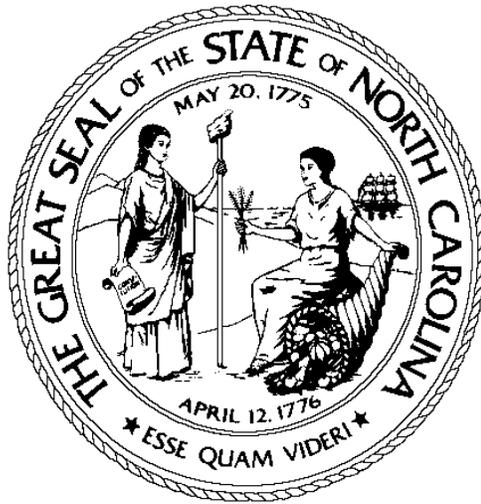


North Carolina Department of Insurance



Healthcare Review Program Semiannual Report

for the period of January 1, 2003 – December 31, 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
Release IX	January 1, 2003 – December 31, 2006

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

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Executive Summary

North Carolina's External Review 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 State Health Plans which includes an indemnity plan, Teachers' and State Employees' Comprehensive Major Medical Plan (State Health Plan Indemnity Plan or SHP Indemnity Plan) and effective October 1, 2006, a Preferred Provider Organization plan, NC *SmartChoice* (State Health Plan PPO Plan or SHP PPO 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. This report provides a summary of external review and consumer counseling activity data over a four-year period, from January 1, 2003 – December 31, 2006.

During the period of January 1, 2003 – December 31, 2006, the HCR Program received 967 requests for external review. In comparing year to year request activity, the volume of request activity showed growth and stability. In the first full year of operation, 2003, the Program received 220 requests for external review. In 2004, the Program received 201 requests, a drop of 8.6 percent from the previous year. In 2005, the number of requests increased by 44.8 percent, to 291. In 2006, 255 requests were received, a decline of 16.3 percent from the previous year. Of the 967 requests received, 163 (16.8%) involved a re-submission of a request by individuals who were previously ineligible for an external review because their request was incomplete. Thus, 804 different individuals requested an external review during this four-year period. Of these requests, 387 (48.1%) were accepted during this four-year period.

Of the 387 cases that were accepted, 42.6 percent of the cases were decided in favor of the consumer, either due to the insurer reversing its own denial (16 cases), or the IRO overturning the insurer's noncertification (149 cases). IROs issued decisions on 371 cases. An analysis of the type of accepted cases that were reviewed by an IRO for this four-year period showed that 43 cases (11.5%) involved decisions for services that were cosmetic, 124 cases (33.4%) involved decisions that services were experimental/investigational, and 204 cases (55%) involved medical necessity determinations. Of the cases accepted during this four-year reporting period, IROs overturned 18 (41.8%) of the cosmetic cases, 34 (27.4%) of the experimental/investigational

cases and 97 (47.5%) of the medical necessity cases. Since the HCR Program began July 1, 2002, a total of 408 cases were accepted for review, resulting in coverage for the disputed service for 43.1 percent of the consumers who requested an external review.

Throughout the four-year reporting period, surgical services represented the largest percentage of accepted cases (38.5%) followed by inpatient mental health with 12.7 percent, durable medical equipment (DME) with 11.6 percent and skilled nursing facility care at 7.0 percent. For surgical services, orthognothic surgery (TMJ) represented the largest number of cases (29) followed by vein surgery (22 cases), gastric bypass surgery (21 cases) and breast reduction and vagus verve stimulator (VNS) surgery each had 14 cases. In 2003, surgical services represented 45.6 percent of all accepted cases and 50 percent of all overturned cases for that year. In 2004, the percentage share of accepted surgical services cases declined to 29.8 percent and represented 25.8 percent of all overturned cases. In 2005, the percentage share of surgical services cases rose to 35.5 percent and represented 29.7 percent of all overturned cases that year. In 2006, surgical services represented 41.6 percent of all accepted cases and 39 percent of all overturned cases. Additionally, surgical services represented 11.1 percent of all reversed cases in 2005 and 16.7 percent in 2006. Also noteworthy is the number and percentage share of accepted inpatient mental health cases that has steadily increased over the four-year reporting period. In 2003, inpatient mental health cases represented 7.8 percent of accepted cases and five percent of all cases overturned that year. In 2006, inpatient mental health cases comprised 17.7 percent of accepted cases and 22 percent of all cases overturned. Also in 2006, inpatient mental health cases represented 50 percent of all cases reversed by the insurer that year.

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 July 1, 2002, is \$13,375. In 2006, the average amount of allowed charges assumed by the insurer in the six (6) cases where the insurer reversed its own noncertification was \$8,304 (with a total of \$33,214.32). The average amount of allowed charges assumed by the insurer for decisions that were overturned in favor of the consumer was \$10,432 (with a total of \$385,998). **Since July 1, 2002, the cumulative total of services provided to consumers as a result of external review is \$2,247,010.09. 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 \$900, 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 107 reviews performed by an IRO during 2006 was \$611. However, the average cost for all IRO reviews since the Program began is \$572.

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 N. C. Gen. Stat. § 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, 2006, to December 31, 2006, 13 different health benefit plans, plus the SHP Indemnity Plan and SHP PPO Plan had a total of 113 cases that were eligible for external review (*15 plans total – includes SHP Indemnity and SHP PPO*). Case origination from State Health Plan's Indemnity Plan, Blue Cross & Blue Shield of North Carolina, and UnitedHealthcare of North Carolina, Inc. comprised 83.2 percent of the external review activity (*3 plans – includes SHP Indemnity*). Twelve other insurers made up the remaining 16.8 percent of cases (*12 plans – includes SHP PPO*). With 48 (42.5%) accepted cases in 2006, the State Health Plan's Indemnity 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 29 accepted cases. UnitedHealthcare of North Carolina, Inc. had the third largest number of accepted cases in 2006 with 17 (15%). 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 2006 shows that the rate of external review activity for all HMOs required to report data has remained relatively unchanged from previous years, with insurers still having less than one (1) case per 100,000 members.

The HCR Program also provides counseling to consumers who have questions or need assistance with issues involving their insurer's utilization review or internal appeal and grievance process. Consumers receive counseling from a staff of professional nurses who understand the clinical aspects of cases as well. For the period of January 1, 2003 through December 31, 2006, the HCR Program received 1,674 requests for assistance from consumers. A comparison of consumer counseling case volume by year shows a steady volume of activity over the four-year period. Beginning in 2004, the Program began collecting information on the nature of the consumer calls. In 2004, 535 consumer calls were received and 55.7 percent of the calls involved Program staff providing counseling on utilization review and internal appeals and grievance issues and external review. In 2006, 370 calls were received, however 71.4 percent of the calls involved consumer counseling on utilization review and appeals and grievance issues.

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 four-year reporting period, community outreach and education activities have included participation in health fairs, speaking engagements to consumers, physicians and office practice administrators, hospital administration, publications, radio interviews, and mailing out written materials. 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. In 2006, an external review services contact card, designed to be included in an address/telephone file along with a Program brochure and letter from the Commissioner of Insurance highlighting the importance of the Program was mailed to physicians practice administrators and hospital business managers. All of these outreach activities have contributed to informing and educating the provider community and public, of the availability of external review services.

The HCR Program continues to utilize a consumer satisfaction survey with all accepted cases in order to obtain feedback from consumers regarding their external review experience. Since the Program began on July 1, 2002, 391 surveys have been sent and 219 (56%) consumers or authorized representative responded. Of the 121 responders whose decision was overturned, 118 (97.5%) stated they would tell a friend about external review. Of the 91 responders whose decision was upheld by the IRO, 68 (74.7%) stated that they would also tell a friend about external review.

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 appeals and grievance issues.

North Carolina's External Review law applies to persons covered under a fully insured health plan, the North Carolina State Health Plan which includes an indemnity plan, the Teachers' and State Employees' Comprehensive Major Medical Plan (State Health Plan Indemnity Plan or SHP Indemnity Plan) and effective October 1, 2006, NC *SmartChoice*, a Preferred Provider Organization Plan (State Health Plan PPO Plan or SHP PPO Plan); and the Health Insurance Program for Children (known as CHIP).

This report, which is required under N. C. Gen. Stat. § 58-50-95, is intended to provide a summary and comparative analysis of the HCR Program's external review and consumer counseling activities for the Program's last four calendar years of operation (January 1, 2003 – December 31, 2006) as well as Program activity specific to 2006. 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.

This report provides a cumulative review of external review and consumer counseling activities for the last four calendar years. While the year-to-year number of requests for review and accepted cases remains relatively small for statistical purposes, the cumulative data for this four-year reporting period does provide the opportunity to comment on some trending seen in types of requests, case acceptance, eligibility determinations and general type of service requested. Data relative to specific services requested, case outcomes and insurers remains small for statistical purposes; therefore, the validity of using the data for purposes of drawing conclusions remains limited. The data is presented for review, both in the name of disclosure and because its validity will increase over time as the number of requests for review and cases accepted continues to grow.

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 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 four (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 Commissioner, as requested by the Department.

The HCR Program is responsible for monitoring IRO compliance with statutory requirements on an ongoing basis. 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. 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 N. C. Gen. Stat. § 58-50-92, 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. 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 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. Strategies used to inform and educate consumers and providers have included health fairs, group presentations, publications, radio interviews and direct mailings to physicians, physician office administrators and hospital business managers. 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. In 2006, The HCR Program mailed out to physician practice administrators and hospital business office managers, an HCR Program external review services contact card, designed to be included in an address/telephone file. This card, along with a Program brochure and letter from the Commission of Insurance highlighting the importance of the Program, was well received based on calls the Program staff received from the recipients.

Other initiatives completed during this reporting period include 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.

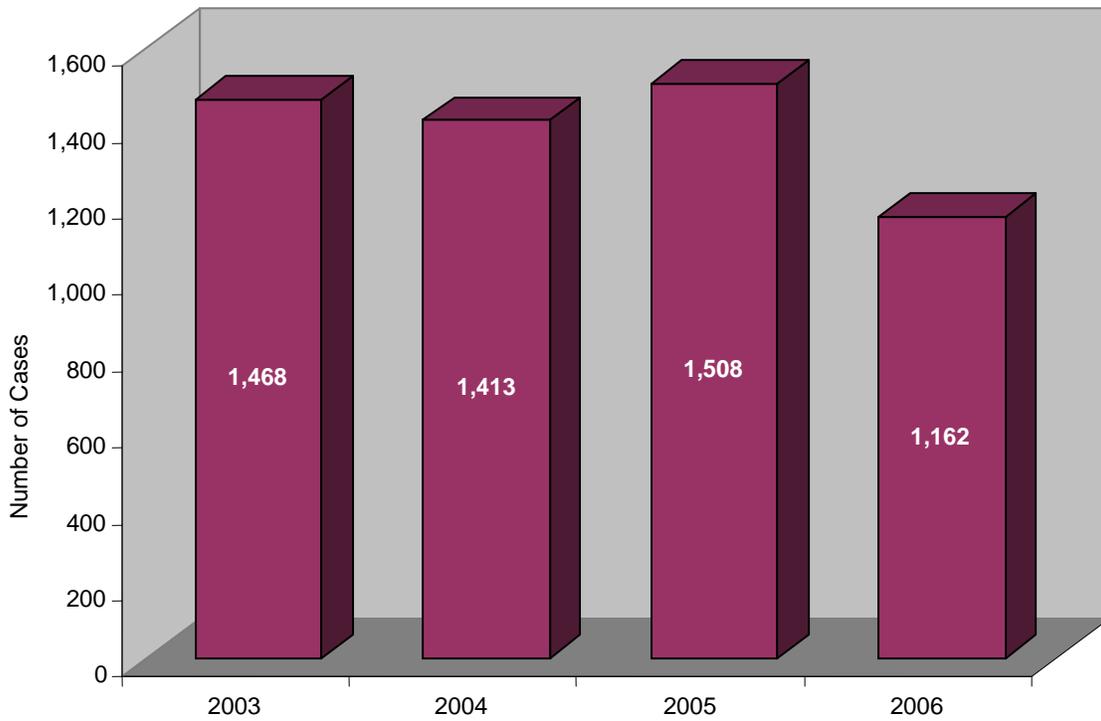
IV. Program Activity Data

A. Consumer Contacts

Consumer Telephone Calls

The HCR Program received 5,551 calls from consumers related to external review and consumer counseling services during the period of January 1, 2003 – December 31, 2006. Figure 1 shows the volume of calls received by year. In June, 2006, the HCR Program experienced an equipment failure relating to the automated phone data collection system. While consumers never lost the ability to contact the HCR Program staff, the ability to capture the call data was lost. In September, 2006, a new PBX phone system was installed, including web-based software to collect phone activity data. Therefore, the volume of phone activity reported in 2006 only reflects eight months of data collection. During the 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 number of calls remains constant, identifying a continued need for consumer information.

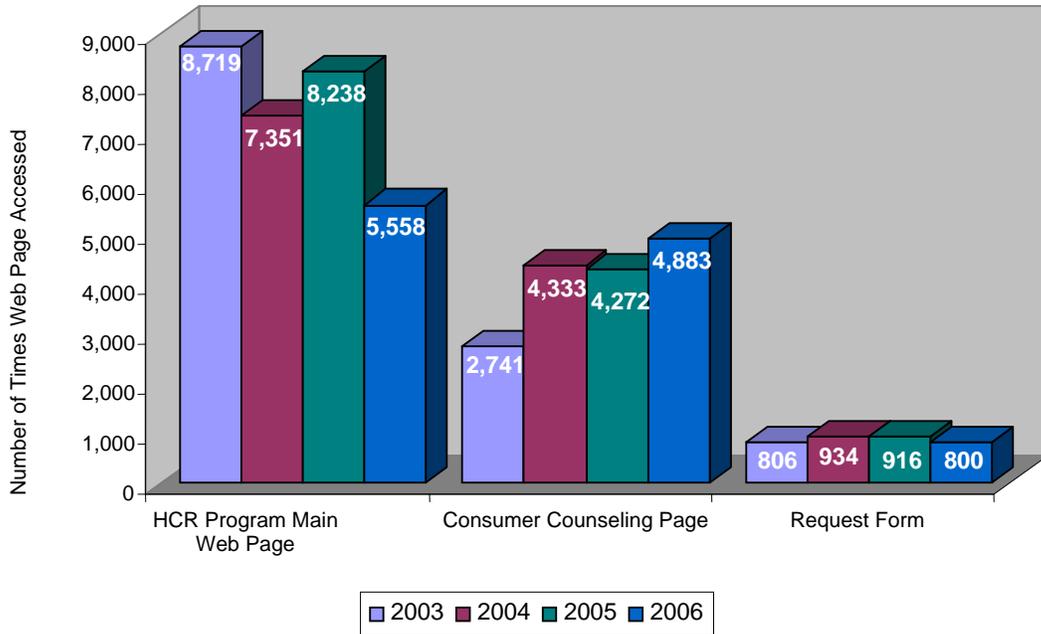
Figure 1: Comparison of External Review and Consumer Counseling Call Volume Received by the HCR Program by Calendar Year, January 1, 2003 – December 31, 2006



Consumer Web Site Contacts

Over the last four years, the HCR Program has utilized the Department’s website to inform and educate consumers about External Review Services. HCR’s web information has been refined over the years based on Program changes, industry comments and consumer feedback. Beginning in 2003, the Program began monitoring the number of consumers accessing different web pages of the Program’s information. The data in Figure 2 shows that a large number of consumers continue to access the main HCR Program website each year. In 2006, changes were made to the Program’s website which allowed consumers to select the Consumer Counseling page first without having to navigate through the Program’s main web page. Thus, the number of consumers who accessed the Program’s main web page declined and the number of consumers accessing the Consumer Counseling web page increased. The collective data shows that consumers continue to seek additional information relating to appeals and grievances on the consumer counseling page. The number of consumers accessing the External Review Request Form web page has remained stable over the last four years.

Figure 2: Comparison of HCR Program Web Site Page Access Activity by Calendar Year, January 1, 2003 – December 31, 2006



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

The HCR Program counseled 1,674 consumers during the period of January 1, 2003 – December 31, 2006. As shown in Figure 3, the volume of consumer counseling cases has remained steady during this four-year reporting period. The graph also shows the percentage of consumer counseling calls that were related to appeals and grievances issues. In 2003, the Program collected call volume activity, but did not designate the nature of the call. In 2004, 535 calls were received and 55.7 percent of the calls involved HCR Program staff providing consumer counseling on utilization review, internal appeals and grievance issues, and external review. In 2005, although fewer calls were received by the Program, a higher percentage of those calls related to counseling on appeals and grievance issues. By 2006, while only 370 calls were received, 71.4 percent of the calls involved counseling the consumer on utilization review, internal appeal and grievance issues, and external review.

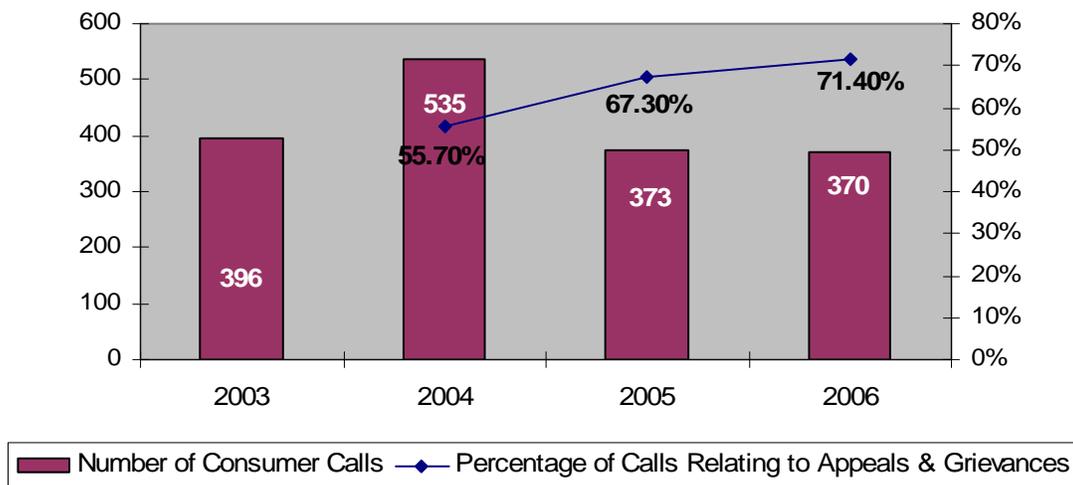
Over the last four years, consumer counseling cases have involved the following issues:

- Insurer’s claim payment.
- Insurance coverage.
- Issues relating to insurance coverage other than health benefit plan.
- Denials made by self-funded employer plans regulated under Employee Retirement Income Security Act (ERISA).
- Network Access.
- Insurers not regulated under North Carolina law.

- Insurance coverage issues.
- Pre-existing condition issues.

HCR Program staff continues to refer consumers to appropriate resources if their concern cannot be addressed by Program staff. During the past four years, consumers have been referred to the Department’s Consumer Services Division, United States Department of Labor, Managed Care Patient Assistance Program and other state insurance regulatory agencies, as well as Federal agencies (i.e., Centers for Medicare & Medicaid Services).

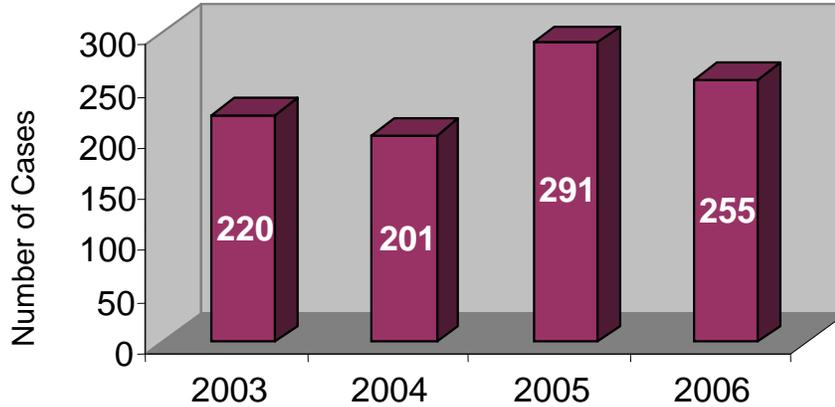
Figure 3: Comparison of Consumer Counseling Case Volume Received by the HCR Program by Calendar Year, January 1, 2003 – December 31, 2006



C. External Review Requests

During the period of January 1, 2003 - December 31, 2006, the HCR Program received 967 requests for external review. Figure 4 compares the volume of requests for each year. The data indicates that the volume of requests received during this reporting period has remained stable. Further analysis by the HCR Program did not find any specific patterns or trends relative to time of year or specific months where the Program receives significantly more or less requests. The HCR Program attributes the sustained level of activity to the 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, 2003 – December 31, 2006



D. Eligibility Determinations on Requests for External Review

A request for external review is made directly to the HCR Program. The HCR Program staff reviews each request for completeness and eligibility. Upon receipt of an incomplete request, the consumer is notified, sent a Request Form and/or notified of the missing information, and given a date to submit the missing information in order for the request to be complete and received by HCR staff as set forth in statute.

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.

A year-to-year analysis of consumers who submit an incomplete request, and the resulting percentage of accepted cases is as follows:

In 2003, 220 requests were received and 46 requests were deemed to be incomplete. Of those requestors, 32 requestors resubmitted a request that was deemed eligible for external review. Four individuals who resubmitted requests were deemed ineligible. Of the 184 individuals requesting an external review, 90 cases (48.9%) were accepted.

In 2004, 201 requests were received and 41 requests were deemed incomplete. Of those requestors, 30 requestors resubmitted a request that was eligible for external review. Four additional resubmitted requests were deemed ineligible. Of the 167 individuals requesting an external review, 77 cases (46.1%) were accepted.

For 2005, the Program saw an increase in the number of “incomplete” requests. Of the 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 and 107 cases (46.3%) were accepted

During 2006, the Program received 255 requests, and 47 requests were deemed incomplete. Of those requestors, 24 resubmitted and an additional eight requests were deemed ineligible. For this year, 222 individuals requested an external review and 113 cases (50.9%) were accepted.

The data shows that over the last four years, the number of individuals requesting an external review has increased. Also, while the number of individuals requesting an external review in 2006 did decline slightly from 2005, the percentage of cases accepted rose. Table 1 explains how the Program considers “incomplete” requests, as it relates to the number of individuals who request an external review.

Table 1: Disposition of Incomplete Requests Made to the HCR Program by Calendar Year, January 1, 2003 – December 31, 2006

Disposition of Incomplete Request	2003	2004	2005	2006
Resubmitted—Accepted for External Review	32	30	43	25
Resubmitted—Not Accepted Due to:				
* Service Excluded	1	0	1	0
* No Medical Necessity Determination	0	1	2	2
* Self Funded	1	0	2	2
* Situs of Contract Not NC	1	0	1	1
* Past Required Time Frame	0	1	4	0
* Request Withdrawn	0	0	1	0
* Internal Appeals Not Exhausted	1	1	5	3
* No Denial Issued	0	0	1	0
* Expedited Criteria Not Met	0	1	0	0
Subtotal:	4	4	17	8
Never Resubmitted, Request made by:				
* Provider	1	1	12	6
* Consumer	7	5	11	8
* Authorized Representative	2	1	2	0
Subtotal:	10	7	25	14
Grand Total of Incomplete Requests:	46	41	85	47

Of the 967 requests received during this four-year reporting period, 163 (16.8%) involved re-submission of a request previously denied because it was incomplete. Therefore, eligibility determinations were made on 804 different individuals requesting external review during this time.

Figure 5 shows the disposition of requests for external review for the period of January 1, 2003 – December 31, 2006. The percentage of requests that have been determined to be eligible has generally remained constant over the last four years, as has the percentage of requests that were determined to be ineligible for review. A year-by-year breakdown of the percentage of requests eligible by request type is as follows:

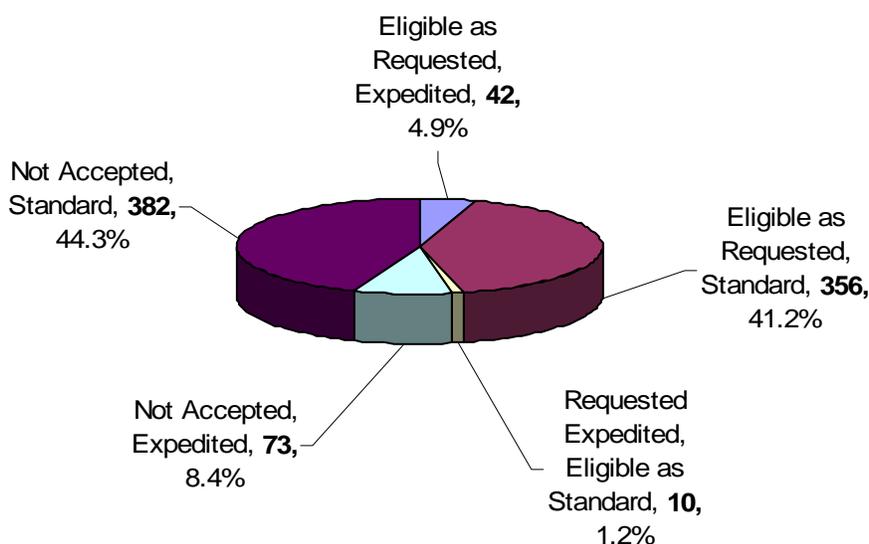
Standard Requests:

- 2003 – 43.5% Deemed Eligible
- 2004 – 40.1% Deemed Eligible
- 2005 – 40.7% Deemed Eligible
- 2006 – 48.7% Deemed Eligible

Expedited Requests:

- 2003 – 5.4% Deemed Eligible
- 2004 – 6.0% Deemed Eligible
- 2005 – 5.6% Deemed Eligible
- 2006 – 2.2% Deemed Eligible

Figure 5: Comparison of Disposition of External Review Requests Received by Calendar Year, January 1, 2003 – December 31, 2006



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.

Table 2 shows the number of cases that were not accepted for review and the reasons for which they were not accepted for each year of operation. During this four-year reporting period, 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). In 2006, the number of incomplete requests declined to 14 (12.8%), as did the number of incomplete requests from providers. Also in 2006, nine requests for external review were not accepted due to the consumer missing the insurer’s timeframe to request an appeal in order to exhaust the internal appeal process. In previous years, this has not been a reason for non-acceptance.

Some other general observations based on the data collected over the four-year period are as follows:

- The number of denials due to “no medical necessity denial” has remained constant.
- The number of requests from consumers covered under a self-funded plan has steadily increased.
- In 2006, there was a decline in the number of requests denied because the consumer did not complete the insurer’s internal appeal process.
- In requesting an external review, 2006 was the first year that the percentage of eligible cases (50.9%) was greater than the percentage of ineligible cases (49.1%).

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.

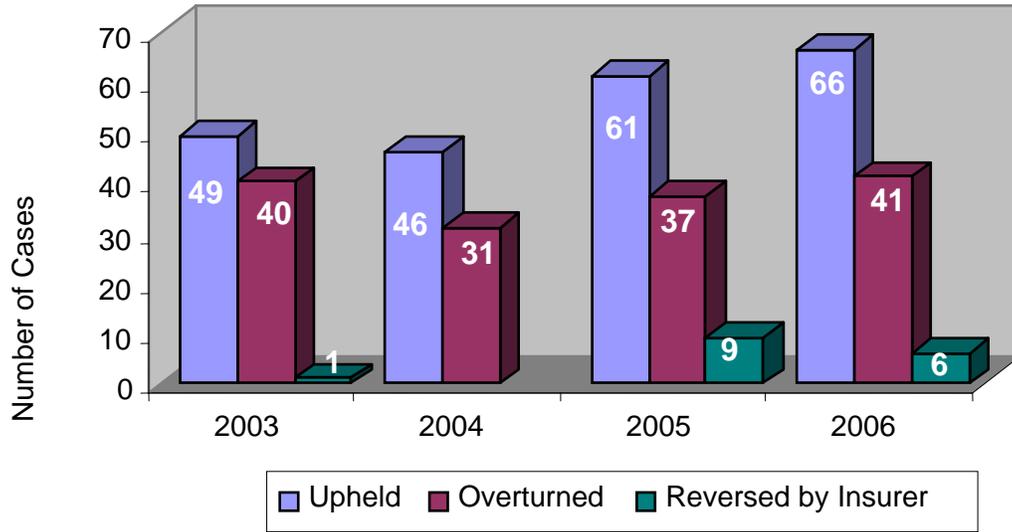
**Table 2: Reasons for Non-Acceptance of an External Review Request,
January 1, 2003 – December 31, 2006**

Reason for Non-acceptance	Number of Requests			
	2003	2004	2005	2006
INELIGIBLE				
Denial Decision Pre-dates Law	1	0	0	0
Missed Insurer's Timeframe to Complete Appeals	0	0	0	9
Health Criteria Not Met For Expedited, Not Eligible as Standard	8	4	3	0
Not a Medical Necessity Determination	18	20	25	25
Request Withdrawn	1	4	3	4
Service Excluded	14	8	8	3
No Denial Issued	0	2	6	1
Insurer's Expedited Appeal not Requested Prior to Request	0	0	1	0
Not Covered Under Health Plan	0	2	0	0
Retrospective Services-- Not Eligible For Expedited	0	2	1	2
Past 60 Day Request Time Frame	7	6	5	5
Insurer Appeal Process Not Exhausted	17	19	22	12
Insurance Type Not Eligible For External Review	5	5	2	4
Request is Incomplete, No Resubmission of Request	10	7	25	14
Total Ineligible	81	79	101	79
NO JURISDICTION				
Contract Situs Not In NC	3	1	7	7
Self-Funded	9	10	14	23
Medicare HMO	1	0	2	0
Total No Jurisdiction	13	11	23	30
Total Requests Not Accepted	94	90	124	109

E. Outcomes of Accepted Cases

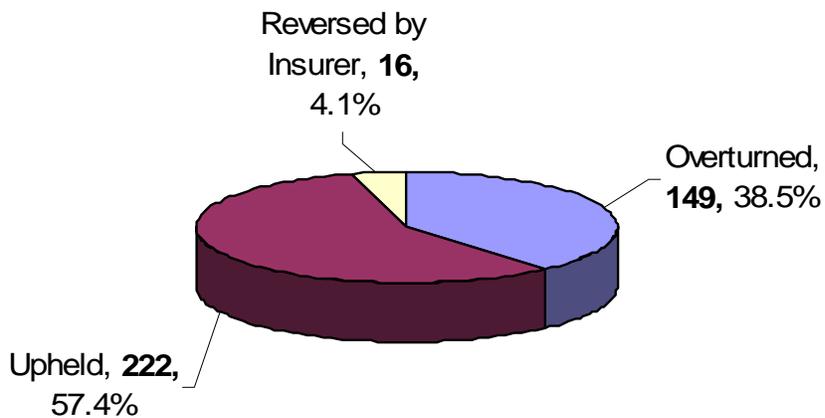
During this four-year reporting period, the HCR Program has accepted a total of 387 cases for external review. From January 1, 2003 – December 31, 2006, the ratio of cases upheld compared to cases overturned or reversed by the insurer has remained relatively constant. In 2003, 45.5 percent of the cases were overturned/reversed, in 2004, 40.2 percent of the cases were overturned, in 2005, 42.9 percent of the cases were overturned/reversed and in 2006, 41.5 percent of the cases were overturned/reversed. Figure 6 shows the outcomes of external reviews performed compared by calendar year.

Figure 6: Comparison of Case Outcomes by Calendar Year, January 1, 2003 – December 31, 2006



Of the 387 cases accepted for external review in this four-year reporting period, 42.6 percent of the cases have resulted in coverage for the disputed services for 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 7.

Figure 7: Percentage of Outcomes for All Accepted Cases, January 1, 2003 – December 31, 2006



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. Figure 8 shows a comparison of cases accepted by type of review by calendar year. Figure 9 shows a comparison of expedited external review requests received and accepted by calendar year.

Figure 8: Comparison of External Review Cases Accepted by Type of Review by Calendar Year, January 1, 2003 – December 31, 2006

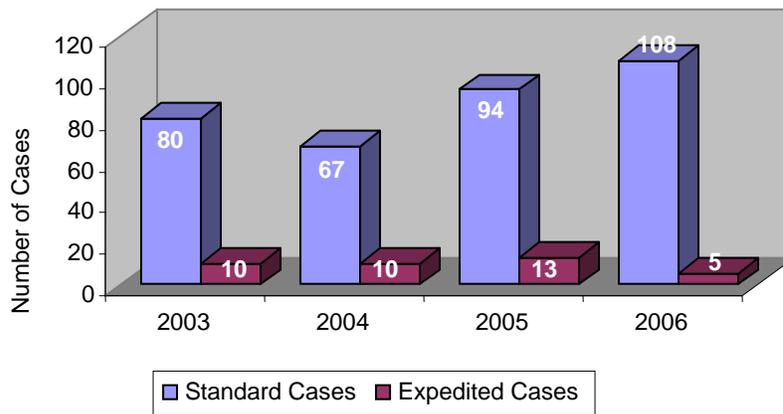
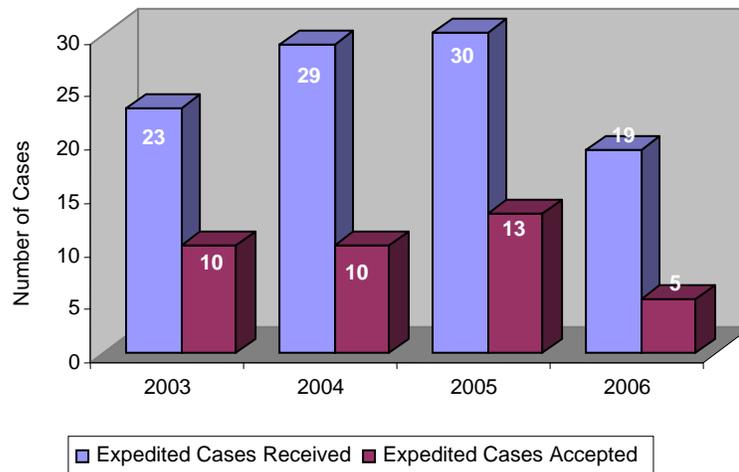


Figure 9: Comparison of Expedited External Review Requests Received and Accepted by Calendar Year, January 1, 2003 – December 31, 2006



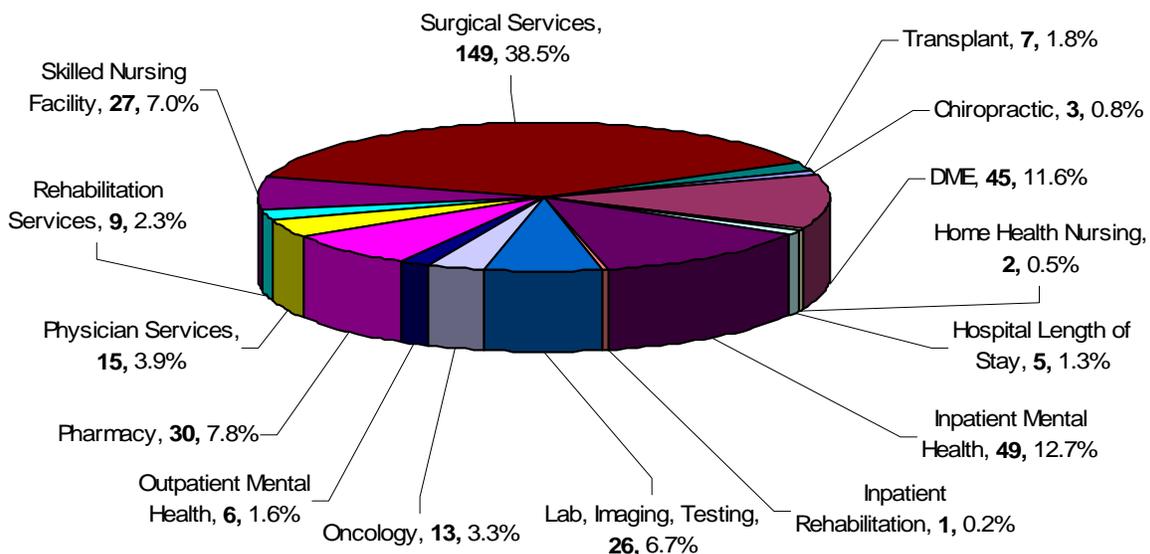
G. Average Time to Process Accepted Cases

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 45th calendar day following the date of the HCR Program’s receipt of the request. For an expedited request, the IRO has until the 4th business day following the HCR Program’s receipt of the request. Most cases accepted on a standard basis are completed between the 36th and 45th day. Most cases accepted on an expedited basis are completed between the 3rd and 4th business day. In no case was the mandated deadline for a decision not met during this four-year reporting period.

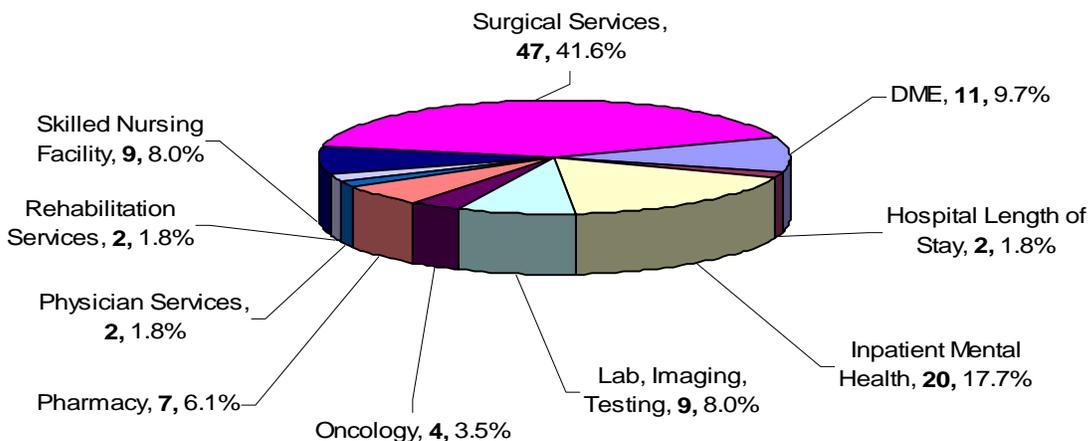
V. Activity by Type of Service Requested

The HCR Program classifies accepted cases into “general” service categories. In order to give the reader a full picture of the types of service that are the subject of external review, the discussion of activity by type of service will first encompass cumulative activity and then compare activity by calendar year where comparison is relevant. Figure 10 shows the cumulative number of accepted cases by type of service requested for January 1, 2003 – December 31, 2006. Surgical service continues to be the largest share of accepted cases, representing 38.5 percent of the 387 accepted cases for external review. Inpatient mental health has the second largest share of requests (12.7%) with durable medical equipment (DME) with the third largest share of requests (11.6%). Figure 11 shows the number of accepted cases by type of service for 2006. The type of service requested by consumers that was subject to external review in 2006 is proportionately similar to what the HCR Program has seen over the last four years.

Figure 10: Accepted Cases by Type of Service Requested, January 1, 2003 – December 31, 2006



**Figure 11: Accepted Cases by Type of Service Requested
January 1, 2006 – December 31, 2006**



Although the HCR Program historically reports primarily on the basis of the general types of services under dispute, information on specific service types is also kept by the Program to analyze activity and identify trends.

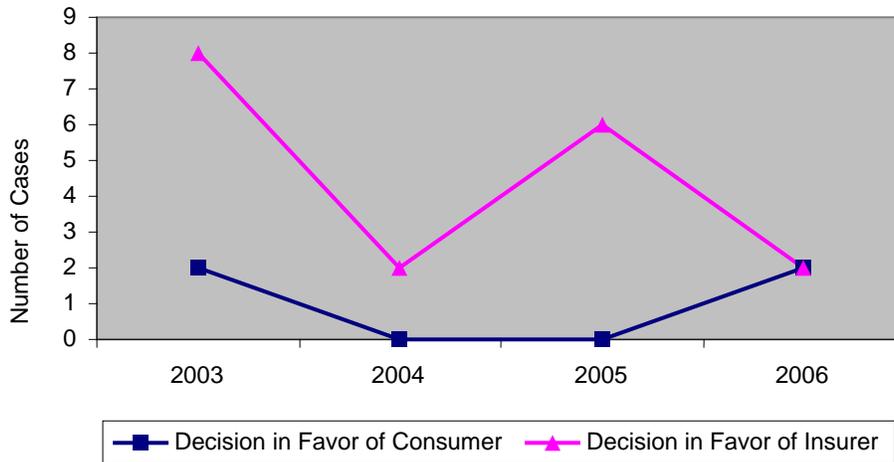
Table 3 gives the reader a listing of the specific services, along with the number of accepted cases for that service, that made up the general type of service category used for reporting for the period of July 1, 2002 – December 31, 2006. As has been reported in previous years, surgical service cases represent the largest number of accepted cases. By specific service type, orthognothic surgery represented the largest number of cases (29) followed by vein surgery (22 cases), and gastric bypass surgery (21 cases). Breast reduction and vagus nerve stimulator (VNS) surgeries each had 14 cases.

**Table 3: Type of General Service and Specific Services Requested
for all Accepted Cases for External Review, July 1, 2002 – December 31, 2006**

Type of General Services and Specific Services Requested			
Chiropractics (3)	Inpatient Mental Health (50)	Pharmacy (32)	Surgical Services (156)
• Chiropractic Services (3)	• Admission-Acute Setting (5)	• Botox (9)	• Blepharoplasty (2)
DME (50)	• Length of Stay-Acute Setting (25)	• Synagis (5)	• Brain Surgery (1)
• Anodyne Therapy (2)	• Admission-Residential Setting (15)	• Non-Steroidal Antiinflammatory (3)	• Breast Reduction (14)
• Blood Monitoring Device (2)	• Length of Stay-Residential Setting (2)	• Growth Hormone (1)	• Capsulorrhaphy (2)
• Bone Growth Stimulator (2)	• Partial Hospitalization Level (3)	• Remicade (2)	• Cochlear Implant (1)
• CPAP (1)	Inpatient Rehabilitation (1)	• Steroid Injections (1)	• Craniectomy (1)
• CPM Machine (2)	• Orthopedic Rehabilitation (1)	• IV Antibiotics for Lyme Disease (2)	• Discectomy (2)
• Cranial Banding (24)	Lab, Imaging, Testing (26)	• Chelation Therapy (3)	• Ears, Nose, Throat (4)
• Electronic Speech Aid (2)	• Cardiac Risk Assessment (4)	• Provigil (3)	• Essure Sterilization (1)
• External Insulin Pump (1)	• Full Body Photography (1)	• Zelnorm (2)	• Gall Bladder Surgery (2)
• Leg Prosthesis (2)	• Gastroenterological Testing (2)	• Prilosec (1)	• Gastric Bypass Surgery (21)
• Nocturnal Enuresis Alarm (1)	• General Blood Work (2)	Physician Services (15)	• Hysterectomy (4)
• Orthotics (1)	• MRI (4)	• Extracorporeal Shockwave (5)	• IDET (2)
• Oxygen Chamber (Hyperbaric) (2)	• Oncotype Breast Cancer Assay (6)	• General Physician Treatment (2)	• Intrauterine Surgery (2)
• Scooter, Motorized (2)	• PET Scan (4)	• Insulin Potentiation (1)	• In Utero Surgery (1)
• Stair Lift (1)	• Polysomnogram (1)	• Laser Treatment / Dermatology (7)	• Keloid Removal (1)
• UVB Light Machine (1)	• Testing/Evaluation for Taste/Smell (1)	Rehabilitation Services (11)	• Lipoma Removal (1)
• Vest Airway Clearance System (4)	• Transcranial Doppler (1)		• Liposuction (1)
Emergency Treatment (1)	Oncology (13)	• Biofeedback (1)	• Lumbar Laminectomy (1)
• Emergency Infectious Disease (1)	• SIR-Spheres Therapy (6)	• Cardiac Rehabilitation (2)	• Metal on Metal Resurfacing (5)
Home Health Nursing (3)	• Renal Ablation (2)	• Physical Therapy (1)	• Mole Removal (1)
• Private Duty Nursing (3)	• Chemotherapy (1)	• Speech Therapy (7)	• Orthognothic/Oral Surgery (29)
Hospital Length of Stay (5)	• Mammosite Radiation (2)	Skilled Nursing Facility (28)	• Ortho Graft/Replacement (7)
• Cardiac (2)	• Intraperitoneal Chemotherapy (2)	• Skilled Nursing Facility (28)	• Panniculectomy (12)
• Cancer (1)	Outpatient Mental Health (6)	Transplant (8)	• Pectus Excavatum (1)
• Gastroenterology (1)	• Psychoanalysis (1)	• Corneal Transplant (1)	• RACZ Neurolysis (1)
• Neurology (1)	• Substance Abuse (4)	• Stem Cell Transplant (7)	• Vein Surgery (22)
	• Medication Management (1)		• Vagus Nerve Stimulator (14)

Figure 12 demonstrates the favorable outcomes for consumers and insurers as it relates to the cases involving vein surgery that have been received by the HCR Program over the past four years. Case outcomes have consistently favored the insurer for this type of service, with only four cases in four years being decided in favor of the consumer. During 2004 and 2005 there were no cases decided in favor of the consumer.

Figure 12: Outcomes of Vein Surgery Cases, January 1, 2003 – December 31, 2006



The information in Figure 13 represents the outcomes for orthognothic surgery for the four-year reporting period. This specific type of service resulted in more favorable outcomes for consumers than insurers for each of the years reported. In 2003 and 2004 there were no cases that were decided in favor of the insurer. During 2005 and 2006, this type of service resulted in a more than twice the positive outcome for consumers than for insurers.

Figure 13: Outcomes of Orthognothic Surgery Cases, January 1, 2003 – December 31, 2006

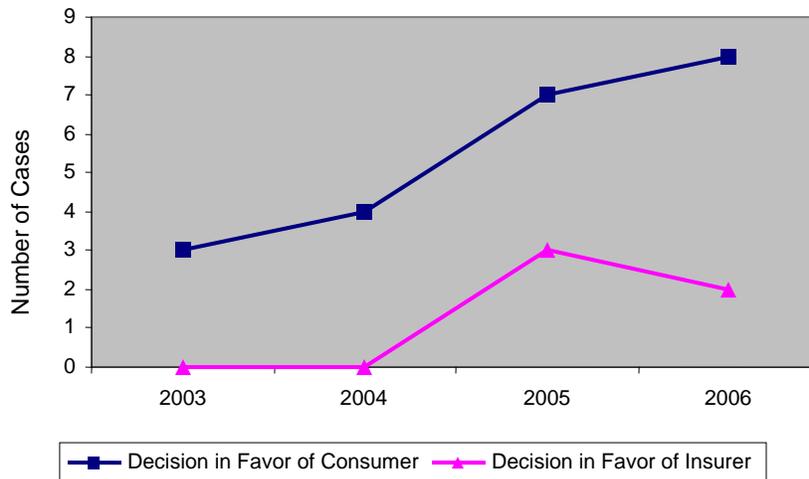


Figure 14 shows the outcomes for gastric bypass surgery cases received by the HCR Program for the past four years. The outcomes for this type of case are variable, showing a decline in favorable outcomes for consumers in 2004 and 2005. The outcomes became more favorable for consumers in 2006.

Figure 14: Outcomes of Gastric Bypass Surgery Cases, January 1, 2003 – December 31, 2006

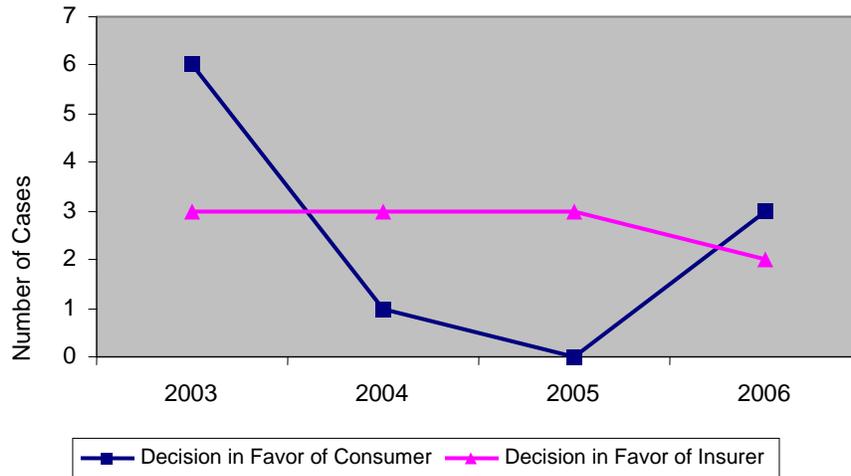


Figure 15 shows the outcomes for DOC Band (cranial banding) cases received by the HCR Program. Outcomes in 2003 and 2004 clearly showed a more favorable outcome toward consumers than insurers. Favorable outcomes for insurers remained constant between 2004 and 2006. Outcomes for consumers show a sharp decline in 2005 and no cases were decided in favor of the consumer in 2006.

Figure 15: Outcomes of DOC Band Cases, January 1, 2003 – December 31, 2006

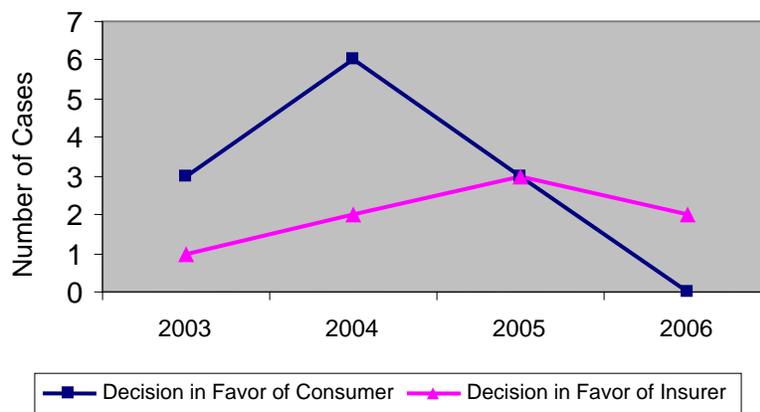


Figure 16 shows that in 2003 and 2004, the majority of IRO decisions for skilled nursing facility service upheld the insurer's decision. In 2005 and 2006, the reverse was true and the majority of cases were overturned.

Figure 16: Outcomes of Skilled Nursing Facility Cases, January 1, 2003 – December 31, 2006

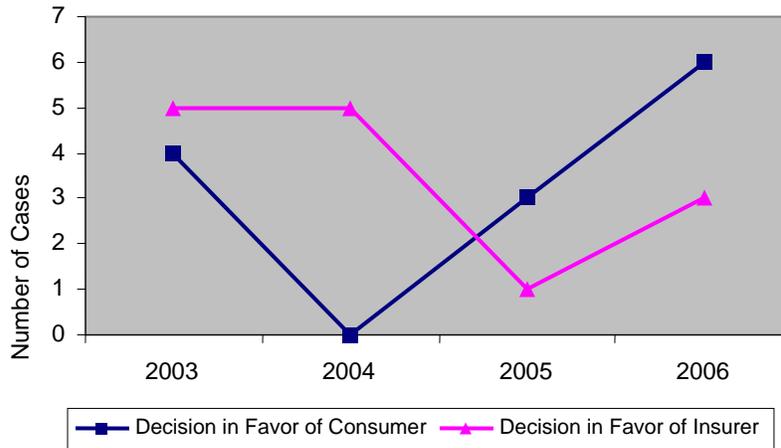


Figure 17 shows that in 2003 and 2004, the majority of IRO decisions for inpatient mental health cases upheld the insurer's decision. By 2005, consumers had experienced a sharp increase in cases decided in their favor which continued into 2006.

Figure 17: Outcomes of Inpatient Mental Health Cases, January 1, 2003 – December 31, 2006

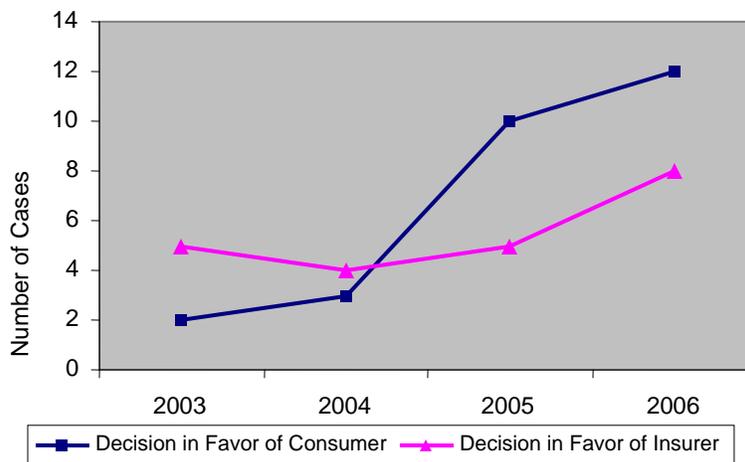


Table 4 shows a comparison of the percentage share that each service type held for all accepted cases as well as for each case outcome by calendar year for the reporting period. In reviewing the data, the following observations are noted:

- Throughout the four-year reporting period, surgical services have consistently had the largest number of accepted cases.
- In year 2003, surgical cases represented 50 percent of all overturned cases. In the following years, the percentage share of surgical cases that were overturned declined to 25.8 percent in 2004, increased to 29.7 percent in 2005, and represented 39 percent of all overturned cases in 2006. In 2005, surgical cases also represented 11.1 percent of all reversed cases and 16.7 percent of all reversed cases in 2006.
- The number and percentage share of accepted inpatient mental health cases has steadily increased over the four-year reporting period. The percentage share of overturned inpatient mental health cases has steadily increased. In 2003, inpatient mental health cases represented 7.8 percent of accepted cases, and represented 5 percent of the cases that were overturned. In 2006, inpatient mental health cases comprised 17.7 percent of accepted cases and 22.0 percent of cases overturned. Also in 2006, inpatient mental health cases represented 50 percent of all cases reversed by the insurer.
- During this four-year reporting period, the volume and percentage share of overturned cases for skilled nursing facility services has fluctuated. In 2003, the Program accepted nine cases which made up 10 percent of the accepted cases and 10 percent of the overturned cases. In 2004, five cases were accepted comprising 6.5 percent of the accepted cases and zero percent of all overturned cases. In 2005, four cases were accepted representing 3.7 percent of accepted cases and 5.4 percent of all overturned cases. In 2006, the volume and percentage share of overturned cases for skilled care services grew with the Program accepting nine cases representing 8 percent of accepted cases and 14.6 percent of all overturned cases.

Table 4: Comparison of Percentage Share of Review Activity by Type of Service Requested, January 1, 2003 – December 31, 2006

Types of Service	2003					2004				2005					2006				
	Number of Accepted Cases	Percentage of Accepted Cases	Outcomes			Number of Accepted Cases	Percentage of Accepted Cases	Outcomes		Number of Accepted Cases	Percentage of Accepted Cases	Outcomes			Number of Accepted Cases	Percentage of Accepted Cases	Outcomes		
			% Overturned	% Reversed	% Upheld			% Overturned	% Upheld			% Overturned	% Reversed	% Upheld			% Overturned	% Reversed	% Upheld
Chiropractic	1	1.1	0.0	0.0	2.0	2	2.6	0.0	4.6	0	0.0	0.0	0.0	0.0	0	0.0	0.0	0.0	0.0
DME	7	7.8	12.5	0.0	4.1	14	18.2	25.8	13.0	13	12.2	8.1	11.1	14.8	11	9.7	7.3	0.0	12.2
Home Health Nursing	2	2.2	0.0	0.0	4.1	0	0.0	0.0	0.0	0	0.0	0.0	0.0	0.0	0	0.0	0.0	0.0	0.0
Hospital Length of Stay	2	2.2	2.5	0.0	2.0	0	0.0	0.0	0.0	1	0.9	0.0	0.0	1.6	2	1.8	0.0	0.0	3.0
Inpatient Mental Health	7	7.8	5.0	0.0	10.2	7	9.1	9.7	8.7	15	14.0	19.0	33.4	8.2	20	17.7	22.0	50.0	12.2
Inpatient Rehabilitation	1	1.1	0.0	0.0	2.0	0	0.0	0.0	0.0	0	0.0	0.0	0.0	0.0	0	0.0	0.0	0.0	0.0
Lab, Imaging, Testing	3	3.3	5.0	0.0	2.0	6	7.8	6.5	8.7	8	7.5	8.1	22.2	5.0	9	8.0	7.3	16.6	7.6
Oncology	3	3.3	2.5	0.0	4.1	3	3.9	3.2	4.4	3	2.8	5.4	0.0	1.6	4	3.5	2.5	0.0	4.5
Outpatient Mental Health	1	1.1	0.0	0.0	2.0	0	0.0	0.0	0.0	5	4.7	5.4	0.0	5.0	0	0.0	0.0	0.0	0.0
Pharmacy	6	6.8	5.0	0.0	8.2	6	7.8	16.1	2.1	11	10.3	5.4	11.1	13.1	7	6.1	7.3	16.7	4.5
Physician Services	3	3.3	0.0	0.0	6.1	4	5.2	6.5	6.5	6	5.6	10.8	0.0	3.3	2	1.8	0.0	0.0	3.0
Rehabilitation Services	2	2.2	5.0	0.0	0.0	4	5.2	3.2	6.5	1	0.9	0.0	0.0	1.6	2	1.8	0.0	0.0	3.0
Skilled Nursing Facility	9	10.0	10.0	0.0	10.2	5	6.5	0.0	10.8	4	3.7	5.4	11.1	1.6	9	8.0	14.6	0.0	4.5
Surgical Services	41	45.6	50.0	100.0	41.0	23	29.8	25.8	30.4	38	35.5	29.7	11.1	42.6	47	41.6	39.0	16.7	45.5
Transplant	2	2.2	2.5	0.0	2.0	3	3.9	3.2	4.3	2	1.9	2.7	0.0	1.6	0	0.0	0.0	0.0	0.0
Total	90	100	100	100	100	77	100	100	100	107	100	100	100	100	113	100	100	100	100

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 by year, 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. Overall, the percentage share of cases accepted for each type of noncertification remains relatively similar throughout the four-year reporting period. Medical necessity cases continue to represent the largest share of noncertification types seen by the Program. For these types of cases, 2006 had the greatest percentage of cases overturned by the IRO with 56.6 percent, followed by 2003 with 48 percent, 2005 with 44.2 percent and 2004 with 37.5 percent of the cases overturned by the IRO. Outcomes in 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. However, of the eight cases that were overturned, six cases were for cranial banding (durable medical equipment). Of the seven cosmetic cases whose outcome was upheld, two of those cases were cranial banding. In 2005, almost twice as many cosmetic cases were upheld as were overturned. A closer review of the case type did not reveal any propensity for one type of service. For all four 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, 2003 – December 31, 2006

Service Type	2003						2004					
	Medical Necessity		Exp. / Inv.		Cosmetic		Medical Necessity		Exp. / Inv.		Cosmetic	
	Overturned	Upheld	Overturned	Upheld	Overturned	Upheld	Overturned	Upheld	Overturned	Upheld	Overturned	Upheld
Chiropractic	--	1	--	--	--	--	--	2	--	--	--	--
DME	2	2	1	--	2	--	1	2	1	2	6	2
Home Health Nursing	--	2	--	--	--	--	--	--	--	--	--	--
Hospital Length of Stay	1	1	--	--	--	--	--	--	--	--	--	--
Inpatient Mental Health	2	5	--	--	--	--	3	4	--	--	--	--
Inpatient Rehabilitation	--	1	--	--	--	--	--	--	--	--	--	--
Lab, Imaging, Testing	2	--	--	1	--	--	--	2	2	2	--	--
Oncology	--	--	1	2	--	--	--	--	1	2	--	--
Outpatient Mental Health	--	1	--	--	--	--	--	--	--	--	--	--
Pharmacy	--	3	2	1	--	--	2	1	2	--	1	--
Physician Services	--	1	--	2	--	--	1	--	--	1	1	1
Rehabilitation Services	2	--	--	--	--	--	--	2	1	1	--	--
Skilled Nursing Facility	4	5	--	--	--	--	--	5	--	--	--	--
Surgical Services	12	5	5	13	3	2	8	6	--	5	--	4
Transplant	--	--	1	1	--	--	--	1	1	1	--	--
Total	25	27	10	20	5	2	15	25	8	14	8	7
Percentage of Case Volume	58.4%		33.7%		7.9%		51.9%		28.6%		19.5%	

Table 5: Comparison of Outcomes of Accepted External Review Requests by Service Type and Denial Type by Calendar Year, January 1, 2003 – December 31, 2006 (Cont.)

Service Type	2005						2006					
	Medical Necessity		Exp. / Inv.		Cosmetic		Medical Necessity		Exp. / Inv.		Cosmetic	
	Overturned	Upheld	Overturned	Upheld	Overturned	Upheld	Overturned	Upheld	Overturned	Upheld	Overturned	Upheld
Chiropractic	--	--	--	--	--	--	--	--	--	--	--	--
DME	1	3	--	4	2	2	3	4	--	2	--	2
Home Health Nursing	--	--	--	--	--	--	--	--	--	--	--	--
Hospital Length of Stay	--	1	--	--	--	--	--	2	--	--	--	--
Inpatient Mental Health	7	5	--	--	--	--	9	8	--	--	--	--
Inpatient Rehabilitation	--	--	--	--	--	--	--	--	--	--	--	--
Lab, Imaging, Testing	1	--	2	3	--	--	1	--	2	4	--	1
Oncology	--	--	2	1	--	--	--	--	1	3	--	--
Outpatient Mental Health	2	3	--	--	--	--	--	--	--	--	--	--
Pharmacy	--	3	2	5	--	--	1	1	2	2	--	--
Physician Services	1	1	1	--	2	1	--	--	--	2	--	--
Rehabilitation Services	--	1	--	--	--	--	--	2	--	--	--	--
Skilled Nursing Facility	2	1	--	--	--	--	6	3	--	--	--	--
Surgical Services	9	11	1	9	1	6	14	6	2	20	--	4
Transplant	--	--	1	1	--	--	--	--	--	--	--	--
Total	23	29	9	23	5	9	34	26	7	33	0	7
Percentage of Case Volume	53%		32.7%		14.3%		56.1%		37.4%		6.5%	

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 2003, 11.1 percent of the cases accepted were processed on an expedited basis. Clinical case types included: renal ablation, botox injections for migraine headache and myofacial pain syndrome, SIR-Spheres therapy for colon cancer, in-utero surgery, denial of continued inpatient hospital stay for a perforated bowel, nursing services (LPN) for bowel program, private duty nursing.

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.

In 2006, only 4.4 percent of the cases accepted were handled on an expedited basis. The cases involved: laser ablation of RGSV and LGSV for phlebectomy, CPAP, vagus nerve stimulator implantation, and Zelnorm for scleroderma.

For 2003 and 2004, only 30 percent of expedited cases were decided in favor of the patient. In 2005, 61.5 percent of expedited cases were decided in favor of the patient by the IRO or reversed by the insurer. Similarly in 2006, 60 percent of the expedited cases were either decided in favor of the patient by the IRO or reversed by the insurer.

Table 6: Comparison of Outcomes of Requests by Type of Service Requested by Type of Review Granted by Calendar Year, January 1, 2003 – December 31, 2006

Service Type	2003						2004				2005						2006					
	Standard			Expedited			Standard		Expedited		Standard			Expedited			Standard			Expedited		
	Overturned	Reversed	Upheld	Overturned	Reversed	Upheld	Overturned	Upheld	Overturned	Upheld	Overturned	Reversed	Upheld									
Chiropractics	--	--	1	--	--	--	--	2	--	--	--	--	--	--	--	--	--	--	--	--	--	--
DME	5	--	2	--	--	--	8	5	--	1	3	1	9	--	--	--	2	--	8	1	--	--
Home Health Nursing	--	--	--	--	--	2	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Hospital Length of Stay	1	--	--	--	--	1	--	--	--	--	--	--	1	--	--	--	--	--	2	--	--	--
Inpatient Mental Health	2	--	5	--	--	--	3	4	--	--	7	3	5	--	--	--	9	3	8	--	--	--
Inpatient Rehabilitation	--	--	1	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Lab, Imaging, Testing	1	--	1	1	--	--	2	4	--	--	3	1	3	--	1	--	3	1	5	--	--	--
Oncology	--	--	--	1	--	2	1	--	--	2	--	--	--	2	--	1	1	--	3	--	--	--
Outpatient Mental Health	--	--	1	--	--	--	--	--	--	--	2	--	3	--	--	--	--	--	--	--	--	--
Pharmacy	1	--	3	1	--	1	4	1	1	--	2	--	5	--	1	3	3	--	3	--	1	--
Physician Services	--	--	3	--	--	--	2	3	--	--	4	--	2	--	--	--	--	--	2	--	--	--
Rehabilitation Services	2	--	--	--	--	--	1	3	--	--	--	--	1	--	--	--	--	--	2	--	--	--
Skilled Nursing Facility	4	--	5	--	--	--	--	2	--	3	1	--	1	1	1	--	6	--	3	--	--	--
Surgical Services	20	1	19	--	--	1	7	14	1	--	10	1	26	1	--	--	15	1	28	1	--	2
Transplant	1	--	1	--	--	--	--	1	1	1	--	--	--	1	--	1	--	--	--	--	--	--
Total	37	1	42	3	0	7	28	39	3	7	32	6	56	5	3	5	39	5	64	2	1	2
Percentage of Cases	88.9%			11.1%			87%		13%		87.9%			12.1%			95.6%			4.4%		

A. Insurer and Type of Service Activity

In 2006, cases originating from State Health Plan’s Indemnity Plan, Blue Cross & Blue Shield of North Carolina, and UnitedHealthcare of North Carolina, Inc., comprised 83.2 percent of the external review activity. Twelve other insurers made up the remaining 16.8 percent of cases. Eight of the insurers had only one case, State Health Plan’s PPO Plan had four external review cases in 2006, WellPath Select, Inc. had three cases, the North Carolina Medical Society Health Benefit Trust had two cases as did Guardian Life Insurance Company of America. With 48 cases accepted during 2006, the State Health Plan’s Indemnity 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 29 accepted cases. The percentage share of insurer activity for 2006 is depicted in Figure 18 (A) and (B).

Figure 18: Insurers’ Share of Accepted External Review Requests, January 1, 2006 – December 31, 2006

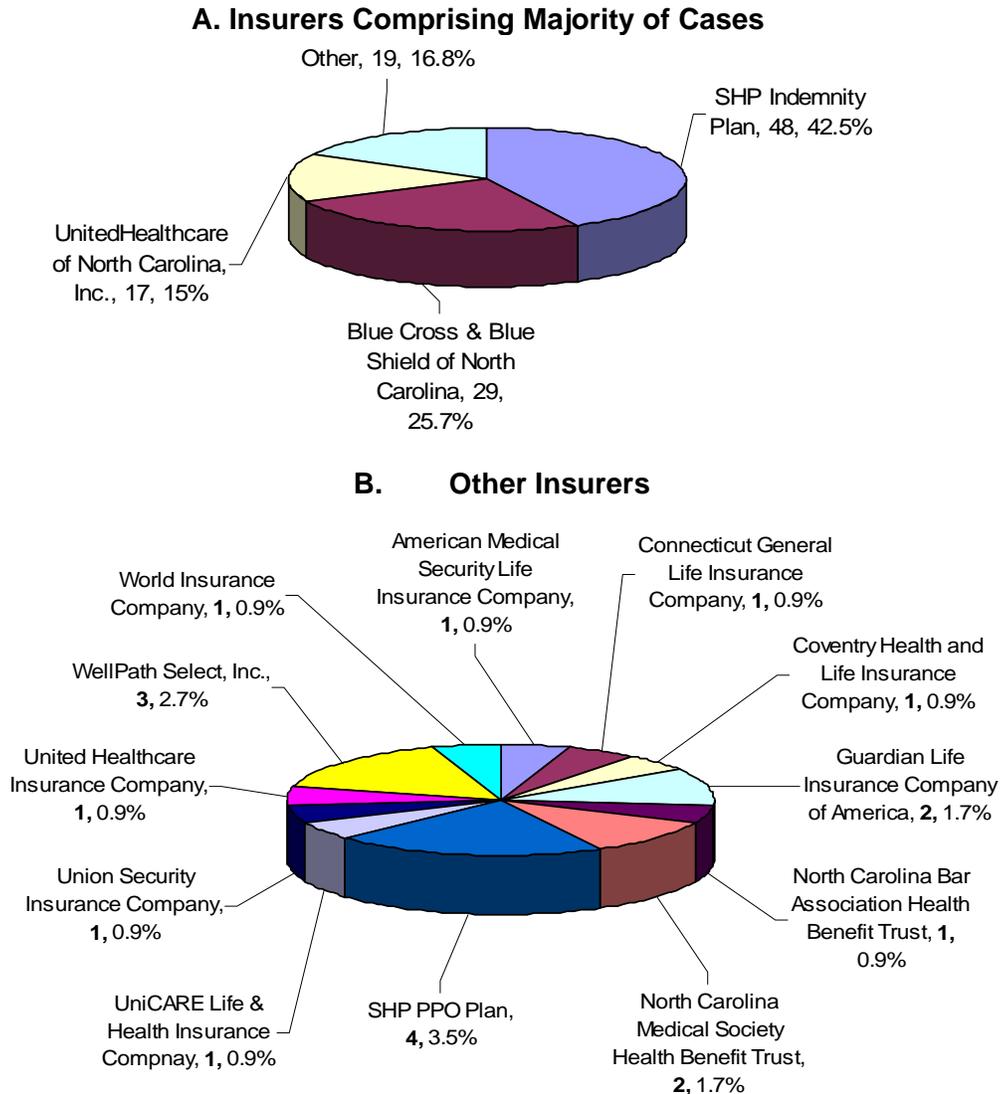
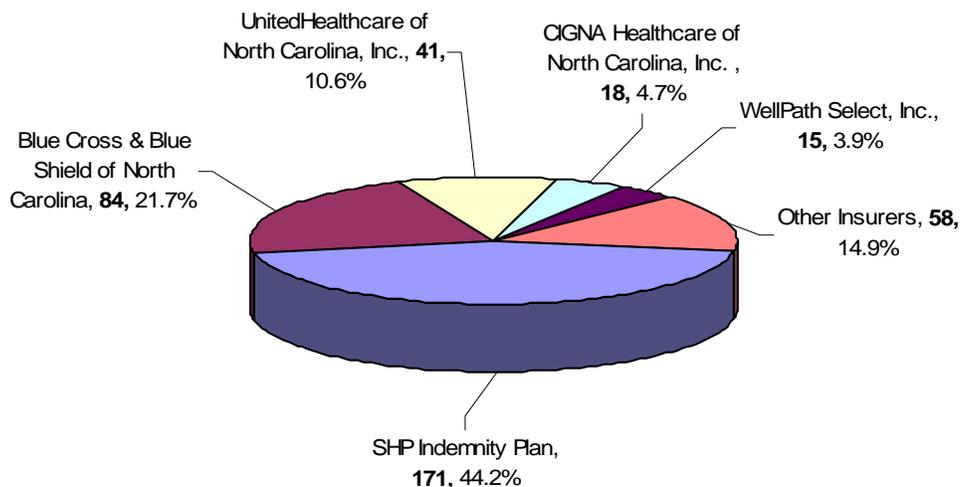


Figure 19 shows the insurers with the majority of accepted external review requests for the reporting period of January 1, 2003 – December 31, 2006. State Health Plan’s Indemnity plan has consistently had the largest number and percentage share of accepted requests over the four-year reporting period. Twenty-six other insurers, State Health Plan’s PPO plan, CHIP and two MEWAs make up the “Other Insurers” category for the four-year reporting period.

**Figure 19: Insurers with Majority of Accepted External Review Requests
January 1, 2003 – December 31, 2006**



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 both the State Health Plan’s Indemnity and PPO plans, and for CHIP is reported to the Program upon request.

Table 7 provides a comparison of accepted case activity by insurer by member months from January 1, 2003 – December 31, 2006. The data compares the top five insurers who have had the most accepted cases, and who report member month data. The data shows that the rate of external review activity for all HMOs and the State Health Plan’s Indemnity plan has remained constant over the four-year period, and that all have had a case rate of less than one (1) case per 100,000 members. 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, 2003 – December 31, 2006**

Insurer	2003			2004			2005			2006		
	Number of Cases	Member Months	Cases per 100,000	Number of Cases	Member Months	Cases per 100,000	Number of Cases	Member Months	Cases per 100,000	Number of Cases	Member Months	Cases per 100,000
Blue Cross & Blue Shield of North Carolina	6	2,158,617	0.28	4	1,791,103	0.22	5	1,205,944	0.41	2	1,057,396	0.19
CIGNA Healthcare of North Carolina, Inc.	10	1,573,647	0.64	3	1,087,330	0.27	5	898,669	0.56	0	--	0.0
SHP Indemnity Plan	39	6,742,967	0.58	36	6,275,459	0.57	48	7,015,840	0.68	48	6,070,902	0.79
UnitedHealthcare of North Carolina, Inc.	4	2,980,756	0.13	4	2,870,681	0.14	16	2,426,485	0.66	17	1,874,474	0.90
WellPath Select, Inc.	5	739,089	0.68	2	768,012	0.26	5	754,699	0.66	3	730,130	0.41

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 for 2006. 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 State Health Plan's Indemnity plan, the percentage of their cases overturned by the IRO and the percentage of cases upheld by the IRO has remained relatively similar from 2004 to 2006. In 2004, State Health Plan's Indemnity plan had 38.89 percent of its accepted cases overturned, in 2005, 31.25 percent and in 2006, 33.3 percent of the accepted cases were overturned. For Blue Cross & Blue Shield of North Carolina, the insurer has seen a decline in the percentage of accepted cases that were overturned by an IRO between 2004 and 2006. In 2004, 35 percent of the insurer's cases were overturned, in 2005, 30 percent and in 2006, 27.6 percent of the cases were overturned. For UnitedHealthcare of North Carolina, Inc., the percentage range of cases overturned has fluctuated. In 2004, 50 percent of the insurer's cases were overturned, in 2005, 37.5 percent and in 2006, 47 percent of the accepted cases were overturned. Due to the relatively small number of requests per insurer, and the number of accepted cases, it remains 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, 2006 – December 31, 2006

Insurer and Type of Service	2006			
	Number of Accepted Cases	Outcomes		
		Percent Overturned	Percent Reversed by Insurer	Percent Upheld
American Medical Security Life Insurance Company	1			
• Hospital Length of Stay	1	--	--	100.0
Total Percentage for Insurer		--	--	100.0
Blue Cross & Blue Shield of North Carolina	29			
• DME	1	--	--	100.0
• Inpatient Mental Health	7	28.6	--	71.4
• Lab, Imaging, Testing	3	33.3	--	66.7
• Oncology	2	--	--	100.0
• Pharmacy	1	--	--	100.0
• Physician Services	1	--	--	100.0
• Surgical Services	14	35.7	--	64.3
Total Percentage for Insurer		27.6	--	72.4
Connecticut General Life Insurance Company	1			
• Surgical Services	1	--	--	100.0
Total Percentage for Insurer		--	--	100.0
Coventry Health and Life Insurance Company	1			
• Surgical Services	1	--	--	100.0
Total Percentage for Insurer		--	--	100.0
Guardian Life Insurance Company of America	2			
• Hospital Length of Stay	1	--	--	100.0
• Surgical Services	1	--	--	100.0
Total Percentage for Insurer		--	--	100.0
North Carolina Bar Association Health Benefit Trust	1			
• Surgical Services	1	100.0	--	--
Total Percentage for Insurer		100.0	--	--
North Carolina Medical Society Employees Benefit Trust	2			
• Inpatient Mental Health	1	100.0	--	--
• Surgical Services	1	100.0	--	--
Total Percentage for Insurer		100.0	--	--
SHP Indemnity Plan	48			
• DME	8	12.5	--	87.5
• Inpatient Mental Health	5	20.0	40.0	40.0
• Lab, Imaging, Testing	2	50.0	--	50.0
• Pharmacy	3	33.3	--	66.7
• Physician Services	1	--	--	100.0
• Rehabilitation Services	2	--	--	100.0
• Skilled Nursing Facility	9	66.7	--	33.3
• Surgical Services	18	33.3	5.6	61.1
Total Percentage for Insurer		33.3	6.3	60.4
SHP PPO Plan	4			
• DME	1	100.0	--	--
• Surgical Services	3	66.7	--	33.3
Total Percentage for Insurer		75.0	--	25.0

Table 8: Comparison of Accepted Case Activity by Insurer and Type of Service Requested by Calendar Year, January 1, 2006 – December 31, 2006 (Cont.)

Insurer and Type of Service	2006			
	Number of Accepted Cases	Outcomes		
		Percent Overturned	Percent Reversed by Insurer	Percent Upheld
UniCARE Life & Health Insurance Company	1			
• Oncology	1	--	--	100.0
Total Percentage for Insurer		--	--	100.0
Union Security Insurance Company	1			
• Inpatient Mental Health	1	100.0	--	--
Total Percentage for Insurer		100.0	--	--
United HealthCare Insurance Company	1			
• Pharmacy	1	--	100.0	--
Total Percentage for Insurer		--	100.0	--
UnitedHealthcare of North Carolina, Inc.	17			
• Inpatient Mental Health	4	75.0	25.0	--
• Lab, Imaging, Testing	3	33.3	33.3	33.4
• Oncology	1	100.0	--	--
• Pharmacy	2	100.0	--	--
• Surgical Services	7	14.3	--	85.7
Total Percentage for Insurer		47.0	11.8	41.2
WellPath Select, Inc.	3			
• DME	1	100.0	--	--
• Inpatient Mental Health	2	50.0	--	50.0
Total Percentage for Insurer		66.7	--	33.3
World Insurance Company	1			
• Lab, Imaging, Testing	1	--	--	100.0
Total Percentage for Insurer		--	--	100.0

Table 9 lists the five insurers with the largest number of accepted cases and the insurer's outcome for the period of January 1, 2003 – December 31, 2006. Of these five insurers, Blue Cross & Blue Shield of North Carolina has the lowest percentage of cases overturned for the four-year reporting period.

**Table 9: Top Five Insurers Outcomes by Case Type,
January 1, 2003 – December 31, 2006**

Insurer and Type of Service	Number of Accepted Cases	Insurer's Outcome		
		Percent Overturned	Percent Reversed	Percent Upheld
Blue Cross & Blue Shield of North Carolina	84			
• DME	6	50.0	--	50.0
• Home Health Nursing	1	--	--	100.0
• Hospital Length of Stay	1	--	--	100.0
• Inpatient Mental Health	9	33.3	--	66.7
• Inpatient Rehabilitation	1	--	--	100.0
• Lab, Imaging, Testing	8	25.0	--	75.0
• Oncology	4	50.0	--	50.0
• Outpatient Mental Health	2	--	--	100.0
• Pharmacy	3	33.3	--	66.7
• Physician Services	6	50.0	--	50.0
• Surgical Services	43	27.9		72.1
Total Percentage for Insurer		31.0	--	69.0
CIGNA HealthCare of North Carolina, Inc.	18			
• DME	1	--	--	100.0
• Inpatient Mental Health	2	100.0	--	--
• Oncology	1	100.0	--	--
• Pharmacy	6	33.3	16.7	50.0
• Physician Services	2	--	--	100.0
• Surgical Services	6	50.0	16.7	33.3
Total Percentage for Insurer		44.4	11.1	44.5
SHP Indemnity Plan	171			
• DME	29	34.5	3.4	62.1
• Inpatient Mental Health	18	27.8	22.2	50.0
• Lab, Imaging, Testing	6	33.3	--	66.67
• Oncology	5	--	--	100.0
• Outpatient Mental Health	2	--	--	100.0
• Pharmacy	8	50.0	--	50.0
• Physician Services	5	40.0	--	60.0
• Rehabilitation Services	7	42.9	--	57.1
• Skilled Nursing Facility	26	42.3	3.9	53.8
• Surgical Services	58	34.5	1.7	63.8
• Transplant	7	42.9	--	57.1
Total Percentage for Insurer		35.1	4.1	60.8

**Table 9: Top Five Insurers Outcomes by Case Type,
January 1, 2003 – December 31, 2006 (Cont.)**

Insurer and Type of Service	Number of Accepted Cases	Insurer's Outcome		
		Percent Overturned	Percent Reversed	Percent Upheld
UnitedHealthcare of North Carolina, Inc.	41			
• DME	2	50.0	--	50.0
• Inpatient Mental Health	8	50.0	12.51	37.5
• Lab, Imaging, Testing	5	60.0	20.0	20.0
• Oncology	1	100.0	--	--
• Outpatient Mental Health	2	100.0	--	--
• Pharmacy	7	42.9	--	57.1
• Surgical Services	16	37.5	--	62.5
Total Percentage for Insurer		48.8	4.9	46.3
WellPath Select, Inc.	15			
• DME	1	1	--	--
• Inpatient Mental Health	5	3	--	2
• Lab, Imaging, Testing	2	1	1	--
• Surgical Services	7	5	--	2
Total Percentage for Insurer		66.7	6.7	26.6

VI. Activity by IRO

A. Summary by IRO

During the period of January 1, 2003 – December 31, 2006, IROs rendered 371 external review decisions for consumers. Although 387 cases were accepted for external review during these two years, 16 cases were reversed by the insurer prior to an IRO decision being rendered. The cases sent to IROs for independent review encompass a variety of insurers, noncertification reasons and specific types of services. Table 10 compares the number of cases assigned to each IRO with the number and percentage of their review decisions, by calendar year. The data shows that for three (3) IROs who have received a larger proportion of cases (IPRO, Maximus CHDR, and Permedion), their percentage of case outcomes overturned versus upheld are similar. 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 contracting periods for IROs vary as indicated in Table 10, where “NA” indicates not-applicable, meaning that the IRO was not under contract with the Department at that time. The contract period with Hayes, Plus ended June 30, 2004, NMR’s contract became effective July 1, 2005, and the contract periods for Carolina Center for Clinical Information (3CI) and Prest & Associates ended on June 30, 2005. MCMC’s contract became effective July 1, 2005, but did not receive any cases in 2005 and only one case in 2006 as a result of screening for conflict of interest. Although Permedion’s contract to perform IRO services for the HCR Program did not

become effective until January 1, 2004, the case assigned to them was received on December 31, 2003, and determined to be eligible on January 7, 2004, thereby leaving Permedion eligible for IRO assignment.

Table 10: Comparison of IRO Activity Summary by Calendar Year, January 1, 2003 – December 31, 2006

IRO	2003					2004					2005				2006					
	Number Assigned	Over turned		Upheld		Number Assigned	Over turned		Upheld		Number Assigned	Over turned		Upheld		Number Assigned	Over turned		Upheld	
		Number	Percentage	Number	Percentage		Number	Percentage	Number	Percentage		Number	Percentage	Number	Percentage		Number	Percentage	Number	Percentage
3CI	13	10	76.9	3	23.1	7	3	42.9	4	57.1	6	3	50.0	3	50.0	NA	--	--	--	--
Hayes, Plus	25	6	24.0	19	76.0	6	1	16.7	5	83.3	NA	--	--	--	--	NA	--	--	--	--
IPRO	25	11	44.0	14	56.0	22	9	40.9	13	59.1	33	13	39.4	20	60.6	27	13	48.1	14	51.9
Maximus CHDR	24	13	54.2	11	45.8	22	11	50.0	11	50.0	29	11	38.0	18	62.0	27	14	51.9	13	48.1
MCMC	NA	--	--	--	--	NA	--	--	--	--	0	0	0.0	0	0.0	1	0	0.0	1	100.0
NMR, Inc.	NA	--	--	--	--	NA	--	--	--	--	8	2	25.0	6	75.0	23	7	30.4	16	69.6
Permedion	1	0	0.0	1	100.0	19	7	36.8	12	63.2	22	8	36.4	14	63.6	29	7	24.1	22	75.9
Prest & Associates	1	0	0.0	1	100.0	1	0	0.0	1	100.0	0	0	0.0	0	0.0	NA	--	--	--	--
All Cases	89	40	44.9	49	55.1	77	31	40.3	46	59.7	98	37	37.7	61	62.3	107	41	38.3	66	61.7

NA-Not Applicable – Not a Contracted IRO

The Department seeks to contract with IROs that have extensive experience in providing independent medical review of health plan coverage denials for state or government agencies. The procurement process is accomplished by issuing a request for proposal (RFP) for IROs to perform reviews of health plan utilization review noncertifications. The Department issued its first request for proposal on February 22, 2002, and from that process, five IROs (Carolina Center for Clinical Information, Hayes, Plus, IPRO, Maximus CHDR and Prest & Associates) were deemed to have met the statutory requirements, and whose proposals were within commercially reasonable fees charged for similar services in the industry. The Department has issued the same RFP several times over the last four years to ensure a staggered schedule of IRO contract ending dates.

In completing the Technical Application Form of the RFP, IROs are 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 are 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 are 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 N. C. Gen. Stat. § 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 are evaluated to determine if an IRO satisfied the minimum qualifications established under N. C. Gen. Stat. § 58-50-87. Using evaluation criteria included in the RFP, each IRO's technical proposal is 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 are 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 are recommended to the Chief Deputy Commissioner.

B. Decisions by Type of Service Requested and Insurer

Table 11 reports the outcomes for the service type for all IRO decisions from January 1, 2003 – December 31, 2006. This enables the reader to compare an aggregate of the IRO's percentage of outcomes for that same general type of service for the four-year reporting period. Outcomes for DME cases saw a reduction in cases overturned over the four-year period. A large part of these cases upheld involved cranial banding. External review requests for inpatient mental health grew, with a sizeable percentage of requests being generated from one provider. Over time, the percentage outcome of these inpatient mental health cases overturned grew. External review requests for surgical services continues to comprise the largest volume of cases by service type, and the percentage outcome of cases overturned versus cases upheld has remained relatively similar.

Table 11: Comparison of All IRO Outcomes (Percentages) by General Service Type for All Insurers by Calendar Year, January 1, 2003 – December 31, 2006

Service Type	2003			2004			2005			2006		
	Number of Decisions	Outcomes		Number of Decisions	Outcomes		Number of Decisions	Outcomes		Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld									
Chiropractics	1	--	100.0	2	--	100.0	--	--	--	--	--	--
DME	7	71.4	28.6	14	57.1	42.9	12	25.0	75.0	11	27.3	72.7
Home Health Nursing	2	--	100.0	--	--	--	--	--	--	--	--	--
Hospital Length of Stay	2	50.0	50.0	--	--	--	1	--	100.0	2	--	100.0
Inpatient Mental Health	7	28.6	71.4	7	42.3	57.1	12	58.3	41.7	17	52.9	47.1
Inpatient Rehabilitation	1	--	100.0	--	--	--	--	--	--	--	--	--
Lab, Imaging, Testing	3	66.7	33.3	6	33.3	66.7	6	50.0	50.0	8	37.5	62.5
Oncology	3	--	100.0	3	33.3	66.7	3	33.3	66.7	4	25.0	75.0
Outpatient Mental Health	1	--	100.0	--	--	--	5	40.0	60.0	--	--	--
Pharmacy	6	33.3	66.7	6	83.3	16.7	10	83.3	16.7	6	50.0	50.0
Physician Services	3	--	100.0	5	40.0	60.0	6	66.7	33.3	2	--	100.0
Rehabilitation Services	2	100.0	--	4	25.0	75.0	1	--	100.0	2	--	100.0
Skilled Nursing Facility	9	44.4	56.6	5	--	100.0	3	66.7	33.3	9	66.7	33.3
Surgical Services	40	50.0	50.0	22	36.3	63.6	37	29.7	70.3	46	34.8	65.2
Transplant	2	50.0	50.0	3	33.3	66.7	2	50.0	50.0	--	--	--

Table 12 shows each IRO's decisions by individual insurer for January 1, 2003 – December 31, 2006. An IRO is assigned a case on the basis of: a) an alphabetical rotation that is required by law, b) that the IRO has a qualified clinical expert to review the case, and c) that there is no conflict of interest. The nature of the denial has no bearing on the assignment to an IRO.

Table 12: Comparison of IRO Decisions by Insurer by Calendar Year, January 1, 2003 – December 31, 2006

IRO and Insurer	2003			2004			2005			2006		
	Number of Decisions	Outcomes		Number of Decisions	Outcomes		Number of Decisions	Outcomes		Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld									
3CI	13			7			6			NA		
• American Medical Security Life Insurance Company	NA	--	--	NA	--	--	1	0.0	100.0	NA	--	--
• Celtic Insurance Company	1	100.0	0.0	NA	--	--	NA	--	--	NA	--	--
• FirstCarolinaCare, Inc.	1	100.0	0.0	NA	--	--	NA	--	--	NA	--	--
• Guardian Life Insurance Company of America	NA	--	--	1	100.0	0.0	NA	--	--	NA	--	--
• GE Group Life Assurance Company	1	100.0	0.0	NA	--	--	NA	--	--	NA	--	--
• Humana Insurance Company	NA	--	--	1	0.0	100.0	NA	--	--	NA	--	--
• MAMSI Life and Health Insurance Company	NA	--	--	NA	--	--	1	100.0	0.0	NA	--	--
• New England Life Insurance Company	1	0.0	100.0	NA	--	--	NA	--	--	NA	--	--
• Optimum Choice of the Carolinas	1	100.0	0.0	NA	--	--	NA	--	--	NA	--	--
• Principal Life Insurance Company	2	0.0	100.0	1	0.0	100.0	NA	--	--	NA	--	--
• Trustmark Insurance Company	NA	--	--	1	0.0	100.0	NA	--	--	NA	--	--
• UnitedHealthcare of North Carolina, Inc.	4	100.0	0.0	3	66.7	33.3	3	33.3	66.6	NA	--	--
• WellPath Select, Inc.	2	100.0	0.0	NA	--	--	1	100.0	--	NA	--	--
Hayes, Plus	25			6			NA	--	--	NA	--	--
• Blue Cross & Blue Shield of North Carolina	5	40.0	60.0	2	50.0	50.0	NA	--	--	NA	--	--
• John Alden Life Insurance Company	1	0.0	100.0	NA	--	--	NA	--	--	NA	--	--
• NC Healthchoice for Children	1	100.0	0.0	NA	--	--	NA	--	--	NA	--	--
• North Carolina Medical Society Employee s Benefit Trust (MEWA)	1	0.0	100.0	NA	--	--	NA	--	--	NA	--	--
• SHP Indemnity Plan	17	17.7	82.3	4	0.0	100.0	NA	--	--	NA	--	--

NA-Not Applicable

**Table 12: Comparison of IRO Decisions by Insurer by Calendar Year,
January 1, 2003 – December 31, 2006 (Cont.)**

IRO and Insurer	2003			2004			2005			2006		
	Number of Decisions	Outcomes		Number of Decisions	Outcomes		Number of Decisions	Outcomes		Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld									
IPRO	25			22			33			27		
• Blue Cross & Blue Shield of North Carolina	5	60.0	40.0	8	37.5	62.5	6	66.7	33.3	5	20.0	80.0
• CIGNA HealthCare of North Carolina, Inc.	2	50.0	50.0	1	100.0	0.0	2	--	100.0	NA	--	--
• Connecticut General Life Insurance Company	1	0.0	100.0	NA	--	--	NA	--	--	1	0.0	100.0
• John Alden Life Insurance Company	NA	--	--	2	100.0	0.0	1	100.0	0.0	NA	--	--
• NC Healthchoice for Children	NA	--	--	NA	--	--	2	100.0	0.0	NA	--	--
• North Carolina Medical Society Employees Benefit Trust (MEWA)	NA	--	--	NA	--	--	1	100.0	0.0	NA	--	--
• PARTNERS National Health Plans of North Carolina	1	100.0	0.0	NA	--	--	NA	--	--	NA	--	--
• Principal Life Insurance Company	1	0.0	100.0	NA	--	--	NA	--	--	NA	--	--
• SHP Indemnity Plan	12	41.7	58.3	10	30.0	70.0	17	23.5	76.5	10	50.0	50.0
• SHP PPO Plan	NA	--	--	NA	--	--	NA	--	--	3	100.0	0.0
• Time Insurance Company	NA	--	--	1	0.0	100.0	1	0.0	100.0	NA	--	--
• Union Security Insurance Company	NA	--	--	NA	--	--	NA	--	--	1	100.0	0.0
• UnitedHealthcare of North Carolina, Inc.	NA	--	--	NA	--	--	2	0.0	100.0	6	50.0	50.0
• United Healthcare Insurance Company	1	0.0	100.0	NA	--	--	NA	--	--	NA	--	--
• WellPath Select, Inc.	2	50.0	50.0	NA	--	--	1	100.0	0.0	1	0.0	100.0

NA-Not Applicable

**Table 12: Comparison of IRO Decisions by Insurer by Calendar Year,
January 1, 2003 – December 31, 2006 (Cont.)**

IRO and Insurer	2003			2004			2005			2006		
	Number of Decisions	Outcomes		Number of Decisions	Outcomes		Number of Decisions	Outcomes		Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld									
Maximus CHDR	24			22			29			27		
• American Medical Security Life Insurance Company	NA	--	--	NA	--	--	NA	--	--	1	0.0	100.0
• Blue Cross & Blue Shield of North Carolina	5	0.0	100.0	5	40.0	60.0	7	--	100.0	7	28.6	71.4
• CIGNA HealthCare of North Carolina, Inc.	7	57.1	42.9	NA	--	--	1	100.0	0.0	NA	--	--
• Connecticut General Life Insurance Company	NA	--	--	NA	--	--	1	0.0	100.0	NA	--	--
• Coventry Health and Life Insurance Company	NA	--	--	NA	--	--	NA	--	--	1	0.0	100.0
• Federated Mutual Insurance Company	NA	--	--	1	0.0	100.0	NA	--	--	NA	--	--
• MAMSI Life and Health Insurance Company	NA	--	--	1	100.0	0.0	NA	--	--	NA	--	--
• NC Healthchoice for Children	NA	--	--	1	0.0	100.0	NA	--	--	NA	--	--
• North Carolina Medical Society Employees Benefit Trust	NA	--	--	NA	--	--	NA	--	--	1	100.0	0.0
• SHP Indemnity Plan	9	77.7	22.2	12	50.0	50.0	11	36.4	63.6	12	58.3	41.7
• Time Insurance Company	NA	--	--	1	100.0	0.0	NA	--	--	NA	--	--
• United Healthcare Insurance Company	1	100.0	0.0	NA	--	--	NA	--	--	NA	--	--
• UnitedHealthcare of North Carolina, Inc.	NA	--	--	NA	--	--	7	54.1	42.9	4	75.0	25.0
• WellPath Select, Inc.	1	0.0	100.0	1	100.0	0.0	2	100.0	0.0	1	100.0	0.0
• World Insurance	1	100.0	0.0	NA	--	--	NA	--	--	NA	--	--
MCMC	NA			NA			0			1		
• World Insurance Company	NA	--	--	NA	--	--	NA	--	--	1	0.0	100.0
NMR, Inc.	NA			NA			8			23		
• Blue Cross & Blue Shield of North Carolina	NA	--	--	NA	--	--	NA	--	--	10	40.0	60.0
• CIGNA HealthCare of North Carolina, Inc.	NA	--	--	NA	--	--	1	0.0	100.0	NA	--	--
• Guardian Life Insurance Company	NA	--	--	NA	--	--	NA	--	--	1	0.0	100.0
• North Carolina Bar Association Health Benefit Trust	NA	--	--	NA	--	--	NA	--	--	1	100.0	0.0
• SHP Indemnity Plan	NA	--	--	NA	--	--	7	28.6	71.4	10	20.0	80.0
• SHP PPO Plan	NA	--	--	NA	--	--	NA	--	--	1	0.0	100.0

NA-Not Applicable

Table 12: Comparison of IRO Decisions by Insurer by Calendar Year, January 1, 2003 – December 31, 2006 (Cont.)

IRO and Insurer	2003			2004			2005			2006		
	Number of Decisions	Outcomes		Number of Decisions	Outcomes		Number of Decisions	Outcomes		Number of Decisions	Outcomes	
		Percent Overturned	Percent Upheld									
Permedion	1			19			22			29		
• Blue Cross & Blue Shield of North Carolina	NA	--	--	5	20.0	80.0	7	28.6	71.4	7	14.3	85.7
• CIGNA Healthcare of North Carolina, Inc.	NA	--	--	2	50.0	50.0	NA	--	--	NA	--	--
• Guardian Life Insurance Company	NA	--	--	NA	--	--	NA	--	--	1	0.0	100.0
• Mutual of Omaha Insurance Company	NA	--	--	1	0.0	100.0	NA	--	--	NA	--	--
• North Carolina Medical Society Employees Benefit Trust	NA	--	--	NA	--	--	NA	--	--	1	100.0	0.0
• SHP Indemnity Plan	1	0.0	100.0	10	50.0	50.0	9	55.6	44.4	13	15.4	73.3
• Trustmark Insurance Company	NA	--	--	NA	--	--	1	0.0	100.0	NA	--	--
• UniCARE Life & Health Insurance Company	NA	--	--	NA	--	--	NA	--	--	1	0.0	100.0
• United Healthcare Insurance Company	NA	--	--	NA	--	--	1	0.0	100.0	NA	--	--
• UnitedHealthcare of North Carolina, Inc.	NA	--	--	1	0.0	100.0	4	25.0	75.0	5	40.0	60.0
• WellPath Select, Inc.	NA	--	--	NA	--	--	NA	--	--	1	100.0	0.0
Prest & Associates	1			1			NA			NA		
• MAMSI Life and Health Insurance Company	1	0.0	100.0	NA	--	--	NA	--	--	NA	--	--
• WellPath Select, Inc.	NA	--	--	1	0.0	100.0	NA	--	--	NA	--	--

NA-Not Applicable

The total number of cases for any IRO, and the number of assigned cases by insurer that were reviewed by an IRO is still too small to identify trends or make any evaluative statements.

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 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 \$900 for an expedited review. These fees are fixed per-case fees bid by each IRO; they do not vary by the type of service that is covered. An IRO may charge an insurer a cancellation fee if the insurer reverses its own decision after the IRO has proceeded with the review. Insurers were not charged a rate for review where the insurer reversed its own decision prior to the IRO review beginning. The average cost to insurers for the 107 reviews performed during 2006 was \$611. However, the average cost for all IRO reviews since the HCR Program began is \$572.

For 2006, the average amount of allowed charges assumed by the insurer in the six (6) cases where the insurer reversed its own noncertification was \$8304.00 (with a total of \$33,214.32). The average amount of allowed charges assumed by the insurer for decisions that were overturned in favor of the consumer was \$10,432 (with a total of \$385,998.16).

The average cost of allowed charges from all cases that have been reversed by the insurer or overturned by an IRO since the Program began is \$13,375. 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-	\$776,915.56
2006-	\$419,212.48

To date, the cumulative total of services provided to consumers as a result of external review since the Program commenced is \$2,247,010.09. 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 20 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 may have changed with this report as a result of capturing the cost of previously overturned services that were completed during this past year.

Figure 20: Yearly and Cumulative Value of Allowed Charges for Overturned or Reversed Services, July 1, 2002 – December 31, 2006

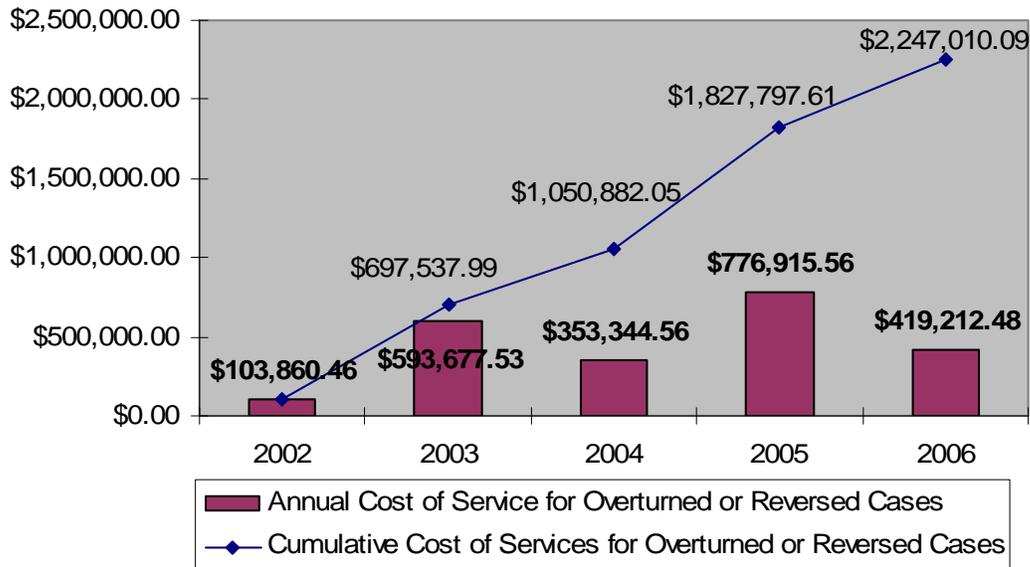


Table 13 shows the average total cost of the IRO review and cost of allowed charges for cases that were reversed by the insurer or overturned (average and cumulative) since the Program began operations, by type of service requested.

Table 13: Cost of IRO Review, Average and Cumulative Allowed Charges by Type of Service Requested, July 1, 2002 – December 31, 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	
Chiropractics	\$408	\$0	\$0	\$0
DME	566	605	5002	110,047
Emergency Treatment	0	450	1,096	1,096
Home Health Nursing	498	450	55,230	55,230
Hospital Length of Stay	530	300	788	788
Inpatient Mental Health	618	525	17,838	499,478
Inpatient Rehabilitation	450	0	0	0
Lab, Imaging, Testing	552	462	1,730	22,491
Oncology	729	738	41,511	207,557
Outpatient Mental Health	506	450	716	1,432
Pharmacy	630	573	1,990	27,860
Physician Services	528	625	1,103	6,618
Rehabilitation Services	489	500	1,948	7,794
Skilled Nursing Facility	629	525	4,245	46,696
Surgical Services*	573	556	12,550	715,351
Transplant	673	758	181,524	544,572
All Cases	\$581	\$557	\$13,375	\$2,247,010

* 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. Since the Program began on July 1, 2002, 391 surveys were sent and 219 (56%) consumers or authorized representatives responded.

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 a change in legislation to allow for consumers to receive this information in 2005.

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, 97.5 percent stated they would tell a friend about external review. While this number is to be expected, what is relevant is that 74.7 percent of the responders, whose decision was upheld, would also tell a friend about external review. As shown in Table 14, 88.1 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 14: Consumer Satisfaction Survey Analysis

Outcome of External Review	Number of Surveys Sent	Number of Surveys Received	Percentage of Respondents	Number of Respondents “would tell a friend”	Percentage of Respondents “would tell a friend”
Overturned	156	121	77.6	118	97.5
Upheld	226	91	40.3	68	74.7
Reversed	9	7	77.8	7	100.0
Total:	391	219	56.0	193	88.1

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 \$2,247,010.09.

This HCR Program Semiannual Report presents external review and consumer counseling activity data which documents the growth of the Program over the past four calendar years, as well as reporting activity and outcomes for calendar year 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. 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.

Over the last four years, the volume of external review requests has shown growth and stability. For the period of January 1, 2003 – December 31, 2006, the number of requests received per calendar year by the HCR Program ranged from a low of 201 in 2004 to 291 in 2005, with a mean of 242 cases for this four-year reporting period. The percentage of requests that have been determined to be eligible has remained constant over the four-year reporting period. For standard requests, the percentage eligible ranged from a low of 40.1 percent in 2004 to a high of 48.7 percent in 2006, with a mean of 43.2 percent of standard requests being eligible. For expedited requests, only 2.2 percent of the requests were eligible in 2006 with 6 percent of the requests eligible in 2004, and a mean of 4.8 percent eligible in the four-year reporting period.

The HCR Program became effective July 1, 2002. During the four years and six months of operation, 408 cases were accepted for review, resulting in coverage for 43.1 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.

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 HCR Program worked with 26 different insurance companies, the State Health Plan's Indemnity and PPO plans, CHIP and two Multiple Employer Welfare Arrangements (MEWAs). All complied with the time frame requirements, and were responsive and cooperative to the HCR 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 four-year reporting period, HCR Program staff provided counseling to 1,674 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 four-year reporting period have included participation in health fairs, speaking engagements, publications, and radio interviews. During this reporting period, the Commissioner of Insurance sent letters to nearly 16,000 actively practicing physicians in North Carolina, hospital business managers and physician practice administrators explaining the importance of external review services. Through the different mailings, the recipients have received external review posters for display in their patient lobby areas, Program brochures and telephone contact cards. 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 HCR 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 four 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.