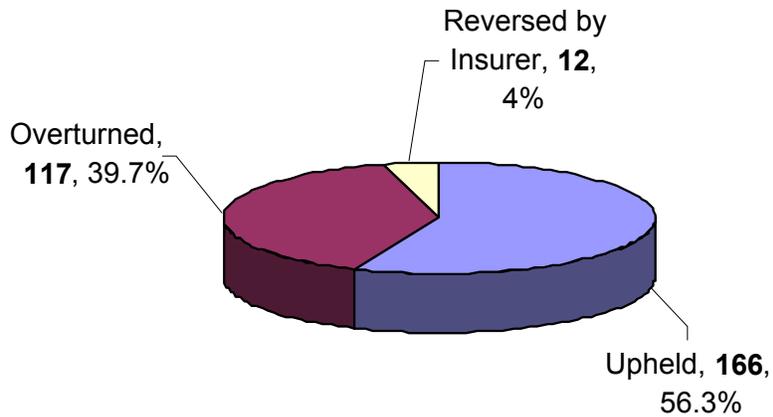
The HCR Program accepted 30 more cases for external review in 2005 than it did in 2004, resulting in a 39 percent increase in case activity. Of the 77 cases accepted in 2004, 40.3 percent resulted in the consumer obtaining coverage for the denied treatment, whereas in 2005, 43 percent of requests were either reversed by the insurer or 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, 2004 – December 31, 2005**



The HCR Program became effective July 1, 2002. During the three years and six months of operation, 295 cases were accepted for review, resulting in coverage for the disputed service for 43.7 percent 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.

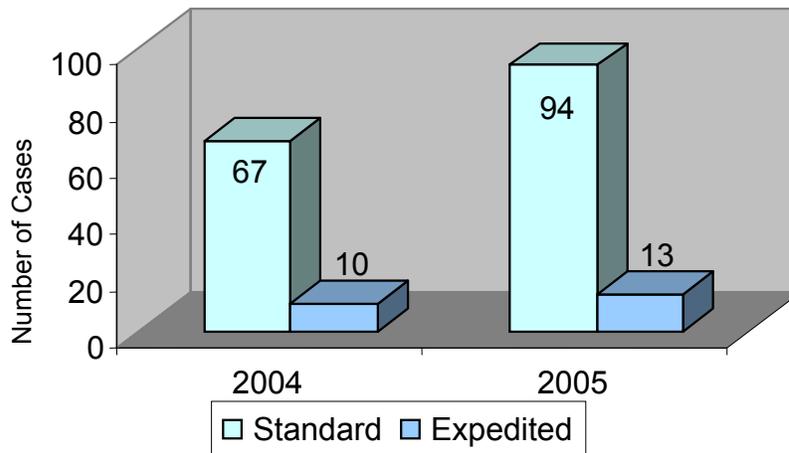
**Figure 8: Percentage of Outcomes for All Accepted Cases, July 1, 2002 – December 31, 2005**



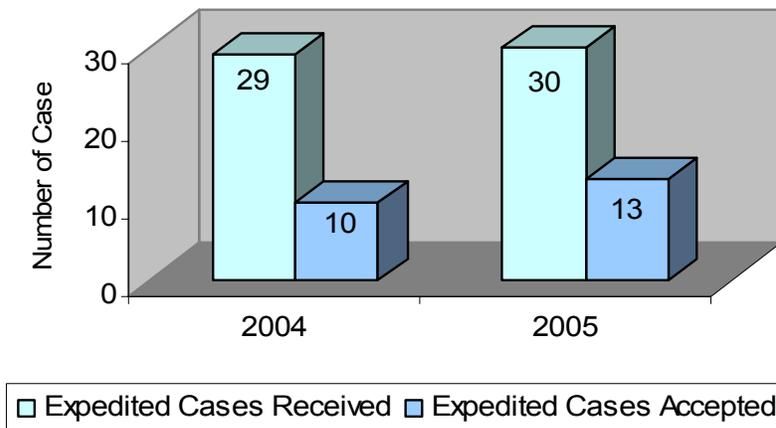
## F. Types of External Review Requested

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, having 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. In 2004, 34.5 percent of expedited requests were accepted, and in 2005 43.3 percent of requests were accepted. Figure 9 shows a comparison of cases accepted by type of review by calendar year. Figure 10 shows a comparison of expedited external review requests and accepted by calendar year.

**Figure 9: Comparison of External Review Cases Accepted by Type of Review by Calendar Year, January 1, 2004 – December 31, 2005**



**Figure 10: Comparison of Expedited External Review Requests Received and Accepted by Calendar Year, January 1, 2004 – December 31, 2005**



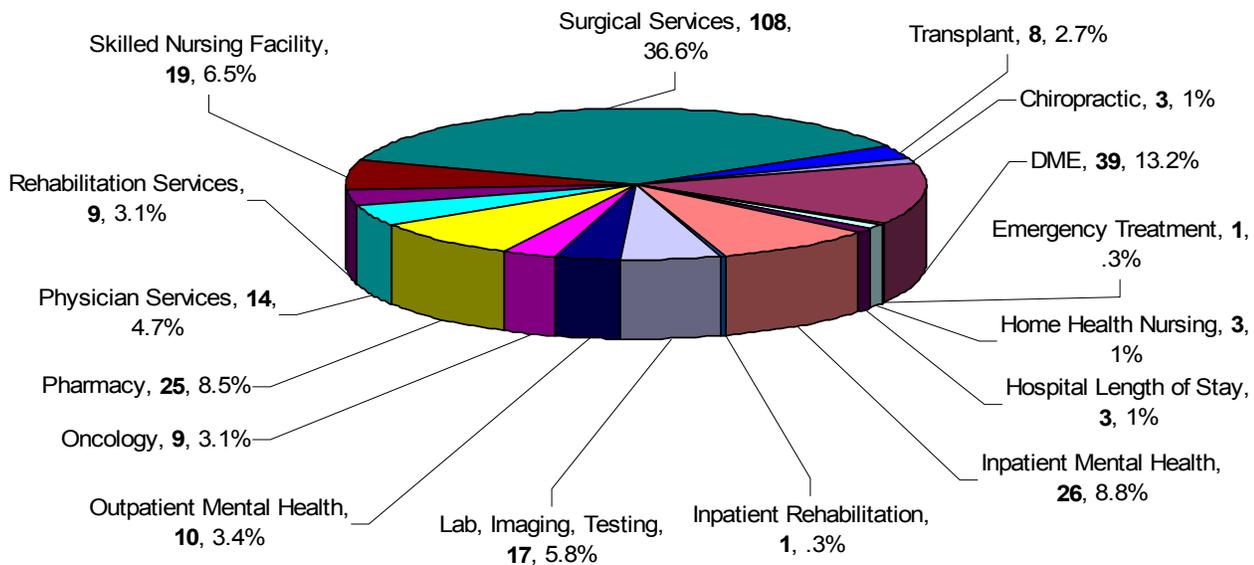
### G. Average Time to Process Accepted Cases

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> business 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 11 shows the cumulative number of accepted cases by type of service requested since the Program began. Surgical service continues to be the largest share of accepted cases, representing 36.6 percent of the 295 accepted cases for external review. Durable medical equipment (DME) has the second largest share of requests (13.2%). Inpatient mental health services and pharmacy are about even with 26 (8.8%) and 25 (8.5%) of the total accepted requests, respectively.

**Figure 11: Accepted Cases by Type of Service Requested, July 1, 2002 – December 31, 2005**



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 3 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 to ascertain if trends for certain subsets of treatment types develop.

**Table 3: Type of General Service and Specific Services Requested  
for all Accepted Cases for External Review, July 1, 2002 – December 31, 2005**

<b>Type of General Service and Specific Services Requested</b>					
<b>Durable Medical Equipment (DME) (39)</b>	<b>Mental Health (36)</b>	<b>Rehabilitation Service (9)</b>	<b>Surgical Services (108)</b>		
<ul style="list-style-type: none"> <li>• Cranial Banding (22)</li> <li>• Blood Monitoring for Lab (2)</li> <li>• Stair Lift (1)</li> <li>• Portable Hyperbaric Oxygen Chamber (2)</li> <li>• Leg Prosthesis (2)</li> <li>• Vest Airway Clearance System (2)</li> <li>• Bone/Cartilage Stimulator (2)</li> <li>• Anodyne Therapy (2)</li> <li>• Nocturnal Enuresis Alarm (1)</li> <li>• Electronic Speech Aid (1)</li> <li>• Orthotics (1)</li> <li>• Scooter (1)</li> </ul>	<u>Inpatient</u> <ul style="list-style-type: none"> <li>• Admission, Acute Psych (3)</li> <li>• LOS, Acute Psych (15)</li> <li>• Admission, Residential (9)</li> <li>• LOS, Residential Treatment (1)</li> <li>• Partial Hospitalization Level (2)</li> </ul> <u>Outpatient</u> <ul style="list-style-type: none"> <li>• Substance Abuse Treatment (6)</li> </ul>	<ul style="list-style-type: none"> <li>• Speech Therapy (7)</li> <li>• Physical Therapy (1)</li> <li>• Biofeedback (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Gall Bladder (2)</li> <li>• Panniculectomy (10)</li> <li>• Hysterectomy (4)</li> <li>• Breast Reduction (14)</li> <li>• Gastric Bypass (16)</li> <li>• TMJ/Orthognothic Surgery (19)</li> <li>• Electrothermal Arthroscopic Capsulorrhaphy (2)</li> <li>• Osteochondral Autograft Transfer (1)</li> <li>• Lumbar Laminectomy (1)</li> <li>• Vein Surgery (18)</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 (3)</li> <li>• Tonsillectomy (2)</li> <li>• Meniscal Allograph Procedure (2)</li> <li>• Essure Sterilization (1)</li> <li>• Keloid Surgery (1)</li> <li>• Percutaneous Decompression/ Disectomy (1)</li> <li>• RACZ Neurolysis (1)</li> <li>• Pectus Excavatum (1)</li> <li>• Allograft Implant Knee Surgery (1)</li> <li>• Arthroscopic Mosaicplasty (1)</li> </ul>		
		<b>Transplant (8)</b>		<ul style="list-style-type: none"> <li>• Stem Cell Transplant (7)</li> <li>• Corneal Transplant (1)</li> </ul>	
		<b>Chiropractic (3)</b>		<b>Lab, Imaging, Testing (17)</b>	<b>Pharmacy (25)</b>
<ul style="list-style-type: none"> <li>• Chiropractic Service (3)</li> </ul>	<ul style="list-style-type: none"> <li>• PET Scan (4)</li> <li>• Cardiac Arrhythmia/Risk Assessment (3)</li> <li>• Polysomnogram (1)</li> <li>• General Blood Work (2)</li> <li>• Gastroenterological testing (2)</li> <li>• Transcranial Doppler (1)</li> <li>• MRI (2)</li> <li>• Full Body Photography (1)</li> <li>• Testing and Evaluation for Taste/ Smell (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Botox (6)</li> <li>• Synagis (5)</li> <li>• Non-steroidal Anti-inflammatory (3)</li> <li>• Growth Hormone (1)</li> <li>• Remicade (2)</li> <li>• Steroid Injection (1)</li> <li>• IV Antibiotics-Lyme (2)</li> <li>• Chelation Therapy (2)</li> <li>• Provigil (3)</li> </ul>			
<b>Emergency Treatment (1)</b>		<ul style="list-style-type: none"> <li>• Insulin Potentiation (1)</li> <li>• Extracorporeal Shock Wave Therapy (4)</li> <li>• Intradiscal Electrothermal Therapy (1)</li> <li>• Laser/Dermatology (6)</li> <li>• General Physician Treatment (2)</li> </ul>	<b>Physician Services (14)</b>		
<ul style="list-style-type: none"> <li>• Infectious Disease (1)</li> </ul>			<ul style="list-style-type: none"> <li>• Insulin Potentiation (1)</li> <li>• Extracorporeal Shock Wave Therapy (4)</li> <li>• Intradiscal Electrothermal Therapy (1)</li> <li>• Laser/Dermatology (6)</li> <li>• General Physician Treatment (2)</li> </ul>		
<b>Hospital Length of Stay (LOS) (3)</b>			<ul style="list-style-type: none"> <li>• Cardiac (2)</li> <li>• Gastroenterology (1)</li> </ul>		
<ul style="list-style-type: none"> <li>• Cardiac (2)</li> <li>• Gastroenterology (1)</li> </ul>					
<b>Home Health Nursing (3)</b>	<b>Oncology (9)</b>	<ul style="list-style-type: none"> <li>• Private Duty Nursing (3)</li> </ul>			
<ul style="list-style-type: none"> <li>• Orthopedic (1)</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 (2)</li> <li>• Intraperitoneal Hyperthermic Chemotherapy (2)</li> </ul>	<ul style="list-style-type: none"> <li>• Insulin Potentiation (1)</li> <li>• Extracorporeal Shock Wave Therapy (4)</li> <li>• Intradiscal Electrothermal Therapy (1)</li> <li>• Laser/Dermatology (6)</li> <li>• General Physician Treatment (2)</li> </ul>			
<b>Inpatient Rehabilitation (1)</b>	<ul style="list-style-type: none"> <li>• Skilled Nursing Facility (19)</li> </ul>	<ul style="list-style-type: none"> <li>• Skilled Nursing Facility (19)</li> </ul>			
<ul style="list-style-type: none"> <li>• Skilled Nursing Facility (19)</li> </ul>	<ul style="list-style-type: none"> <li>• Skilled Nursing Facility (19)</li> </ul>	<ul style="list-style-type: none"> <li>• Skilled Nursing Facility (19)</li> </ul>			

In an analysis of activity of accepted cases and outcomes by calendar year, the Program has noted some changes. In 2004, 57 percent of the DME cases accepted involved the use of DOC bands, and 75 percent of those were overturned in favor of the consumer. In 2005, 46.1 percent of the DME cases involved DOC Bands, of which 50 percent were decided in favor of the consumer either through IRO decision or the insurer reversing its own decision. In 2004, mental health cases were comprised of only 7 inpatient mental health issues. In 2005, the Program noted an increase in mental health related cases that were accepted which were comprised of both inpatient and outpatient mental health. This realizes a 185 percent increase in this type of activity. These cases resulted in a 60 percent overturn or reversal status for the consumer. It is noteworthy that 70 percent of the requests for mental health services in 2005 came from providers, with 40 percent of these cases coming from one provider.

The data also shows that in 2005, the Program received external review requests for types of services not seen in 2004. Those services included:

- Oncology services- Intraperitoneal Hyperthermic Chemotherapy (2 cases—100 percent overturned by the IRO);
- Pharmacy services- Provigil (3 cases—100% upheld by the IRO); and
- Physician services- laser treatment for rosacea (3 cases—66.7% overturned).

For surgical service in 2004, four (4) cases involving orthognothic surgery were accepted and 100 percent of them were overturned by the IRO in favor of the consumer. In 2005, 10 cases were accepted and 70 percent were overturned in favor of the consumer. Gastric bypass surgery cases became a less significant volume of cases received. In 2004, four (4) cases involving bariatric surgery were accepted, with only one (1) case being overturned. In 2005, three (3) cases were received and they were all upheld by the IRO. The only other type of surgery that received any significant type of volume in 2005 was vein surgery, in which six (6) were received and all six (6) were upheld by the IRO. This mirrors the outcomes for vein surgery from 2004.

Table 4 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 increased in 2005 from 28.6 percent to 35.5 percent.

In 2004, there were no cases accepted where an insurer reversed its own noncertification during the external review process. In 2005, there were nine (9) cases (8.4%) where the insurer reversed its own noncertification, but there were not any significant numbers in any one type of service to notice any discernable trends. It is important to remember that the numbers of cases for each service type remains small, comprised of differing specific services and therefore, not suitable for drawing general conclusions about specific services or frequency of case outcomes.

**Table 4: Comparison of Percentage Share of Review Activity by Type of Service Requested,  
January 1, 2004 – December 31, 2005**

Type of Service	2004				2005				
	Number of Accepted Cases	Percent of All Accepted Cases	Outcome of Accepted Cases		Number of Accepted Cases	Percent of All Accepted Cases	Outcome of Accepted Cases		
			Percent of All Cases Overturned	Percent of All Cases Upheld			Percent of All Cases Overturned	Percent of All Cases Reversed	Percent of All Cases Upheld
Chiropractic	2	2.60	0.00	4.35	0	0.00	0.00	0.00	0.00
DME	14	18.18	25.81	13.04	13	12.15	8.11	11.11	14.75
Hospital Length of Stay	0	0.00	0.00	0.00	1	0.93	0.00	0.00	1.64
Inpatient Mental Health	7	9.09	9.67	8.69	14	13.08	18.91	22.22	8.20
Lab, Imaging, Testing	6	7.80	6.45	8.69	8	7.48	8.11	22.22	4.92
Outpatient Mental Health	0	0.00	0.00	0.00	6	5.61	5.41	11.11	4.92
Oncology	3	3.89	3.23	4.35	3	2.80	5.41	0.00	1.64
Pharmacy	6	7.80	16.12	2.17	11	10.28	5.41	11.11	13.11
Physician Services	5	6.49	6.45	6.53	6	5.61	10.81	0.00	3.28
Rehabilitation Services	4	5.19	3.23	6.53	1	0.93	0.00	0.00	1.64
Skilled Nursing Facility	5	6.49	0.00	10.86	4	3.74	5.41	11.11	1.64
Surgical Services	22	28.57	25.81	30.44	38	35.51	29.72	11.11	42.62
Transplant	3	3.90	3.23	4.35	2	1.88	2.70	0.00	1.64
<b>Total</b>	<b>77</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>107</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 5.

The data in Table 5, which depicts only those cases that proceeded to a full review by the IRO, shows that there were those types of services where denial decisions were made solely on the basis of medical necessity. Those service types were chiropractic, hospital length of stay, inpatient mental health, and skilled nursing facility. 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. Of the cases that were accepted for external review, but were reversed by the insurer prior to an IRO decision being rendered, 89 percent involved medical necessity denials and 11 percent involved a denial made on the cosmetic nature of the service. All were reversed by the insurer when presented with additional information to be considered.

Overall, in both 2004 and 2005 the percentage share of cases accepted for each type of noncertification is similar. Medical necessity cases continue to represent the largest share of noncertification types seen by the Program. For these types of cases, 2005 had a greater percentage of cases overturned by the IRO (37.5% in 2004 and 44.2% in 2005). In 2004, cosmetic outcomes remained relatively even between overturned and upheld. In 2005, almost twice as many cosmetic cases were upheld as were overturned. In both years, outcomes for cases denied due to the experimental or investigational nature of the treatment for the condition, were almost twice as (or more) 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 5: Comparison of Outcomes of Accepted External Review Requests by Service Type and Denial Type by Calendar Year, January 1, 2004 – December 31, 2005**

Service Type	2004						2005					
	Medical Necessity		Experimental / Investigational		Cosmetic		Medical Necessity		Experimental / Investigational		Cosmetic	
	Overtaken	Upheld	Overtaken	Upheld	Overtaken	Upheld	Overtaken	Upheld	Overtaken	Upheld	Overtaken	Upheld
Chiropractic	--	2	--	--	--	--	--	--	--	--	--	--
DME	1	2	1	2	6	2	1	3	--	4	2	2
Hospital Length of Stay	--	--	--	--	--	--	--	1	--	--	--	--
Inpatient Mental Health	3	4	--	--	--	--	7	5	--	--	--	--
Lab, Imaging, Testing	--	2	2	2	--	--	1		2	3	--	--
Outpatient Mental Health	--	--	--	--	--	--	2	3	--	--	--	--
Oncology	--	--	1	2	--	--	--		2	1	--	--
Pharmacy	2	1	2	--	1	--	--	3	--	3	--	--
Physician Services	1	--	--	2	1	1	1	1	3	2	2	1
Rehabilitation Services	--	2	1	1	--	--	--	1	--	--	--	--
Skilled Nursing Facility	--	5	--	--	--	--	2	1	--	--	--	--
Surgical Services	8	6	--	4	--	4	9	11	1	9	1	6
Transplant	--	1	1	1	--	--	--		1	1	--	--
<b>Total</b>	<b>15</b>	<b>25</b>	<b>8</b>	<b>14</b>	<b>8</b>	<b>7</b>	<b>23</b>	<b>29</b>	<b>9</b>	<b>23</b>	<b>5</b>	<b>9</b>
<b>Total Percentage of Case Volume</b>	<b>51.9%</b>		<b>28.6%</b>		<b>19.5%</b>		<b>53.1%</b>		<b>32.6%</b>		<b>14.3%</b>	

Table 6 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 2004, 12.9 percent 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, Synagis injection for premature infant lung development, discharge from skilled nursing facility, tonsillectomy and stem cell transplant.

During 2005, 12.1 percent of the cases accepted were handled on an expedited basis. The cases involved: cardiac catheterization, Intraperitoneal Hyperthermic chemotherapy, Mammosite Radiation, Synagis, continued stay at a skilled nursing facility, tonsillectomy, and bone marrow transplant.

For 2004, only 30 percent of expedited cases were decided in favor of the patient. Of all standard external review outcomes in 2004, 41.7 percent of standard external reviews were decided in favor of consumers. The percentage of standard cases decided in favor of consumers either by an IRO or the insurer reversing itself remained similar in 2005 at 40.4 percent. The outcome for expedited cases in 2005 rose to 61.5 percent in favor of the consumer, with five (5) cases overturned by the IRO and three (3) cases reversed by the insurer. There remains 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 6: Comparison of Outcomes of Requests by Type of Service Requested by Type of Review Granted by Calendar Year, January 1, 2004 – December 31, 2005**

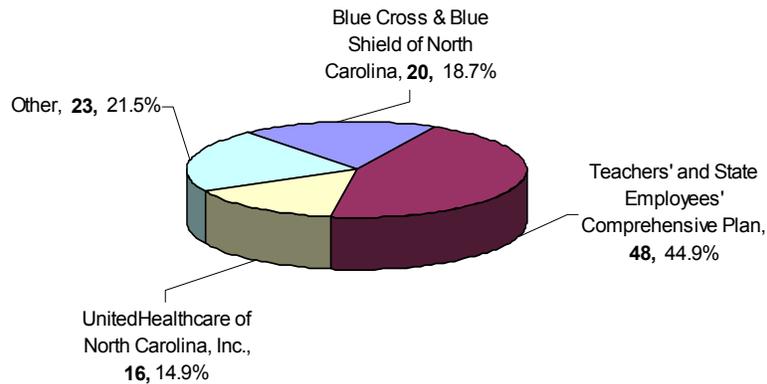
Service Type	2004						2005					
	Standard Review			Expedited Review			Standard Review			Expedited Review		
	Overtuned	Reverse	Upheld	Overtuned	Reverse	Upheld	Overtuned	Reverse	Upheld	Overtuned	Reverse	Upheld
Chiropractic	--	--	2	--	--	--	--	--	--	--	--	--
DME	8	--	5	--	--	1	3	1	9	--	--	--
Hospital Length of Stay	--	--	--	--	--	--	--	--	1	--	--	--
Inpatient Mental Health	3	--	4	--	--	--	7	2	5	--	--	--
Lab, Imaging, Testing	2	--	4	--	--	--	3	1	3	--	1	--
Outpatient Mental Health	--	--	--	--	--	--	2	1	3	--	--	--
Oncology	1	--	--	--	--	2	--	--	--	2	--	1
Pharmacy	4	--	1	1	--	--	2	--	5	--	1	3
Physician Services	2	--	3	--	--	--	4	--	2	--	--	--
Rehabilitation Services	1	--	3	--	--	--	--	--	1	--	--	--
Skilled Nursing Facility	--	--	2	--	--	3	1	--	1	1	1	--
Surgical Services	7	--	14	1	--	--	10	1	26	1	--	--
Transplant	--	--	1	1	--	1	--	--	--	1	--	1
<b>Total</b>	<b>28</b>	<b>0</b>	<b>39</b>	<b>3</b>	<b>0</b>	<b>7</b>	<b>32</b>	<b>6</b>	<b>56</b>	<b>5</b>	<b>3</b>	<b>5</b>

## A. Insurer and Type of Service Activity

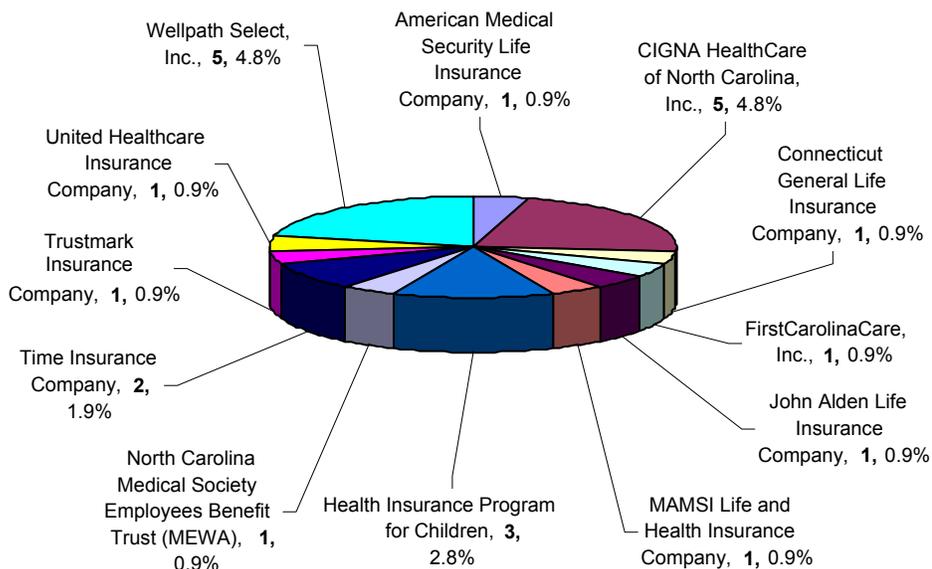
In 2005, cases origination from the State Health Plan, Blue Cross & Blue Shield of North Carolina, and UnitedHealthcare of North Carolina, Inc. comprised 78.5 percent of the external review activity. Eleven other insurers plus CHIP made up the remaining 21.5 percent of cases, with only one (1) case arising from most of those 11 insurers. With 48 cases accepted during 2005, the State Health Plan remains the health plan with the largest number of requests for external review. Blue Cross & Blue Shield of North Carolina, the state's largest insurer, had the second largest number with 20 accepted cases. The percentage share of insurer activity is depicted in Figure 12 (A) and (B).

**Figure 12: Insurer's Share of Accepted External Review Requests, January 1, 2005 – December 31, 2005**

### A. Insurers Comprising Majority of Cases



### B. Other Insurers



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 month" data to the Department 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 for CHIP is reported to the Program upon request.

Table 7 compares the 2004 rate of external review activity per 100,000 members to that activity of 2005. Analysis of health plans with member month data shows that the rate of external review activity for all HMOs that are required to report data has increased from 2004. The number of requests for external review from consumers covered under an HMO was 13 in 2004; this number increased to 39 in 2005. While there was an increase in the number of requests, there remain no HMOs that have a case rate of more than one per 100,000 member months.

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

Indemnity or PPO plans comprise a very small volume of external review requests. Blue Cross & Blue Shield of North Carolina does not report the member month data for its non-HMO business. With the exception of the non-HMO business for Blue Cross & Blue Shield of North Carolina with 15 cases, no other PPO or indemnity plan experienced more than two (2) external review cases during 2005.

In comparing activity between 2004 and 2005, the Program is seeing similar data. A small number of large healthplans comprise the majority of cases for external review, while a larger number of smaller healthplans make up less than 22 percent of activity in 2005. 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 draw any conclusions regarding insurers and external review activity.

**Table 7: Comparison of Accepted Case Activity by Insurer by Member Months by Calendar Year, January 1, 2004 – December 31, 2005**

Insurer	2004			2005		
	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
American Medical Security Life Insurance Company	0	N/A	N/A	1	NR	N/A
Blue Cross & Blue Shield of North Carolina (HMO)	4	1,791,103	0.22	5	1,205,944	0.41
Blue Cross & Blue Shield of North Carolina (Non-HMO)	16	NR	N/A	15	NR	N/A
CIGNA HealthCare of North Carolina, Inc.	3	1,087,330	0.27	5	898,669	0.56
Connecticut General Life Insurance Company	0	N/A	N/A	1	NR	N/A
Federated Mutual Insurance Company	1	NR	N/A	0	N/A	N/A
FirstCarolinaCare, Inc.	0	120,316	N/A	1	126,792	0.79
Fortis Insurance Company/ Time Insurance Company (9/6/05)	2	NR	N/A	2	NR	N/A
Guardian Life Insurance Company of America	1	NR	N/A	0	N/A	N/A
Humana Insurance Company	1	NR	N/A	0	N/A	N/A
John Alden Life Insurance Company	2	NR	N/A	1	NR	N/A
MAMSI Life and Health Insurance Company	1	NR	N/A	1	NR	N/A
Mutual of Omaha Insurance Company	1	NR	N/A	0	N/A	N/A
Health Insurance Program for Children	1	1,471,703	0.06	3	1,621,908	0.18
North Carolina Medical Society Employees Benefit Trust (MEWA)	0	N/A	N/A	1	NR	N/A
Principal Life Insurance Company	1	NR	N/A	0	N/A	N/A
Teachers' and State Employees' Comprehensive Plan	36	6,275,459	0.57	48	7,015,840	0.68
Trustmark Insurance Company	1	NR	N/A	1	NR	N/A
UnitedHealthcare of North Carolina, Inc.	4	2,870,681	0.14	16	2,426,485	0.66
United Healthcare Insurance Company	0	N/A	N/A	1	NR	N/A
WellPath Select, Inc.	2	768,012	0.26	5	754,699	0.66

NR-Not Reported  
N/A-Not Applicable

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. For insurers with the largest number of requests (State Health Plan 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 2004 to 2005. 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: Comparison of Accepted Case Activity by Insurer and Type of Service Requested by Calendar Year, January 1, 2004 – December 31, 2005**

Insurer and Type of Service	2004			2005			
	Number of Accepted Cases	Insurer's Outcome		Number of Accepted Cases	Insurer's Outcome		
		Percent Overturned	Percent Upheld		Percent Overturned	Percent Reversed	Percent Upheld
<b>American Medical Security Life Insurance Company</b>	<b>N/A</b>			<b>1</b>			-
• Hospital Length of Stay		--	--	1	--	--	100.00
<b>Total Percentage for Insurer</b>		--	--		--	--	<b>100.00</b>
<b>Blue Cross &amp; Blue Shield of North Carolina</b>	<b>20</b>			<b>20</b>			
• DME	2	50.00	50.00	1	--	--	100.00
• Inpatient Mental Health	1	100.00	--	1	--	--	100.00
• Lab, Imaging, Testing	3	--	100.00	2	50.00	--	50.00
• Oncology	N/A	--	--	2	100.00	--	--
• Outpatient Mental Health	N/A	--	--	2	--	--	100.00
• Pharmacy	1	100.00	--	N/A	--	--	--
• Physician Services	4	25.00	75.00	2	100.00	--	--
• Surgical Services	9	33.33	66.67	10	10.00	--	90.00
<b>Total Percentage for Insurer</b>		<b>35.00</b>	<b>65.00</b>		<b>30.00</b>	--	<b>70.00</b>
<b>CIGNA HealthCare of North Carolina, Inc.</b>	<b>3</b>			<b>5</b>			
• Inpatient Mental Health	N/A	--	--	1	100.00	--	--
• Pharmacy	2	100.00	--	3	--	33.33	66.67
• Surgical Services	1	--	100.00	1	--	--	100.00
<b>Total Percentage for Insurer</b>		<b>66.67</b>	<b>33.33</b>		<b>20.00</b>	<b>20.00</b>	<b>60.00</b>
<b>Connecticut General Life Insurance Company</b>	<b>N/A</b>			<b>1</b>			
• DME	N/A	--	--	1	--	--	100.00
<b>Total Percentage for Insurer</b>		--	--		--	--	<b>100.00</b>
<b>Federated Mutual Insurance Company</b>	<b>1</b>			<b>N/A</b>			
• Chiropractic	1	--	100.00		--	--	--
<b>Total Percentage for Insurer</b>		--	<b>100.00</b>		--	--	--
<b>FirstCarolinaCare, Inc.</b>	<b>N/A</b>			<b>1</b>			
• Lab, Imaging, Testing	N/A	--	--	1	--	100.00	--
<b>Total Percentage for Insurer</b>		--	--		--	<b>100.00</b>	--
<b>Fortis Insurance Company/Time Insurance Company</b>	<b>2</b>			<b>2</b>			
• DME	N/A	--	--	1	--	--	100.00
• Lab, Imaging, Testing	1	100.00	--	N/A	--	--	--
• Surgical Services	1	--	100.00	1	--	100.00	--
<b>Total Percentage for Insurer</b>		<b>50.00</b>	<b>50.00</b>		--	<b>50.00</b>	<b>50.00</b>

N/A-Not Applicable

**Table 8: Comparison of Accepted Case Activity by Insurer and Type of Service Requested by Calendar Year, January 1, 2004 – December 31, 2005 (Cont'd.)**

Insurer and Type of Service	2004			2005			
	Number of Accepted Cases	Insurer's Outcome		Number of Accepted Cases	Insurer's Outcome		
		Percent Overturned	Percent Upheld		Percent Overturned	Percent Reversed	Percent Upheld
<b>Guardian Life Insurance Company of America</b>	<b>1</b>			<b>N/A</b>			
Inpatient Mental Health	1	100.00	--		--	--	--
<b>Total Percentage for Insurer</b>		<b>100.00</b>	--		--	--	--
<b>Humana Insurance Company</b>	<b>1</b>			<b>N/A</b>			
• Chiropractic	1	--	100.00		--	--	--
<b>Total Percentage for Insurer</b>		--	<b>100.00</b>		--	--	--
<b>John Alden Life Insurance Company</b>	<b>2</b>			<b>1</b>			
• DME	1	100.00	--	N/A	--	--	--
• Outpatient Mental Health	N/A	--	--	1	100.00	--	--
• Pharmacy	1	100.00	--	N/A	--	--	--
<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>			
• Oncology	1	100.00	--	N/A	--	--	--
• Skilled Nursing Facility	N/A	--	--	1	100.00	--	--
<b>Total Percentage for Insurer</b>		<b>100.00</b>	--		<b>100.00</b>	--	--
<b>Mutual of Omaha Insurance Company</b>	<b>1</b>			<b>N/A</b>			
• Surgical Services	1	--	100.00		--	--	--
<b>Total Percentage for Insurer</b>		--	<b>100.00</b>		--	--	--
<b>Health Insurance Program for Children</b>	<b>1</b>			<b>3</b>			
• Outpatient Mental Health	N/A	--	--	1	--	100.00	--
• Rehabilitation Services	1	--	100.00	N/A	--	--	--
• Surgical Services	N/A	--	--	2	100.00	--	--
<b>Total Percentage for Insurer</b>		--	<b>100.00</b>		<b>66.67</b>	<b>33.33</b>	--
<b>North Carolina Medical Society Employees Benefit Trust (MEWA)</b>	<b>N/A</b>			<b>1</b>			
• Physician Services	N/A	--	--	1	100.00	--	--
<b>Total Percentage for Insurer</b>		--	--		<b>100.00</b>	--	--
<b>Principal Life Insurance Company</b>	<b>1</b>			<b>N/A</b>			
• Rehabilitation Services	1	--	100.00		--	--	--
<b>Total Percentage for Insurer</b>		--	<b>100.00</b>		--	--	--

N/A-Not Applicable

**Table 8: Comparison of Accepted Case Activity by Insurer and Type of Service Requested by Calendar Year, January 1, 2004 – December 31, 2005 (Cont'd.)**

Insurer and Type of Service	2004			2005			
	Number of Accepted Cases	Insurer's Outcome		Number of Accepted Cases	Insurer's Outcome		
		Percent Overturned	Percent Upheld		Percent Overturned	Percent Reversed	Percent Upheld
<b>Teachers' and State Employees' Comprehensive Plan</b>	<b>36</b>			<b>48</b>			
• DME	11	54.55	45.45	8	25.00	12.50	62.50
• Inpatient Mental Health	3	33.33	66.67	6	33.33	3.33	33.34
• Lab, Imaging, Testing	1	--	100.00	2	--	--	100.00
• Outpatient Mental Health	N/A	--	--	1	--	--	100.00
• Oncology	2	--	100.00	1	--	--	100.00
• Pharmacy	1	100.00	--	4	50.00	--	50.00
• Physician Services	1	100.00	--	3	33.33	--	66.67
• Rehabilitation Services	2	50.00	50.00	1	--	--	100.00
• Skilled Nursing Facility	5	--	100.00	3	33.33	33.33	33.34
• Surgical Services	7	42.86	57.14	17	35.30	--	64.70
• Transplant	3	33.33	66.67	2	50.00	--	50.00
<b>Total Percentage for Insurer</b>		<b>38.89</b>	<b>61.11</b>		<b>31.25</b>	<b>8.33</b>	<b>60.42</b>
<b>Trustmark Insurance Company</b>	<b>1</b>			<b>1</b>			
• Pharmacy	1	--	100.00	N/A	--	--	--
• Surgical Services	N/A	--	--	1	--	--	100.00
<b>Total Percentage for Insurer</b>		--	<b>100.00</b>		--	--	<b>100.00</b>
<b>United HealthCare Insurance Company</b>	<b>N/A</b>			<b>1</b>			
• Surgical Services	N/A	--	--	1	--	--	100.00
<b>Total Percentage for Insurer</b>		--	--		--	--	<b>100.00</b>
<b>UnitedHealthcare of North Carolina, Inc.</b>	<b>4</b>			<b>16</b>			
• DME	N/A	--	--	2	50.00	--	50.00
• Inpatient Mental Health	1	--	100.00	3	33.33	--	66.67
• Lab, Imaging, Testing	1	100.00	--	1	100.00	--	--
• Outpatient Mental Health	N/A	--	--	2	100.00	--	--
• Pharmacy	N/A	--	--	4	--	--	100.00
• Surgical Services	2	50.00	50.00	4	25.00	--	75.00
<b>Total Percentage for Insurer</b>		<b>50.00</b>	<b>50.00</b>		<b>37.50</b>	--	<b>62.50</b>
<b>WellPath Select, Inc.</b>	<b>2</b>			<b>5</b>			
• Inpatient Mental Health	1	--	100.00	2	100.00	--	--
• Lab, Imaging, Testing	N/A	--	--	2	50.00	50.00	--
• Surgical Services	1	100.00	--	1	100.00	--	--
<b>Total Percentage for Insurer</b>		<b>50.00</b>	<b>50.00</b>		<b>80.00</b>	<b>20.00</b>	--

N/A-Not Applicable

## **VI. Activity by IRO**

### **A. Summary by IRO**

During the period of January 1, 2004 – December 31, 2005, IROs rendered 175 external review decisions for consumers. Although 184 cases were accepted for external review during these two years, nine (9) cases were reversed by the insurer prior to an IRO decision being rendered in 2005. The cases sent to IROs for independent review encompass a variety of insurers, noncertification reasons and specific types of services. Table 9 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 reviewer. The contract for Hayes Plus expired on June 30, 2004 when the IRO declined to extend their contract for one (1) additional year. Permedion's contract became effective January 1, 2004. Additionally, the contract periods for Carolina Center for Clinical Information (3CI) and Prest & Associates ended on June 30, 2005.

In February of 2005, the Department initiated a Request for Proposal (RFP) for IROs to Perform Reviews of Health Plan Utilization Review Non-Certifications. The Department received seven (7) proposals in response to its RFP. In completing the Technical Application Form, IROs were required to respond, in detail, to the following sections:

- Qualifications and Experience,
- Clinical Reviewers,
- Quality Assurance and Confidentiality,
- Independent Review Process and Information Systems, and
- Financial Profile.

In providing a cost proposal, IROs were required to submit a price quote which, if accepted, would remain in force for the entirety of the two-year contract period, and included an additional one-year extension if mutually agreeable to both parties. IRO cost proposals were required to include the following:

- A total price quote for a standard review,
- A total price quote for an expedited review,
- A total price quote for a cancellation fee for a standard review, and
- A total price quote for a cancellation fee for an expedited review.

As required under NCGS § 58-50-94(b), the IRO proposals were evaluated by a nine-member Evaluation Committee whose membership included insurers subject to external review, health care providers, and insureds. Proposals were evaluated to determine if an IRO satisfied the minimum qualifications established under NCGS § 58-50-87. Using evaluation criteria included in the RFP, each IRO's technical proposal was scored on a "points earned" basis. Only those IROs with an acceptable technical score had their cost proposals opened and evaluated. In evaluating cost proposals, the Evaluation Committee identified those proposals that were within

commercially reasonable fees charged for similar services in the industry. Those proposals deemed to provide the best combination of technical and cost values to the State of North Carolina were recommended to the Assistant Commissioner.

The four (4) IROs that were deemed eligible to participate in North Carolina’s external review program and with whom contracts were executed are:

- Island Peer Review Organization (IPRO)—(Lake Success, NY)
- MAXIMUS CHDR—(Pittsford, NY)
- MCMC—(Bethesda, MD)
- National Medical Reviews, Inc. (NMR, Inc.)—(Trevose, PA)

Both IPRO and MAXIMUS CHDR have been contracted vendors with the Department’s HCR Program since July 1, 2002. MCMC and NMR, Inc. are new vendors working with the HCR Program. As previously noted, Permedion has been a contracted vendor since January 1, 2004.

The data in Table 9 shows the IRO activity summary for 2004 and 2005. It shows that for the three (3) IROs who have received a larger proportion of cases (IPRO, MAXIMUS CHDR, and Permedion) the outcomes are similar. Prest & Associates and 3CI did not receive any further case assignments after June 30, 2005. MCMC did not receive any cases as a result of screening for conflict of interest.

**Table 9: Comparison of IRO Activity Summary by Calendar Year, January 1, 2004 – December 31, 2005**

IRO	2004					2005				
	Number Assigned	Overturned		Upheld		Number Assigned	Overturned		Upheld	
		#	%	#	%		#	%	#	%
3CI	7	3	42.86	4	57.14	6	3	50.00	3	50.00
Hayes Plus	6	1	16.67	5	83.33	N/A	--	--	--	--
IPRO	22	9	40.91	13	59.09	33	13	39.40	20	60.60
MAXIMUS CHDR	22	11	50.00	11	50.00	29	11	38.00	18	62.00
MCMC	N/A	--	--	--	--	0	--	--	--	--
NMR, Inc.	N/A	--	--	--	--	8	2	25.00	6	75.00
Permedion	19	7	36.84	12	63.16	22	8	36.36	14	63.64
Prest & Associates	1	0	0.00	1	100.00	0	--	--	--	--
<b>All Cases</b>	<b>77</b>	<b>31</b>	<b>40.26</b>	<b>46</b>	<b>59.74</b>	<b>98</b>	<b>37</b>	<b>37.75</b>	<b>61</b>	<b>62.25</b>

N/A-Not Applicable

## B. Decisions 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. In 2005, outcomes for types of service with the highest number of cases (DME, Pharmacy, Surgical Services) for the IROs with the largest number of cases assigned (IPRO, MAXIMUS CHDR, Permedion) are similar. Table 10 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 11 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 10: Comparison of IRO Decisions by Type of Service Requested by Calendar Year, January 1, 2004 – December 31, 2005**

IRO and Type of Service	2004			2005		
	Number of Decisions	Outcomes		Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld		Percent Overturned	Percent Upheld
<b>3CI *</b>	<b>7</b>			<b>6</b>		
• Chiropractic	1	--	100.00	N/A	--	--
• DME	N/A	--	--	1	--	100.00
• Hospital Length of Stay	N/A	--	--	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	N/A	--	--
• Rehabilitation Services	1	--	100.00	N/A	--	--
• Skilled Nursing Facility	N/A	--	--	1	100.00	--
• Surgical Services	2	50.00	50.00	1	--	100.00
<b>Hayes Plus **</b>	<b>6</b>			<b>N/A</b>		
• Inpatient Mental Health	1	--	100.00	--	--	--
• Surgical Services	4	25.00	75.00	--	--	--
• Transplant	1	--	100.00	--	--	--
<b>IPRO</b>	<b>22</b>			<b>33</b>		
• DME	6	66.67	33.33	3	33.33	66.67
• Inpatient Mental Health	N/A	--	--	5	60.00	40.00
• Lab, Imaging, Testing	1	--	100.00	1	--	100.00
• Oncology	1	--	100.00	2	100.00	--
• Pharmacy	2	100.00	--	5	20.00	80.00
• Physician Services	2	50.00	50.00	3	66.67	33.33
• Rehabilitation Services	N/A	--	--	1	--	100.00
• Skilled Nursing Facility	4	--	100.00	N/A	--	--
• Surgical Services	5	40.00	60.00	12	33.33	66.67
• Transplant	1	--	100.00	1	--	100.00

\* Contract ended June 30, 2005 \*\* Contract ended June 30, 2004 N/A-Non-Applicable

**Table 10: Comparison of IRO Decisions by Type of Service Requested by  
Calendar Year, January 1, 2004 – December 31, 2005 (Cont'd.)**

IRO and Type of Service	2004			2005		
	Number of Decisions	Outcomes		Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld		Percent Overturned	Percent Upheld
<b>MAXIMUS CHDR</b>	<b>22</b>			<b>29</b>		
• Chiropractic	1	--	100.00	N/A	--	--
• DME	4	50.00	50.00	5	20.00	80.00
• Inpatient Mental Health	2	100.00	--	4	50.00	50.00
• Lab, Imaging, Testing	3	33.33	66.67	3	33.33	66.67
• Outpatient Mental Health	N/A			4	50.00	50.00
• Oncology	1	100.00	--	N/A	--	--
• Pharmacy	1	100.00	--	1	--	100.00
• Physician Services	N/A	--	--	1	--	100.00
• Rehabilitation Services	3	33.33	66.67	N/A	--	--
• Skilled Nursing Facility	N/A	--	--	1	100.00	--
• Surgical Services	7	42.86	57.14	9	33.33	66.67
• Transplant	N/A	--	--	1	100.00	--
<b>MCMC *</b>	<b>N/A</b>	--	--	<b>0</b>	--	--
<b>NMR, Inc. *</b>	<b>N/A</b>			<b>8</b>		
• DME	N/A	--	--	1	--	100.00
• Inpatient Mental Health	N/A	--	--	1	100.00	--
• Pharmacy	N/A	--	--	1	--	100.00
• Physician Services	N/A	--	--	1	100.00	--
• Surgical Services	N/A	--	--	4	--	100.00
<b>Permedion</b>	<b>19</b>			<b>22</b>		
• DME	4	50.00	50.00	2	50.00	50.00
• Inpatient Mental Health	2	--	100.00	1	--	100.00
• Lab, Imaging, Testing	1	--	100.00	1	100.00	--
• Outpatient Mental Health	N/A	--	--	1	--	100.00
• Oncology	1	--	100.00	1	--	100.00
• Pharmacy	2	100.00	--	3	33.33	66.67
• Physician Services	3	33.33	66.67	1	100.00	--
• Skilled Nursing Facility	1	--	100.00	1	--	100.00
• Surgical Services	4	25.00	75.00	11	36.36	63.64
• Transplant	1	100.00	--	N/A	--	--
<b>Prest &amp; Associates **</b>	<b>1</b>			<b>0</b>		
• Inpatient Mental Health	1	--	100.00		--	--

\*Contract became effective July 1, 2005

\*\*Contract ended June 30, 2004

N/A-Not Applicable

The data in Table 11 compares changes in outcomes by general service type between 2004 and 2005. Outcomes for DME cases saw a reduction in cases overturned. In 2004, 57 percent of the DME cases involved DOC Bands, with the remainder of cases comprising of one type of case. In 2005, 42 percent of the cases involved DOC Bands and the remainder of cases involved a variety of different types of DME with each case involving a different type. Overturned outcomes for Pharmacy services dropped in 2005 to 20 percent of cases being decided in favor of the consumer. A comparison of case types from each year reveals that the six (6) cases in 2004 involved a different type of medication for each case. In 2005 only four (4) types of medication were involved, with the majority (5 cases) comprised of Synagis and Provigil. There were no cases overturned by the IRO involving these two (2) medications. The percentage of overturned surgical service cases declined in 2005 by 6.6 percent. A review of the data showed an increase in the percentage of experimental/investigational cases in 2005, 10 cases (27% of accepted surgical service cases) with 90 percent of the cases upheld, compared to 2004 with four (4) cases (18.1% of accepted surgical service cases) with 100 percent of the cases upheld.

**Table 11: Comparison of All IRO Outcomes (Percentages) by General Service Type for All Insurers by Calendar Year, January 1, 2004 – December 31, 2005**

Service Type	2004			2005		
	Number of Decisions	Outcomes		Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld		Percent Overturned	Percent Upheld
Chiropractic	2	--	100.00	--	--	--
DME	14	57.14	42.86	12	25.00	75.00
Hospital Length of Stay	--	--	--	1	--	100.00
Inpatient Mental Health	7	42.86	57.14	12	58.33	41.67
Lab, Imaging, Testing	6	33.33	66.67	6	50.00	50.00
Outpatient Mental Health	--	--	--	5	40.00	60.00
Oncology	3	33.33	66.67	3	66.67	33.33
Pharmacy	6	83.33	16.67	10	20.00	80.00
Physician Services	5	40.00	60.00	6	66.67	33.33
Rehabilitation Services	4	25.00	75.00	1	--	100.00
Skilled Nursing Facility	5	--	100.00	3	66.67	33.33
Surgical Services	22	36.36	63.64	37	29.73	70.27
Transplant	3	33.33	66.67	2	50.00	50.00

Table 12 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 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 12: Comparison of IRO Decisions by Nature of Noncertification by Calendar Year,  
January 1, 2004 – December 31, 2005**

Name of IRO	2004							2005						
	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
3CI	7	2	2	1	2	0	0	6	3	1	0	2	0	0
Hayes Plus	6	1	3	0	1	0	1	NA	--	--	--	--	--	--
IPRO	22	4	6	0	4	5	3	33	6	9	3	8	4	3
MAXIMUS CHDR	22	5	7	4	3	2	1	29	9	9	2	8	0	1
MCMC	N/A	--	--	--	--	--	--	0	0	0	0	0	0	0
NMR, Inc.	N/A	--	--	--	--	--	--	8	2	2	0	3	0	1
Permedion	19	3	6	3	4	1	2	22	3	8	4	2	1	4
Prest & Associates	1	0	1	0	0	0	0	0	0	0	0	0	0	0
<b>Total</b>	<b>77</b>	<b>15</b>	<b>25</b>	<b>8</b>	<b>14</b>	<b>8</b>	<b>7</b>	<b>98</b>	<b>23</b>	<b>29</b>	<b>9</b>	<b>23</b>	<b>5</b>	<b>9</b>
<b>Percentage</b>		<b>51.9%</b>		<b>28.6%</b>		<b>19.5%</b>			<b>53.1%</b>		<b>32.6%</b>		<b>14.3%</b>	

N/A-Not Applicable

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: Comparison of IRO Decisions by Insurer by Calendar Year,  
January 1, 2004 – December 31, 2005**

IRO and Insurer	2004			2005		
	Number of Decisions	% Overturn	% Upheld	Number of Decisions	% Overturn	% Upheld
<b>3CI</b>	<b>7</b>			<b>6</b>		
• American Medical Security Life Insurance Company	N/A	--	--	1	--	100.00
• Guardian Life Insurance Company of America	1	100.00	--	N/A	--	--
• Humana Insurance Company	1	--	100.00	N/A	--	--
• MAMSI Life and Health Insurance Company	N/A	--	--	1	100.00	--
• Principal Life Insurance Company	1	--	100.00	N/A	--	--
• Trustmark Insurance Company	1	--	100.00	N/A	--	--
• UnitedHealthcare of North Carolina, Inc.	3	66.67	33.33	3	33.33	66.67
• WellPath Select, Inc.	N/A	--	--	1	100.00	--
<b>Hayes Plus</b>	<b>6</b>			<b>N/A</b>		
• Blue Cross & Blue Shield of North Carolina	2	50.00	50.00	--	--	--
• Teachers' and State Employees' Comprehensive Plan	4	--	100.00	--	--	--
<b>IPRO</b>	<b>22</b>			<b>33</b>		
• Blue Cross & Blue Shield of North Carolina	8	37.50	62.50	6	66.67	33.33
• CIGNA HealthCare of North Carolina, Inc.	1	100.00	--	2	--	100.00
• Fortis Insurance Company	1	--	100.00	N/A	--	--
• John Alden Life Insurance Company	2	100.00	--	1	100.00	--
• Health Insurance Program for Children	N/A	--	--	2	100.00	--
• North Carolina Medical Society Employees Benefit Trust (MEWA)	N/A	--	--	1	100.00	--
• Teachers' and State Employees' Comprehensive Plan	10	30.00	70.00	17	23.53	76.47
• Time Insurance Company	N/A	--	--	1	--	100.00
• UnitedHealthcare of North Carolina, Inc.	N/A	--	--	2	--	100.00
• WellPath Select, Inc.	N/A	--	--	1	100.00	--

N/A-Not Applicable

**Table 13: Comparison of IRO Decisions by Insurer by Calendar Year,  
January 1, 2004 – December 31, 2005 (Cont'd)**

IRO and Insurer	2004			2005		
	Number of Decisions	% Overturn	% Upheld	Number of Decisions	% Overturn	% Upheld
<b>MAXIMUS CHDR</b>	<b>22</b>			<b>29</b>		
• Blue Cross & Blue Shield of North Carolina	5	40.00	60.00	7	--	100.00
• CIGNA HealthCare of North Carolina, Inc.	N/A	--	--	1	100.00	--
• Connecticut General Life Insurance Company	N/A	--	--	1	--	100.00
• Federated Mutual Insurance Company	1	--	100.00	N/A	--	--
• Fortis Insurance Company	1	100.00	--	N/A	--	--
• MAMSI Life and Health Insurance Company	1	100.00	--	N/A	--	--
• Health Insurance Program for Children	1	--	100.00	N/A	--	--
• Teachers' and State Employees' Comprehensive Plan	12	50.00	50.00	11	36.36	63.64
• UnitedHealthCare of North Carolina, Inc.	N/A	--	--	7	57.14	42.86
• WellPath Select, Inc.	1	100.00	--	2	100.00	--
<b>MCMC</b>	<b>N/A</b>	--	--	<b>0</b>	--	--
<b>NMR, Inc.</b>	<b>N/A</b>			<b>8</b>		
• CIGNA HealthCare of North Carolina, Inc.	--	--	--	1	--	100.00
• Teachers' and State Employees' Comprehensive Plan	--	--	--	7	28.57	71.43
<b>Permedion</b>	<b>19</b>			<b>22</b>		
• Blue Cross & Blue Shield of North Carolina	5	20.00	80.00	7	28.57	71.43
• CIGNA HealthCare of North Carolina, Inc.	2	50.00	50.00	N/A	--	--
• Mutual of Omaha Insurance Company	1	--	100.00	N/A	--	--
• Teachers' and State Employees' Comprehensive Plan	10	50.00	50.00	9	55.56	44.44
• Trustmark Insurance Company	N/A	--	--	1	--	100.00
• United Healthcare Insurance Company	N/A	--	--	1	--	100.00
• UnitedHealthcare of North Carolina, Inc.	1	--	100.00	4	25.00	75.00
<b>Prest &amp; Associates</b>	<b>1</b>			<b>0</b>		
• WellPath Select, Inc.	1	--	100.00		--	--

N/A-Not Applicable

## VII. Cost of External Review Cases

The cost of an external review for a specific case can be comprised of one (1) or two (2) 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 \$450 and \$795 for a standard review, and \$750 and \$895 for an expedited review. These fees are fixed per-case fees bid by each IRO; they do not vary by the type of service that is covered. A cancellation fee was charged to an insurer for one (1) case where the insurer reversed its own decision after the IRO had proceeded with the review. Insurers were not charged a rate for review on the eight (8) cases where the insurer reversed its own decision prior to the IRO review beginning. The average cost to insurers for the remaining 98 reviews performed during 2005 was \$588. However, the average cost for all IRO reviews since the Program began is \$553.

For 2005, the average amount of allowed charges assumed by the insurer in the nine (9) cases where the insurer reversed its own noncertification was \$11,383 (with a total of \$102,443). The average amount of allowed charges assumed by the insurer for decisions that were overturned in favor of the consumer was \$18,763 (with a total of \$600,407).

The average costs of allowed charges from all cases that have been reversed by the insurer or overturned by an IRO since the Program began is \$14,374. The total cost of allowed charges for all cases reversed by the insurer or overturned by the IRO for each year are:

2002-	\$103,712.46
2003-	\$593,677.53
2004-	\$353,344.06
2005-	\$702,850.36

**To date, the cumulative total of services provided to consumers as a result of external review since the Program commenced is \$1,753,628. Because of the prospective nature of five (5) 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 13 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. The total cost of services for each year has changed with this report as a result of capturing the cost of previously overturned services that were completed during 2005.

**Figure 13: Yearly and Cumulative Value of Allowed Charges for Overturned or Reversed Services, July 1, 2002 – December 31, 2005**

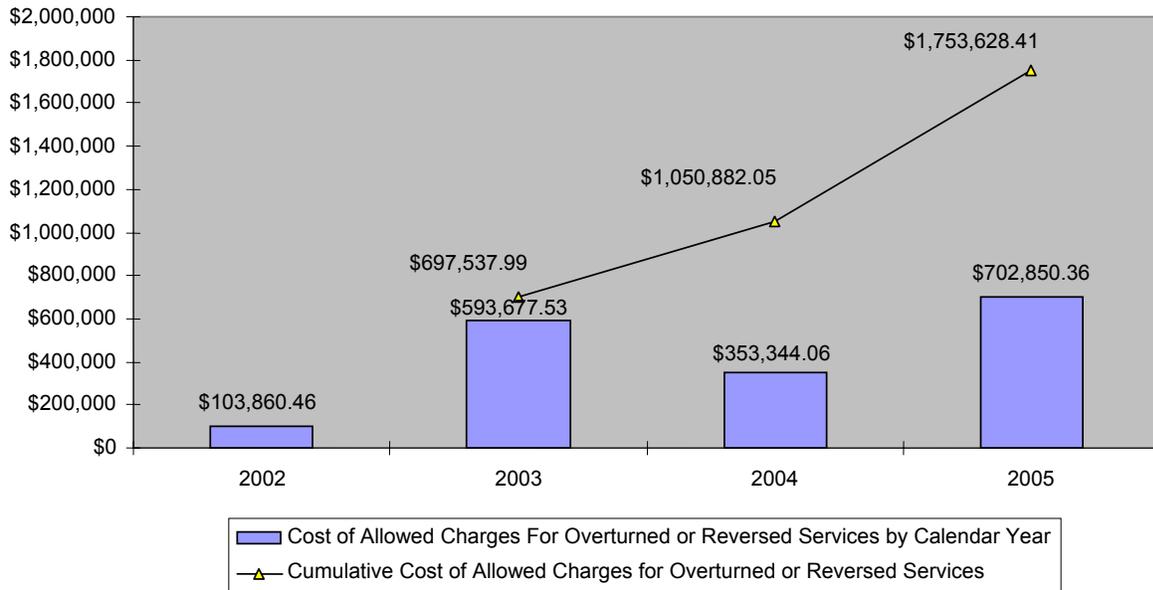


Table 14 shows the average total cost of the IRO review and cost of allowed charges for cases that were reversed by the insurer or overturned (average and cumulative) since the Program began operations, by type of service requested.

**Table 14: Cost of IRO Review, Average and Cumulative Allowed Charges by Type of Service Requested, July 1, 2002 – December 31, 2005**

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	
Chiropractic	\$408	\$0	\$0	\$0
DME	536	582	5,332	101,309
Emergency Treatment	0	450	1,096	1,096
Home Health Nursing	498	450	55,230	55,230
Hospital Length of Stay	548	300	788	788
Inpatient Mental Health	589	473	25,675	385,124
Inpatient Rehabilitation	450	0	0	0
Lab, Imaging, Testing	541	432	1,308	11,768
Outpatient Mental Health	506	450	1,450	4,351
Oncology	817	760	51,621	206,484
Pharmacy	636	591	2,316	25,471
Physician Services	525	625	952	4,758
Rehabilitation Services	455	500	1,948	7,794
Skilled Nursing Facility	612	500	3,864	27,045
Surgical Services*	553	530	11,172	435,725
Transplant	673	758	162,228	486,685
<b>All Cases</b>	<b>\$567</b>	<b>\$542</b>	<b>\$14,374</b>	<b>\$1,753,628</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, 280 surveys were sent and 154 consumers or authorized representative responded. The outcomes of the cases of the responding parties were: 87 overturned, 64 upheld and three (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 suggestions that they should be able to see the information being sent by the insurer to the IRO led to change in legislation to allow for consumers to receive this information.

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, 98.8 percent stated they would tell a friend about external review. While this number is to be expected, what is relevant is that 62.5 percent of the responders, whose decision was upheld, would also tell a friend about external review. As shown in Table 15, 83.7 percent of individuals who went through the external review process stated they would tell a friend about external review, suggesting that external review is viewed to be a valued and important consumer protection.

**Table 15: 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”
Overturned	116	87	75.00	86	98.85
Upheld	159	64	40.25	40	62.50
Reversed	5	3	60.00	3	100.00
<b>Total:</b>	<b>280</b>	<b>154</b>	<b>55.00%</b>	<b>129</b>	<b>83.76%</b>

## IX. Conclusion

External Review is the independent medical review of an insurer denial when the insurer’s decision to deny reimbursement was based on a medical necessity determination. North Carolina’s External Review law provides consumers with another option for resolving coverage disputes with their insurer using this efficient, cost-effective process. In North Carolina, there is

no cost to the consumer for requesting an external review. To date, the cumulative total of services provided to consumers as a result of external review since the Program commenced is \$1,753,628.

The HCR Program Semiannual Report presents external review and consumer counseling data which documents the growth of the Program for the past two calendar years as well as reporting of activity and outcomes for calendar year 2005. 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. While the quantity of data is still relatively small, and general conclusions cannot be made, some overall observations can be reported based upon the data we have available.

During this reporting period, the volume of external review requests showed steady growth with 201 requests received in 2004 and 291 requests in 2005, an increase of 44.8 percent. Of the 184 cases that were accepted during this reporting period, 41.8 percent were decided in favor of the consumer, either due to the insurer reversing its own denial prior to IRO assignment (8 cases), after assignment (1 case), or the IRO overturning the insurer's noncertification (68 cases). Surgical services continues to represent the largest share of accepted cases, and case types include TMJ, Gastric Bypass Surgery, Mammoplasty, Orthopedic/Musculoskeletal and Vein Surgery.

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 appeal decision on appeals and grievances. When the HCR Program receives a request for external review, the insurer is required to provide certain information within statutory time frames, so that eligibility determinations can be made. During this reporting period, the Program worked with 18 different insurance companies, the State Health Plan and the Health Insurance Program for Children. All complied with the time frame requirements, and were responsive and cooperative to the Program's questions or requests for additional information.

There continues to be interest from consumers to receive assistance with issues involving their insurer's utilization review or internal appeals and grievance process. During this two year reporting period, HCR Program staff provided counseling to 908 consumers who contacted our office. In addition to explaining the state law that governs the appeal and grievance process, 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 the treatment, and explain how to use the supporting information and law during the appeal process. Furthermore, this arrangement will provide for continuity for those cases that ultimately progress to external review.

The HCR Program continues to seek out new and different opportunities to promote consumer and provider awareness of external review services through a comprehensive community outreach and education program. Activities during this reporting period have included participation in health fairs, speaking engagements, publications, and radio interviews. A letter from the Commissioner of Insurance was sent to nearly 16,000 actively practicing physicians in North Carolina explaining the importance of external review services, and providing posters for

display in their patient lobby areas. An electronic notice about External Review Services was sent to State Agencies, private sector businesses and allied health providers. The response to this initiative was very positive with the Program receiving the largest number of External Review Requests in one (1) month.

North Carolina's External Review service continues to be an effective vehicle for consumers to resolve coverage disputes with their insurer in a fair, efficient, and cost-effective manner. In this State, consumers can easily request an external review as there are no monetary claims threshold requirements, and no cost to the consumer to request an external review. Over the last two years, improvements to the external review process have been made based on program experience by the staff and suggestions from consumers. In the end, the Healthcare Review Program operates effectively to provide external review services to the citizens of North Carolina.