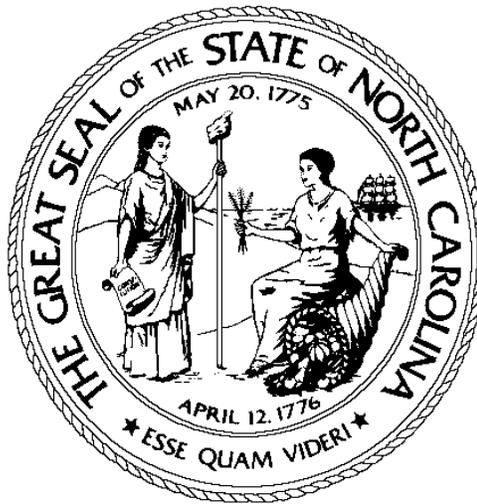


# North Carolina Department of Insurance



## Healthcare Review Program Semiannual Report

for the period of January 1, 2006 – June 30, 2006

**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
Release VIII	January 1, 2006 – June 30, 2006

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

## Table of Contents

Executive Summary .....	i
I. Introduction.....	1
II. Background of the Healthcare Review Program.....	1
III. Program Activities .....	2
A. External Review .....	2
B. Oversight of IROs .....	2
C. Oversight of Insurers (External Review) .....	3
D. Consumer Counseling on UR and Internal Appeal and Grievance Procedures.....	3
IV. Program Activity Data.....	4
A. Consumer Contacts .....	4
<u>Consumer Telephone Calls</u> .....	4
<b>Figure 1: External Review and Consumer Counseling                 Call Volume Received by the HCR Program,                 January 1, 2006 – June 30, 2006.....</b>	4
<u>Consumer Website Contacts</u> .....	4
<b>Figure 2: HCR Program Website Page Access Activity,                 January 1, 2006 – June 30, 2006.....</b>	5
B. Consumer Counseling Activity (Utilization Review, Appeal & Grievances).....	5
<b>Figure 3: Consumer Counseling Case Volume                 Received by the HCR Program,                 January 1, 2006 – June 30, 2006 .....</b>	5
C. External Review Requests .....	6
<b>Figure 4: External Review Requests Received by                 Type of Review Requested,                 January 1, 2006 – June 30, 2006.....</b>	6
D. Eligibility Determinations on Requests for External Review .....	6
<b>Table 1: Disposition of Incomplete Requests Made to the                 HCR Program, January 1, 2006 – June 30, 2006 .....</b>	7

	<b>Figure 5: Disposition of External Review Requests</b>	
	Received, January 1, 2006 – June 30, 2006 .....	7
	<b>Figure 6: Eligibility Determinations for Requests</b>	
	Received, January 1, 2006 – June 30, 2006 .....	8
	<b>Table 2: Reasons for Non-Acceptance of an External Review</b>	
	Request, January 1, 2006 – June 30, 2006.....	8
<b>E.</b>	<b>Outcomes of Accepted Cases.....</b>	<b>9</b>
	<b>Figure 7: Outcomes of Accepted Cases,</b>	
	January 1, 2006 – June 30, 2006.....	9
	<b>Figure 8: Outcomes of Accepted Cases by</b>	
	Type of Review Requested,	
	January 1, 2006 – June 30, 2006.....	9
<b>V.</b>	<b>Activity by Type of Service Requested.....</b>	<b>10</b>
	<b>Figure 9: Accepted Cases by Type of Service Requested,</b>	
	January 1, 2006– June 30, 2006.....	10
	<b>Table 3: Percentage Share of Review Activity by</b>	
	Type of Service Requested,	
	January 1, 2006 – June 30, 2006.....	11
	<b>Table 4: Outcomes of Accepted External Review</b>	
	Requests by Service Type and Denial Type,	
	January 1, 2006 – June 30, 2006.....	12
<b>A.</b>	<b>Insurer and Type of Service Activity.....</b>	<b>12</b>
	<b>Figure 10: Insurer’s Share of Accepted External Review Requests,</b>	
	January 1, 2006 – June 30, 2006.....	13
	<b>Table 5: Accepted Case Activity by Insurer and</b>	
	Type of Service Requested,	
	January 1, 2006 – June 30, 2006.....	14 - 15
<b>VI.</b>	<b>Activity by IRO .....</b>	<b>15</b>
<b>A.</b>	<b>Summary by IRO .....</b>	<b>15</b>
	<b>Table 6: Comparison of IRO Activity Summary,</b>	
	January 1, 2006 – June 30, 2006 .....	16
<b>B.</b>	<b>Decisions by Type of Service Requested.....</b>	<b>16</b>

	<b>Table 7: IRO Decisions by Type of Service Requested, January 1, 2006 – June 30, 2006.....</b>	<b>16 - 17</b>
	<b>Table 8: IRO Decisions by Insurer, January 1, 2006 – June 30, 2006.....</b>	<b>18</b>
<b>VII.</b>	<b>Cost of External Review Cases .....</b>	<b>19</b>
	<b>Table 9: Cost of IRO Review, Average and Cumulative Allowed Charges by Type of Service Requested, January 1, 2006 – June 30, 2006.....</b>	<b>19</b>
	<b>Figure 11: Cumulative Value of Allowed Charges for Overturned or Reversed Services, July, 1, 2002 – June 30, 2006.....</b>	<b>20</b>
<b>VIII.</b>	<b>Conclusion .....</b>	<b>20</b>



## **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 all insurers that offer a health benefit plan and that provide or perform utilization review pursuant to N.C. Gen. Stat § 58-50-61, 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.

Insurers subject to North Carolina's External Review law are required to provide notice of external review rights to covered persons in their noncertification decisions and notices of decision on appeals and grievances. When the Healthcare Review Program (HCR Program or Program) receives a request for external review, the insurer is required to provide certain information to the Program, within statutory time frames, so that eligibility determinations can be made. Once a case is screened for eligibility and accepted by the Program, it is assigned to an Independent Review Organization (IRO) for review. Once issued, the IRO's decision to uphold or reverse the insurer's noncertification decision is binding upon the insurer and upon the covered person, except to the extent that the covered person has other remedies available under applicable state and federal law.

The HCR Program received 132 requests for external review for the period of January 1, 2006 – June 30, 2006. Of the 132 requests received, 17 (12.9%) involved resubmission of a request previously denied because it was incomplete. Therefore, eligibility determinations were made on 115 different individuals requesting external review and 65 cases (56.5%) were accepted. An analysis of the request types of accepted cases for this period showed that 4 cases (6.2%) involved decisions for services that were cosmetic, 19 cases (29.2%) involved decisions that were experimental/investigational, and 42 cases (64.6%) involved medical necessity determinations.

The HCR Program contracts with 5 IROs to provide external review services. During this reporting period, 62 cases were assigned to an IRO for review. One IRO was not assigned any cases as a result of the Program's conflict of interest screening prior to case assignment. All IRO determinations were compliant with notice and time frame requirements as mandated under North Carolina law.

In 3 cases (4.6%), the insurer reversed its noncertification prior to the IRO review, and IRO decisions were issued in the remaining 62 cases. In 25 cases (38.5%), the IRO overturned the insurer's decision, and in 37 cases (56.9%), the IRO upheld the insurer's decision. Of the accepted cases, IROs overturned none of the cosmetic cases, 2 of the experimental/investigational cases (10.5%) and 23 of the medical necessity cases (54.8%).

During this reporting period, the Program accepted 25 cases involving surgical services (38.5%) and 17 cases (26.1%) involving inpatient mental health. Cases involving surgical services were overturned 36 percent of the time, while cases involving inpatient mental health services were overturned or reversed by the insurer 70.6 percent of the time.

During this reporting period, there were 3 cases for which the associated costs of service have not been captured due to the prospective nature of the services. Therefore, costs have been captured for 25 cases for this period. External review decisions that were overturned or reversed during this reporting period resulted in \$235,341 worth of allowed charges for services being provided to consumers. The amount of allowed charges assumed by the insurer in the 3 cases where the insurer reversed its own noncertification was \$29,754, with an average cost of \$9,918 for allowed charges of services. The amount of allowed charges for the 22 cases overturned by IROs was \$205,587, with an average cost of \$8,939 for allowed charges of services. **Since July 1, 2002, the cumulative total of services provided to consumers as a result of external review is \$2,055,819.**

During this reporting period, 9 different insurers, 2 MEWAs (Multiple Employer Welfare Arrangements), and the State Health Plan had a total of 65 cases that were eligible for external review. With 31 accepted cases during this reporting period, the State Health Plan continues as the health plan that has experienced the highest number of cases accepted for external review. Blue Cross & Blue Shield of North Carolina had the second-largest number of accepted cases (16), UnitedHealthcare of North Carolina, Inc. had 7 cases. WellPath Select, Inc. had 3 cases and 8 other companies each had 1 accepted case. This reporting provides an accounting of the cases accepted for review. The case volume is too small to draw conclusions about insurers or how they compare to one another. In the previous report (Release VII, January 1, 2004 – December 31, 2005), the Program provided data which compared insurers by volume of accepted cases using a rate of cases per member per month for calendar year 2003 and 2004. Due to insurer annual reporting requirements of member-months data, the Program will not report on this activity until the next semiannual report, which will provide a comparison of data for calendar year 2005 and 2006.

The HCR Program 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 the case. For this reporting period, the HCR Program received 919 calls from consumers related to external review and consumer counseling services. The HCR Program staff also provided detailed consumer counseling on utilization review and the internal appeal and grievance process for 222 cases. Finally, the Program makes information about External Review Services, the External Review Request Form and instructions, frequently asked questions, and other related information available on the North Carolina Department of Insurance's website, [http://www.ncdoi.com/ER/ConsumerInfo/er\\_main.asp](http://www.ncdoi.com/ER/ConsumerInfo/er_main.asp). The data shows that a large number of consumers accessed this information during the reporting period.

## **I. Introduction**

The Department of Insurance (the Department) established the HCR Program to administer North Carolina's External Review Law. The External Review Law (N.C. Gen. Stat. §§ 58-50-75 through 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 appeal and grievance issues.

This report, which is required under N.C. Gen. Stat. § 58-50-95, is intended to provide a summary of the HCR Program's external review and consumer counseling activities for the period January 1, 2006 – June 30, 2006. 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 data being reported represents 6 months of activity only; therefore, it should not be used for the purpose of identifying discernable trends or drawing conclusions about specific services, insurers, or independent review organizations. A year end report will provide a summary and comparative analysis of the HCR Program's external review and consumer counseling activities for the years 2005 and 2006.

## **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. N.C. Gen. Stat. §§ 58-50-75 through 95, known as the Health Benefit Plan External Review Law, governs the independent external review process. North Carolina's external review law assures covered persons the opportunity for an independent review of an appeal decision or second-level grievance review decision upholding a health plan's noncertification, subject to certain eligibility requirements.

Requests for external review are made directly to the Department and screened for eligibility by HCR Program staff, but the actual medical reviews are conducted by Independent Review Organizations (IROs) that are contracted with the Department. In addition to arranging for external review, staff also counsels consumers on matters relating to utilization review and the internal appeal and grievance processes required to be offered by insurers.

The HCR Program is staffed by a Director, 2 Clinical Analysts and an Administrative Assistant. The Program utilizes registered nurses with broad clinical, health plan utilization review experiences to process external review requests and to enhance the Program's Consumer Counseling services. The HCR Program contracts with 2 board-certified physicians to provide on-call case evaluations of expedited external review requests. The scope of these evaluations is limited to determining whether a request meets medical criteria for expedited review. The consulting physician is available to consult with Program staff and review consumer requests for expedited review at all times.

The HCR Program contracts with 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 N.C. Gen. Stat. § 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 Insurance 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.

### **C. Oversight of Insurers (External Review)**

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

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

### **D. Consumer Counseling on UR and Internal Appeal and Grievance Procedures**

The HCR Program provides consumer counseling on utilization review and internal appeal and grievance issues. Consumers speak with professional registered nurses who are clinically experienced and knowledgeable regarding medical denials. Most consumers contact the HCR Program directly; however, some counseling is provided on a referral basis through the Department's Consumer Services Division.

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.

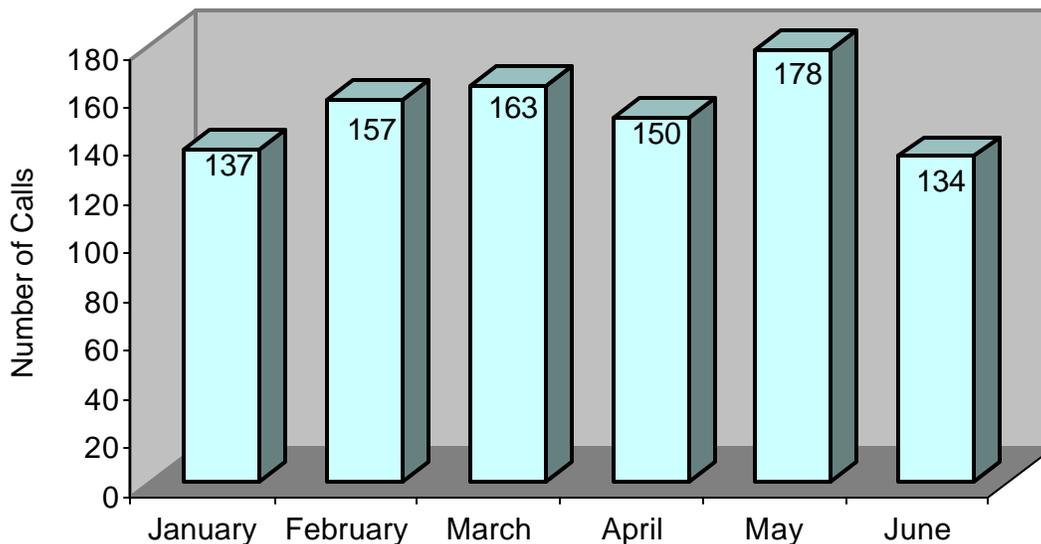
## IV. Program Activity Data

### A. Consumer Contacts

#### Consumer Telephone Calls

The Program received 919 calls from consumers related to external review and consumer counseling services during the period of January 1, 2006 – June 30, 2006. Figure 1 identifies the number of calls received for each month during the 6 month reporting period. 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 volume of call activity remains steady.

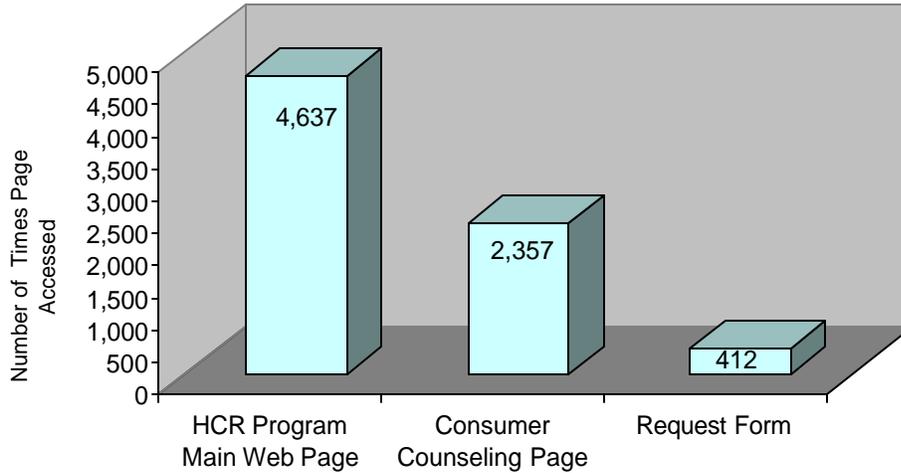
**Figure 1: External Review and Consumer Counseling  
Call Volume Received by the HCR Program,  
January 1, 2006 – June 30, 2006**



#### Consumer Website Contacts

For consumers who have Internet capability, the HCR Program makes information available which includes the External Review Request Form and instructions, frequently asked questions, consumer testimonials about the Program, and the Program's brochure. The data in Figure 2 shows that a large number of consumers accessed the HCR Program's main website during this reporting period. Additionally, consumers continue to seek additional information relating to appeal and grievances on the consumer counseling page. On average, 392 individuals have accessed this consumer counseling site each month.

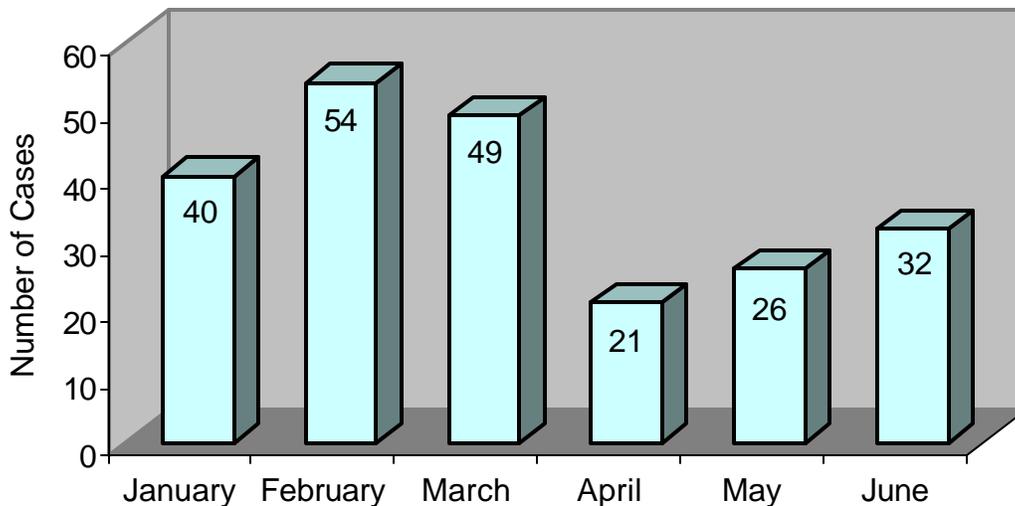
**Figure 2: HCR Program Website Page Access Activity, January 1, 2006 – June 30, 2006**



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

HCR Program staff provided detailed consumer counseling on utilization review and the internal appeal and grievance process for 222 cases. 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 issues. Figure 3 reports the number of consumer cases received each month, which continues to remain steady.

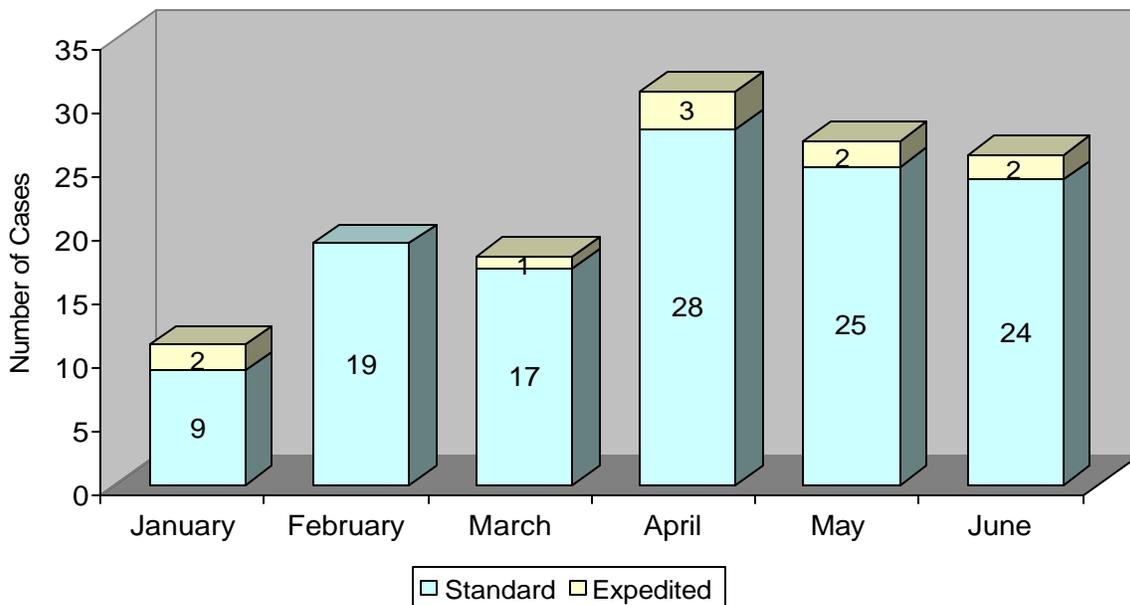
**Figure 3: Consumer Counseling Case Volume Received by the HCR Program, January 1, 2006 – June 30, 2006**



### C. External Review Requests

The HCR Program received 132 requests during the period of January 1, 2006 – June 30, 2006. Figure 4 shows the volume of external review requests, stratified by type of review, received for each month during the 6 month reporting period.

**Figure 4: External Review Requests Received by Type of Review Requested, January 1, 2006 – June 30, 2006**



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

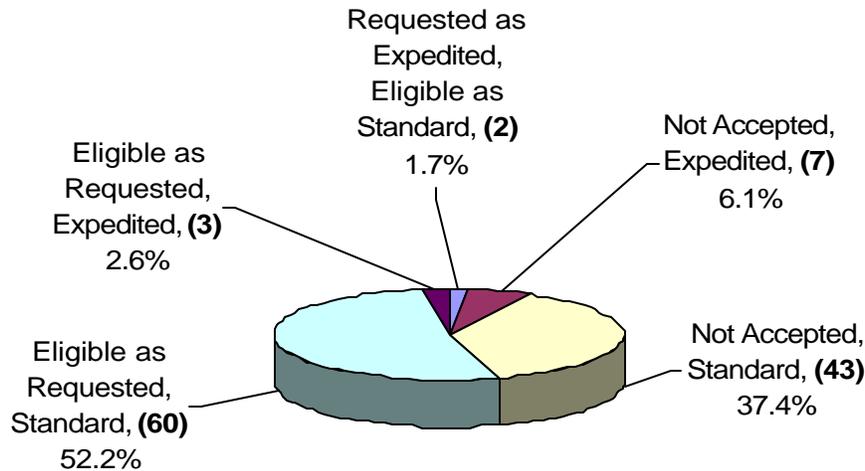
The eligibility of requests received is considered on the basis of the number of individuals who requested review rather than each separate request received. Because consumers may submit an incomplete request for external review and subsequently submit a completed request, counting all incomplete requests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

Of the 132 requests received in this reporting period, 17 (12.9%) involved resubmission of a request previously denied because it was incomplete. Thirteen previously incomplete requests were subsequently accepted for external review. Four previously incomplete requests were deemed to be ineligible. Therefore, eligibility determinations were made on 115 different individuals requesting external review during this period. Table 1 shows the status of all incomplete requests received for the first 6-month period of 2006. Figure 5 shows the disposition of requests for external review during the reporting period.

**Table 1: Disposition of Incomplete Requests Made to the HCR Program, January 1, 2006 – June 30, 2006**

Disposition of Incomplete Request	Number of Requests
Resubmitted—Accepted for External Review	13
Resubmitted—Not Accepted Due to:	
* No medical necessity determination	1
* Self insured	1
* Situs of contract not NC	1
* Internal appeals not exhausted	1
<b>Grand Total of Resubmitted Incomplete Requests:</b>	<b>17</b>

**Figure 5: Disposition of External Review Requests Received, January 1, 2006 – June 30, 2006**



The reason why a case would not be accepted falls into 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 115 individuals’ requests received during the reporting period. For this reporting period, the percentage of requests accepted was the highest of any previous reporting periods since the Program began in July, 2002.

**Figure 6: Eligibility Determinations for Requests Received, January 1, 2006 – June 30, 2006**

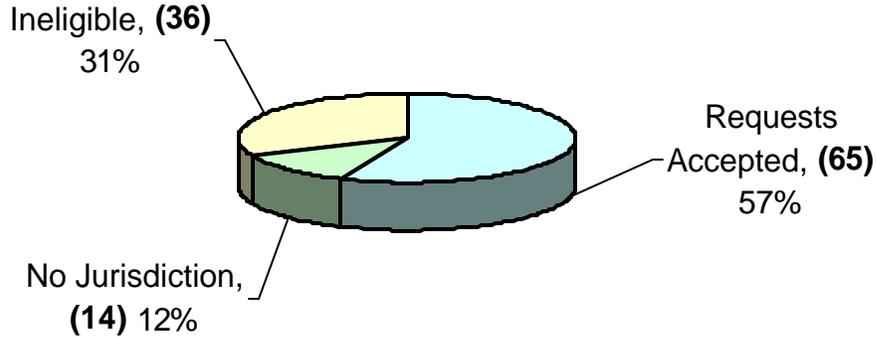


Table 2 illustrates the specific reasons why requests were not accepted for review. Those consumers belonging to a self-funded employer plan was the most common reason why a request was not accepted over the first 6-month period of 2006. The HCR Program staff follows up with all consumers who submit an incomplete request, informing them of their rights and Program requirements. During this reporting period, requests not accepted due to “ineligible” reasons rather than “no jurisdiction” reasons continue to make up the largest numbers for external review requests to be deemed ineligible.

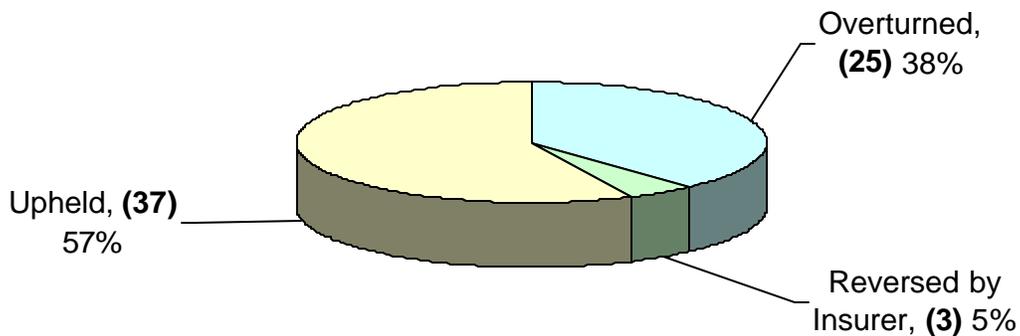
**Table 2: Reasons for Non-Acceptance of an External Review Request, January 1, 2006 – June 30, 2006**

Reason for Non-acceptance	Number of Requests
<b>INELIGIBLE</b>	
Not a Medical Necessity Determination	7
Request Withdrawn	1
Missed Insurer Time Frame for Requesting Appeal	6
Retrospective Services-Not Eligible For Expedited	2
Past 60 Day Request Time Frame	2
Insurer Appeals Process Not Exhausted	6
Insurance Type Not Eligible For External Review	3
Request is Incomplete, No Resubmission of Request	6
Benefit Limitation	2
No Denial	1
<b>Total Ineligible</b>	<b>36</b>
<b>NO JURISDICTION</b>	
Contract Situs Not in NC	4
Self-Funded	10
<b>Total No Jurisdiction</b>	<b>14</b>
<b>Total Requests Not Accepted</b>	<b>50</b>

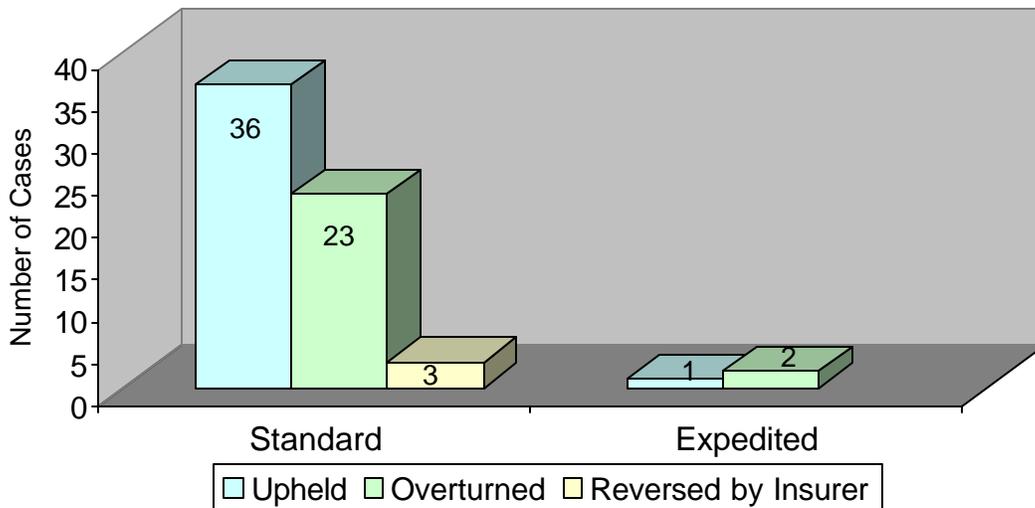
## E. Outcomes of Accepted Cases

Figure 7 shows the outcomes of external reviews performed on all cases (both standard and expedited) accepted between January 1 and June 30, 2006. Of the 65 cases accepted, 43 percent of the cases resulted in outcomes that were in the covered person’s favor, due either to the IRO having overturned the insurer’s noncertification or to the insurer having reversed its own denial. Cases that were “reversed” were decisions made by insurers to reverse their own noncertification and provide coverage for services prior to the case being assigned to an IRO reviewer or prior to the IRO issuing a decision. Figure 8 shows the outcomes for these accepted cases by type of review granted.

**Figure 7: Outcome of Accepted Cases, January 1, 2006 – June 30, 2006**



**Figure 8: Outcomes of Accepted Cases by Type of Review Requested, January 1, 2006 – June 30, 2006**



## V. Activity by Type of Service Requested

The HCR Program classifies accepted cases into general service-type categories. Figure 9 shows the number of accepted cases by type of service requested. Surgical Services represent the largest share of accepted cases, with 25 (38.5%) of the 65 accepted cases. Inpatient Mental Health cases were second in number with 17 (26.2%) of the cases. Durable Medical Equipment (DME) and Skilled Nursing Services both had 5 (7.7%) each of the 65 accepted cases. All other services represent a smaller share of the total accepted cases.

**Figure 9: Accepted Cases by Type of Service Requested, January 1, 2006 – June 30, 2006**

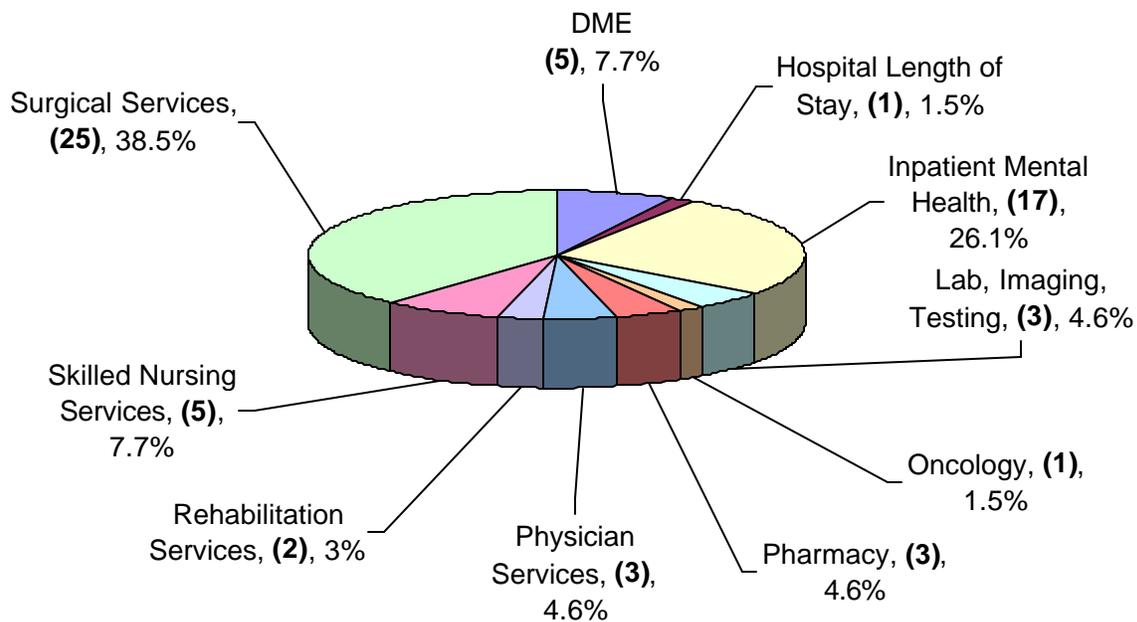


Table 3 shows the percentage share that each service type held for all accepted cases as well as for each case outcome during this reporting period. It is important to remember that the number of cases for each service type remains small, are comprised of differing specific services and therefore, not credible for making generalizations about frequency of case outcomes.

**Table 3: Percentage Share of Review Activity by Type of Service Requested,  
January 1, 2006 – June 30, 2006**

Type of Service	Percent of All Accepted Cases	Outcome of Accepted Cases		
		Percent of All Cases Overturned	Percent of All Cases Reversed	Percent of All Cases Upheld
DME	7.7	8.0	0.0	8.1
Hospital Length of Stay	1.5	0.0	0.0	2.7
Inpatient Mental Health	26.1	36.0	100.0	13.5
Lab, Imaging, Testing	4.6	4.0	0.0	5.4
Oncology	1.5	0.0	0.0	2.7
Pharmacy	4.6	8.0	0.0	2.7
Physician Services	4.6	0.0	0.0	8.1
Rehabilitation Services	3.0	0.0	0.0	5.4
Skilled Nursing Services	7.7	8.0	0.0	8.1
Surgical Services	38.5	36.0	0.0	43.3
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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

**Table 4: Outcomes of Accepted External Review Requests by Service Type and Denial Type, January 1, 2006 – June 30, 2006**

Service Type	Medical Necessity			Experimental/ Investigational			Cosmetic		
	Over- turned	Reversed	Upheld	Over- turned	Reversed	Upheld	Over- turned	Reversed	Upheld
DME	2	0	1	0	0	2	0	0	0
Hospital Length of Stay	0	0	1	0	0	0	0	0	0
Inpatient Mental Health	9	3	5	0	0	0	0	0	0
Lab, Imaging, Testing	0	0	0	1	0	1	0	0	1
Oncology	0	0	0	0	0	1	0	0	0
Pharmacy	1	0	0	1	0	1	0	0	0
Physician Services	0	0	0	0	0	3	0	0	0
Rehabilitation Services	0	0	2	0	0	0	0	0	0
Skilled Nursing Services	2	0	3	0	0	0	0	0	0
Surgical Services	9	0	4	0	0	9	0	0	3
<b>Total</b>	<b>23</b>	<b>3</b>	<b>16</b>	<b>2</b>	<b>0</b>	<b>17</b>	<b>0</b>	<b>0</b>	<b>4</b>

During this reporting period, the majority (61.9%) of outcomes for medical necessity denials were decided in the covered person's favor, due to either the IRO overturning the insurer's noncertification or to the insurer having reversed their own denial. Cosmetic cases upheld in favor of the insurer 100 percent of the time and experimental/investigational cases were decided in favor of the insurer 89.5 percent of the time.

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

During this reporting period, 9 different insurers, 2 Multiple Employer Welfare Arrangements (MEWAs), plus the State Health Plan had a total of 65 cases that were eligible for external review. Figure 10 shows the distribution of cases among those insurers, providing an accounting of cases accepted for review. With 31 accepted cases, the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan is the health plan that has experienced the highest number of cases accepted for external review. Blue Cross & Blue Shield of North Carolina, the health plan with the second highest number of requests, had 16 cases. UnitedHealthcare of North Carolina, Inc. had the third largest number of accepted cases with 7.

**Figure 10: Insurer's Share of Accepted External Review Requests, January 1, 2006 – June 30, 2006**

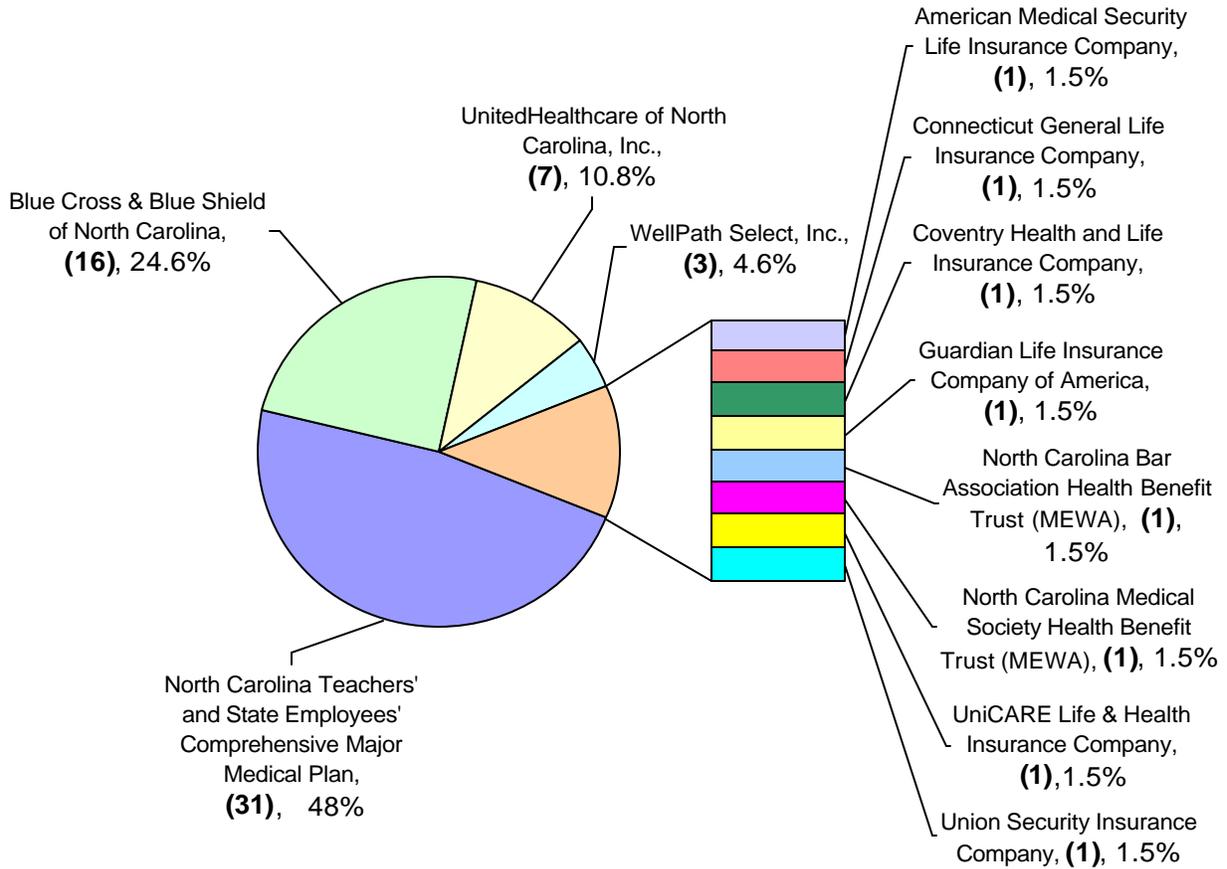


Table 5 reports information about the nature of services that were the subject of each insurer's external review cases and the outcome of these cases. This information is expressed in terms of the numeric and percentage distribution of insurer's cases, by type of service, and the outcomes for each type of service, expressed as a percentage of total cases for the type of service.

**Table 5: Accepted Case Activity by Insurer and Type of Service Requested,  
January 1, 2006 – June 30, 2006**

Insurer and Type of Service	Number of Accepted Cases	Insurer's Outcome		
		Insurer's Percent Overturned	Insurer's Percent Reversed	Insurer's Percent Upheld
<b>American Medical Security Life Insurance Company</b>	<b>1</b>			
▪ Hospital Length of Stay	1	--	--	100.0
<b>Total Percentage for Insurer</b>		<b>--</b>	<b>--</b>	<b>100.0</b>
<b>Blue Cross &amp; Blue Shield of North Carolina</b>	<b>16</b>			
▪ Inpatient Mental Health	4	50.0	--	50.0
▪ Lab, Imaging, Testing	2	50.0	--	50.0
▪ Physician Services	2	--	--	100.0
▪ Surgical Services	8	37.5	--	62.5
<b>Total Percentage for Insurer</b>		<b>37.5</b>	<b>--</b>	<b>62.5</b>
<b>Connecticut General Life Insurance Company</b>	<b>1</b>			
▪ Surgical Services	1	--	--	100.0
<b>Total Percentage for Insurer</b>		<b>--</b>	<b>--</b>	<b>100.0</b>
<b>Coventry Health and Life Insurance Company</b>	<b>1</b>			
▪ Surgical Services	1	--	--	100.0
<b>Total Percentage for Insurer</b>		<b>--</b>	<b>--</b>	<b>100.0</b>
<b>Guardian Life Insurance Company of America</b>	<b>1</b>			
▪ Surgical Services	1	--	--	100.0
<b>Total Percentage for Insurer</b>		<b>--</b>	<b>--</b>	<b>100.0</b>
<b>North Carolina Bar Association Health Benefit Trust (MEWA)</b>	<b>1</b>			
▪ Surgical Services	1	100.0	--	--
<b>Total Percentage for Insurer</b>		<b>100.0</b>	<b>--</b>	<b>--</b>
<b>North Carolina Medical Society Health Benefit Trust (MEWA)</b>	<b>1</b>			
▪ Inpatient Mental Health	1	100.0	--	--
<b>Total Percentage for Insurer</b>		<b>100.0</b>	<b>--</b>	<b>--</b>
<b>North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan</b>	<b>31</b>			
▪ DME	4	25.0	--	75.0
▪ Inpatient Mental Health	5	20.0	40.0	40.0
▪ Lab, Imaging, Testing	1	--	--	100.0
▪ Pharmacy	2	50.0	--	50.0
▪ Physician Services	1	--	--	100.0
▪ Rehabilitation Services	2	--	--	100.0
▪ Skilled Nursing Services	5	40.0	--	60.0
▪ Surgical Services	11	45.5	--	54.5
<b>Total Percentage for Insurer</b>		<b>32.3</b>	<b>6.4</b>	<b>61.3</b>

**Table 5: Accepted Case Activity by Insurer and Type of Service Requested,  
January 1, 2006 – June 30, 2006 (Cont.)**

Insurer and Type of Service	Number of Accepted Cases	Insurer's Outcome		
		Insurer's Percent Overturned	Insurer's Percent Reversed	Insurer's Percent Upheld
<b>UniCARE Life &amp; Health Insurance Company</b>	<b>1</b>			
▪ Oncology	1	--	--	100.0
<b>Total Percentage for Insurer</b>		<b>--</b>	<b>--</b>	<b>100.0</b>
<b>Union Security Insurance Company</b>	<b>1</b>			
▪ Inpatient Mental Health	1	100.0	--	--
<b>Total Percentage for Insurer</b>		<b>100.0</b>	<b>--</b>	<b>--</b>
<b>UnitedHealthcare of North Carolina, Inc.</b>	<b>7</b>			
▪ Inpatient Mental Health	4	75.0	25.0	--
▪ Pharmacy	1	100.0	--	--
▪ Surgical Services	2	--	--	100.0
<b>Total Percentage for Insurer</b>		<b>57.1</b>	<b>14.3</b>	<b>28.6</b>
<b>WellPath Select, Inc.</b>	<b>3</b>			
▪ DME	1	100.0	--	--
▪ Inpatient Mental Health	2	50.0	--	50.0
<b>Total Percentage for Insurer</b>		<b>66.7</b>	<b>--</b>	<b>33.3</b>

## VI. Activity by IRO

### A. Summary by IRO

During the period of January 1, 2006 – June 30, 2006, IROs rendered 62 external review decisions for consumers. These cases encompass a variety of insurers, noncertification reasons and specific types of services. This data does not include 3 requests where an insurer reversed its own noncertification prior to the IRO review. 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 and the availability of a qualified expert clinical reviewer. The nature of the denial has no bearing on the assignment to an IRO. All decisions were issued in compliance with statutory time frame requirements and for the required content of written notice of determinations. The data in Table 6 shows the number of cases assigned to each IRO during the first 6-month period of 2006, as well as the number and percentage of cases overturned and upheld. One IRO, MCMC, LLC, did not receive any case assignments during this reporting period due to conflict of interest screening relating to the insurer that was the subject of the external review request.

**Table 6: Comparison of IRO Activity Summary,  
January 1, 2006 – June 30, 2006**

IRO	Number Assigned	Overturned		Upheld	
		Number	Percent	Number	Percent
IPRO	16	8	50.0	8	50.0
Maximus CHDR	17	9	52.9	8	47.1
MCMC, LLC	0	--	--	--	--
NMR, Inc.	13	5	38.5	8	61.5
Permedion	16	3	18.8	13	72.2
<b>All Cases</b>	<b>62</b>	<b>25</b>	<b>40.3</b>	<b>37</b>	<b>59.7</b>

**B. Decision by Type of Service Requested**

Table 7 presents the percentage of case outcomes by the general type of service for each IRO for the reporting period. The table shows how each IRO decided on the cases categorized by the general types of services. Due to the unique circumstances that apply in every case, it is not possible to expect the same decision to be made for similar services. For this reporting period, there is not sufficient data to determine trends for decisions among IROs or by service type.

**Table 7: IRO Decisions by Type of Service Requested,  
January 1, 2006 – June 30, 2006**

IRO and Type of Service	Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld
<b>IPRO</b>	<b>16</b>		
▪ Inpatient Mental Health	5	80.0	20.0
▪ Physician Services	1	0.0	100.0
▪ Skilled Nursing Services	2	0.0	100.0
▪ Surgical Services	8	50.0	50.0
<b>Maximus CHDR</b>	<b>17</b>		
▪ Hospital Length of Stay	1	0.0	100.0
▪ Inpatient Mental Health	3	100.0	0.0
▪ Lab, Imaging, Testing	1	0.0	100.0
▪ Pharmacy	1	100.0	0.0
▪ Physician Services	1	0.0	100.0
▪ Skilled Nursing Services	1	100.0	0.0
▪ Surgical Services	9	44.4	55.6

**Table 7: IRO Decisions by Type of Service Requested,  
January 1, 2006 – June 30, 2006 (Cont.)**

IRO and Type of Service	Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld
<b>NMR, Inc.</b>	<b>13</b>		
▪ DME	1	0.0	100.0
▪ Inpatient Mental Health	2	100.0	0.0
▪ Lab, Imaging, Testing	1	100.0	0.0
▪ Physician Services	1	0.0	100.0
▪ Skilled Nursing Services	1	100.0	0.0
▪ Rehabilitation Services	2	0.0	100.0
▪ Surgical Services	5	20.0	80.0
<b>Permedion</b>	<b>16</b>		
▪ DME	4	50.0	50.0
▪ Inpatient Mental Health	4	0.0	100.0
▪ Lab, Imaging, Testing	1	0.0	100.0
▪ Oncology	1	0.0	100.0
▪ Pharmacy	2	50.0	50.0
▪ Skilled Nursing Services	1	0.0	100.0
▪ Surgical Services	3	0.0	100.0

Table 8 shows each IRO's decisions by insurer. Due to the small number of cases, there is not sufficient data to determine trends or make any evaluative statements. Therefore, the data is provided simply as an accounting of activity.

**Table 8: IRO Decisions by Insurer,  
January 1, 2006 – June 30, 2006**

<b>IRO and Insurer</b>	<b>Number of Decisions</b>	<b>Percent Overturned</b>	<b>Percent Upheld</b>
<b>IPRO</b>	<b>16</b>		
▪ Blue Cross & Blue Shield of North Carolina	4	25.0	75.0
▪ Connecticut General Life Insurance Company	1	0.0	100.0
▪ North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan	6	60.0	40.0
▪ Union Security Insurance Company	1	100.0	0.0
▪ UnitedHealthcare of North Carolina, Inc.	3	66.7	33.3
▪ WellPath Select, Inc.	1	0.0	100.0
<b>Maximus CHDR</b>	<b>17</b>		
▪ American Medical Security Insurance Company	1	0.0	100.0
▪ Blue Cross & Blue Shield of North Carolina	4	25.0	75.0
▪ Coventry Health and Life Insurance Company	1	0.0	100.0
▪ North Carolina Medical Society Health Benefit Trust (MEWA)	1	100.0	0.0
▪ North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan	7	57.1	42.9
▪ UnitedHealthcare of North Carolina, Inc.	2	50.0	50.0
▪ WellPath Select, Inc.	1	100.0	0.0
<b>NMR, Inc.</b>	<b>13</b>		
▪ Blue Cross & Blue Shield of North Carolina	5	60.0	40.0
▪ North Carolina Bar Association Health Benefit Trust (MEWA)	1	100.0	0.0
▪ North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan	7	14.3	85.7
<b>Permedion</b>	<b>16</b>		
▪ Blue Cross & Blue Shield of North Carolina	3	0.0	100.0
▪ Guardian Life Insurance Company of America	1	0.0	100.0
▪ North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan	9	11.1	88.9
▪ UniCARE Life & Health Insurance Company	1	0.0	100.0
▪ UnitedHealthcare of North Carolina, Inc.	1	100.0	0.0
▪ WellPath Select, Inc.	1	100.0	0.0

## VII. Cost of External Review Cases

The cost of an external review for a specific case can be comprised of 1 or 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 \$725 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. Insurers were not charged a rate for review on 3 cases where the insurer reversed its own decision prior to the cases being assigned to an IRO reviewer. The average cost to insurers for the remaining 62 reviews performed was \$608.

The average amount of allowed charges assumed by the insurer in the 3 cases where the insurer reversed its own noncertification was \$9,918. The average amount of allowed charges assumed by the insurer for decisions that were overturned in favor of the consumer was \$8,939. Table 9 shows the average and cumulative costs of the IRO review and allowed charges for cases that were reversed by the insurer or overturned during this reporting period, by type of service requested. Due to the prospective nature of 2 of the cases, the cost of allowed charges are unreported.

**Table 9: Cost of IRO Review, Average and Cumulative Allowed Charges by Type of Service Requested, January 1, 2006 – June 30, 2006**

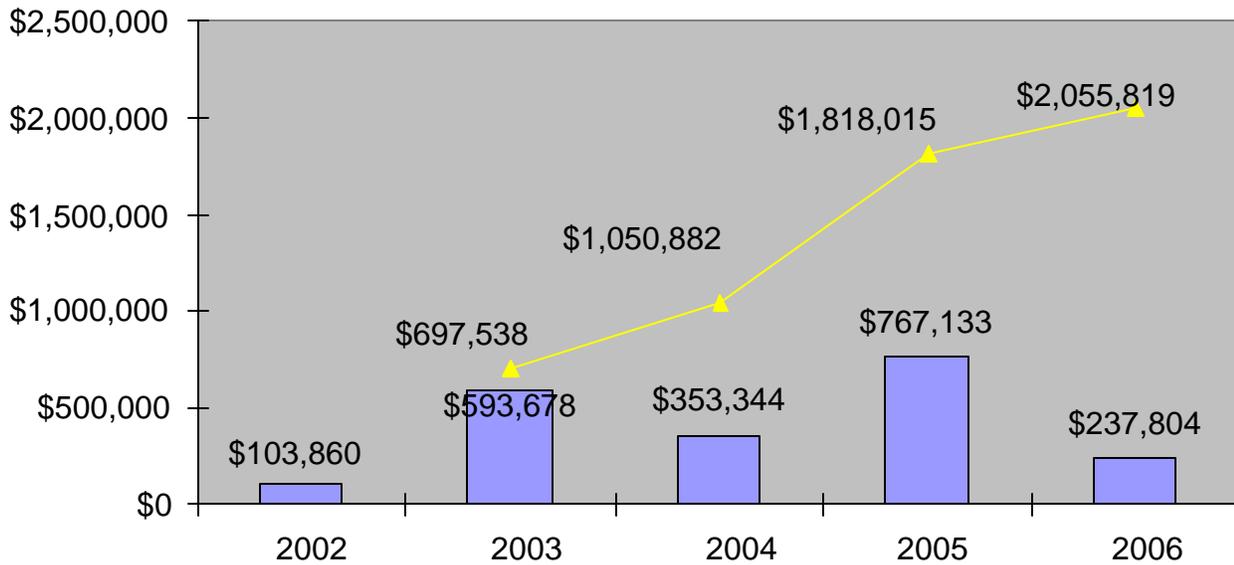
Type of Service Requested	Average Costs of IRO Review for Requests Upheld	Average Costs for Requests Reversed or Overturned		Cumulative Total Allowed Charges for Overturned or Reversed Service
		Cost of IRO Review	Cost of Allowed Charges	
DME	\$625	\$750	\$2,524	\$5,047
Hospital Length of Stay	450	0	0	0
Inpatient Mental Health	665	600	9,286	111,433
Lab, Imaging, Testing	550	575	3,491	3,491
Oncology	650	0	0	0
Pharmacy	650	550	643	1,285
Physician Services	583	0	0	0
Rehabilitation Services	575	0	0	0
Skilled Nursing Services	700	513	2,222	4,444
Surgical Services*	600	605	15,663	109,641
<b>All Cases</b>	<b>\$612</b>	<b>\$602</b>	<b>\$9,052</b>	<b>\$235,341</b>

\* Indicates outstanding costs of service due to prospective nature of service.

Figure 11 shows the cost of the allowed charges for overturned or reversed services that insurers paid each year, as well as the cumulative total of allowed charges for these services.

To date, the cumulative total of services provided to consumers as a result of external review since the Program commenced on July 1, 2002 is \$2,055,819. Because of the prospective nature of 2 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 11: Cumulative Value of Allowed Charges for Overturned or Reversed Services, July 1, 2002 – June 30, 2006**



■ Cost of Allowed Charges for Overturned and Reversed Services by Calendar Year  
▲ Cumulative Cost of Allowed Charges for Overturned and Reversed Services

## VIII. Conclusion

This report presents external review and consumer counseling data for the period of January 1, 2006 – June 30, 2006. Information is provided with respect to external review requests and eligibility determinations, insurers whose decisions were the subject of requests for external review and independent review organizations that reviewed accepted cases. The data presented provides an accounting of activity for this 6-month period only, and therefore, cannot be relied upon to make any generalizations relating to outcomes.

Insurers subject to North Carolina’s External Review law are required to provide notice of external review rights to covered persons in their noncertification decisions and notices of decision on appeals and grievances. When the HCR Program receives a request for external review, the insurer is required to provide certain information to the Program, within statutory

time frames, so that eligibility determinations can be made. During this reporting period, all insurers have complied with time frame requirements.

During this reporting period, the volume of external review requests (132) remained stable in comparison to previous 6-month reporting periods. Of the 65 requests accepted, 43.1 percent were decided in favor of the consumer, either due to the insurer reversing its own denial prior to IRO review, or the IRO overturning the insurer's noncertification. During this reporting period, the cumulative total of allowed charges for overturned or reversed services was \$235,341. **To date, the cumulative total of services provided to consumers as a result of external review since the Program commenced on July 1, 2002 is \$2,055,819.**

In reviewing the number of accepted cases (65 cases) by type of service requested, surgical services represents the largest share of accepted cases (38.5%) followed by inpatient mental health (26.2%), with DME and skilled nursing services both having 7.7 percent. All other services represent a smaller share of the total accepted cases.

The HCR Program contracts with 5 IROs to provide external review services. During this reporting period, IROs rendered 62 external review decisions. One IRO, MCMC, LLC, did not receive any case assignments due to conflict of interest screening relating to the insurer that was the subject of the external review. While the HCR Program has collected data on the number and types of review decisions for each IRO, given the small number of reviews, the data should not be used to draw conclusions about any IRO's tendency to decide a case one way or another. The HCR Program monitors IRO compliance with requirements pertaining to the time frame for issuing a decision, and for the content of written notice of determinations. During this reporting period, all IROs were compliant with statutory requirements.

The HCR Program staff provided consumer counseling to 222 individuals who contacted our office with questions regarding utilization review, and/or the appeal and grievance process. Call volume from consumers remained strong as did the number of consumers accessing online web-based HCR Program consumer counseling information and the External Review Request Form. On average, 392 individuals have accessed the consumer counseling site each month.

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