



# HEALTHCARE REVIEW PROGRAM

**ANNUAL REPORT  
2010**

North Carolina Department of Insurance  
Wayne Goodwin, Commissioner



# **A REPORT ON EXTERNAL REVIEW REQUESTS IN NORTH CAROLINA**

**Healthcare Review Program  
North Carolina Department of Insurance  
Dobbs Building  
430 North Salisbury Street  
Raleigh, N.C. 27603**

**Questions about the report should be directed to:**

**Susan D. Nestor, RN, MSN  
Director  
Healthcare Review Program**

**Telephone: (919) 807 - 6860**

**Fax Number: (919) 807 – 6865**

**E-Mail: [susan.nestor@ncdoi.gov](mailto:susan.nestor@ncdoi.gov)**

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



# Table of Contents

	<b>1</b>
<b>EXECUTIVE SUMMARY</b>	<b>1</b>
<b>INTRODUCTION</b>	<b>1</b>
<b>PROGRAM SERVICES</b>	<b>2</b>
<b>CONSUMER COUNSELING</b>	<b>2</b>
<b>EXTERNAL REVIEW</b>	<b>3</b>
<b>ELIGIBILITY</b>	<b>3</b>
FIGURE 1: DISPOSITION OF EXTERNAL REVIEW REQUESTS RECEIVED IN 2010	3
FIGURE 2: REASONS FOR NON-ACCEPTANCE OF AN EXTERNAL REVIEW REQUEST IN 2010	4
	4
<b>OUTCOMES</b>	<b>4</b>
FIGURE 3: OUTCOMES OF CASES ACCEPTED FOR EXTERNAL REVIEW BY REQUEST TYPE IN 2010	5
	5
<b>ACTIVITY BY TYPE OF SERVICE REQUESTED</b>	<b>5</b>
FIGURE 4: ACCEPTED CASES BY TYPE OF SERVICE REQUESTED IN 2010	6
TABLE 1: PERCENTAGE OF OUTCOMES BY TYPE OF SERVICE REQUESTED IN 2010	7
TABLE 2: OUTCOMES OF ACCEPTED EXTERNAL REVIEW REQUESTS BY SERVICE TYPE AND NATURE OF DENIAL IN 2010	8
	8
TABLE 3: OUTCOMES OF ALL REQUESTS BY GENERAL SERVICE TYPE AND REVIEW TYPE IN 2010	9
<b>HEALTH PLAN OVERSIGHT</b>	<b>9</b>
<b>EXTERNAL REVIEW ACTIVITY BY HEALTH PLAN AND TYPE OF SERVICE</b>	<b>10</b>
FIGURE 5: HEALTH PLANS SHARE OF ACCEPTED EXTERNAL REVIEW REQUESTS IN 2010	11
TABLE 4: ACCEPTED CASE ACTIVITY BY HEALTH PLAN AND TYPE OF SERVICE REQUESTED IN 2010	12
TABLE 4: ACCEPTED CASE ACTIVITY BY HEALTH PLAN AND TYPE OF SERVICE REQUESTED IN 2010 (CONT.)	13
	13
<b>IRO OVERSIGHT</b>	<b>13</b>
<b>EXTERNAL REVIEW ACTIVITY BY IRO</b>	<b>14</b>
TABLE 5: IRO ACTIVITY SUMMARY FOR 2010	15
<b>IRO DECISIONS BY TYPE OF SERVICE REQUESTED AND HEALTH PLAN</b>	<b>15</b>
TABLE 6: ACCEPTED CASE ACTIVITY BY IRO AND TYPE OF SERVICE REQUESTED IN 2010	15
TABLE 6: ACCEPTED CASE ACTIVITY BY IRO AND TYPE OF SERVICE REQUESTED IN 2010 (CONT.)	16
TABLE 7: IRO DECISIONS BY HEALTH PLAN IN 2010	17
<b>CAPTURED COSTS ON OVERTURNED OR REVERSED SERVICES</b>	<b>17</b>
FIGURE 6: YEARLY AND CUMULATIVE VALUE OF ALLOWED CHARGES FOR OVERTURNED OR REVERSED SERVICES	18
	18
<b>COST OF EXTERNAL REVIEW CASES FOR 2010</b>	<b>19</b>
TABLE 8: COST OF IRO REVIEW, AVERAGE AND CUMULATIVE ALLOWED CHARGES	19

BY TYPE OF SERVICE REQUESTED IN 2010	19
<b><u>HCR PROGRAM EVALUATION</u></b>	<b><u>20</u></b>
<b><u>COMMUNITY OUTREACH AND EDUCATION ON EXTERNAL REVIEW AND HCR PROGRAM SERVICES</u></b>	<b><u>20</u></b>
<b><u>CONCLUSION</u></b>	<b><u>21</u></b>

## Executive Summary

The Healthcare Review Program (HCR Program or Program) became effective on 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 (Department) to assure that insureds have the opportunity for an independent medical review of denials (noncertifications) made by their health plan. The Program also counsels consumers who seek guidance and information on utilization review and internal insurer appeals and grievance issues.

In providing consumer counseling, staff explain to the consumer about their health insurers appeal process and suggest case-specific strategies to approaching the appeal and grievance processes. Additionally, staff will explain state laws that govern utilization review and the appeals and grievance process. Consumers speak with professional registered nurses who are clinically experienced and knowledgeable regarding medical denials and consumer rights under North Carolina law. HCR Program staff counseled 341 consumers during 2010.

External review is the independent medical review of a health plan denial and offers another option for resolving coverage disputes between a covered person and their health plan. Requests for external review are made directly to the Department and screened for eligibility by HCR Program staff, but the actual medical reviews are conducted by independent review organizations (IROs) that are contracted with the Department. There is no charge to the consumer for requesting an external review.

In 2010, 204 individuals requested an external review and 97 cases were accepted. Of those accepted, 72 cases were processed on a standard basis and 25 cases were processed on an expedited basis. Overall, outcomes of accepted cases were decided in favor of the consumer 48.5 percent of the time.

The HCR Program captures the cost of allowed charges for overturned or reversed services each year, as well as the cumulative charges for these services. In 2010, the average cost of allowed charges from all cases that were reversed by the health plan or overturned by an IRO was \$21,765.63 with a cumulative total for the year of \$914,156.30, with the costs of four cases yet to be captured due to the prospective nature of the services. Since July 1, 2002, the cumulative total of services provided to consumers as a result of external review is \$4,235,560.30.

The HCR Program continues to promote consumer and provider awareness of external review services through a variety of community outreach and education initiatives. 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. In 2010, 97 surveys were sent at the completion of an external review, of which 48.5 percent were completed and returned. Overall, responders were generally pleased with the customer service they receive while contacting the HCR Program. Consumers reported satisfaction with the HCR Program

staff and information about the external review process. Survey results also showed that 95.7 percent of individuals responding to the survey 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.



## Introduction

North Carolina's external review law (N. C. Gen. Stat. §§ 58-50-75 through 95) provides for the independent medical review of a health plan noncertification, and offers another option for resolving coverage disputes between the covered person and their insurer. A noncertification is a decision made by a health plan that a requested service or treatment is not medically necessary, cosmetic or experimental for the person's condition.

Nine years into operation, North Carolina's Healthcare Review Program (HCR Program or Program) continues to provide North Carolinians with the opportunity to request an independent review of their health plan's noncertification if appeals made directly to the health plan have failed to win coverage. The Program also provides consumer counseling to those who seek guidance and information on utilization review and the health plan's internal appeals and grievance processes.

In North Carolina, external review is available to persons covered under a fully insured health plan, the North Carolina State Health Plan Preferred Provider Organization plan (North Carolina SHP-PPO Plan), the North Carolina Health Choice for Children plan (thru 06/30/2010), and the North Carolina High Risk Pool (Inclusive Health).

For a request to be accepted for external review, the covered person must meet eligibility requirements. Requests for external review are made directly to the HCR Program and each case is reviewed for completeness and eligibility. If accepted for external review, the case is assigned to an independent review organization (IRO) for clinical review and final decision.

The HCR Program is staffed by a Director, two Clinical Review Analysts and an Administrative Assistant. The Program utilizes registered nurses with broad clinical, health plan and utilization review experiences to process external review requests and to enhance the Program's consumer counseling services.

The HCR Program contracts with two 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 warrants an expedited handling of the review. The consulting physician is available to consult with Program staff and review consumer requests for expedited review at all times.

The Program contracts with IROs to perform the independent medical review of external review cases. IROs are subject to many statutory requirements regarding the organization's 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.

This report, which is required under N. C. Gen. Stat. § 58-50-95, is intended to provide a summary of the Program's activities and performance for the calendar year of 2010, as it relates

to the nature and outcomes of the requests accepted for review, the health plans whose decisions are subject to review, and the IROs whose performance of the reviews are essential to the Program's successful operations. Cumulative analysis is provided for the captured costs relating to the services that have been overturned or reversed as a result of the HCR Program to demonstrate the ongoing value that is provided to North Carolina citizens.

## **Program Services**

### **Consumer Counseling**

The HCR Program staff provides consumer counseling to insureds who have received a denial from their health plan and have questions about the appeal process or may not be sure how to proceed with the appeal process. In providing counseling, Program staff explains to consumers their rights under North Carolina law, suggest resources or strategies that may be helpful to them, and explain how to use this information during the appeal process with their health insurance company.

In providing consumer counseling, staff do not give any opinions regarding the appropriateness of the requested treatment, suggest alternate modes of treatment, or provide specific detailed articles or documents that relate to the requested treatment. HCR staff will not give medical advice or prepare the consumer's case for them. Consumers requesting further assistance with the compilation or 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 North Carolina 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.

The Department operates an external review helpline (1-877-885-0231), to assist consumers in answering any questions they may have regarding the appeal process or external review services. The helpline calls are answered by the Program's clinical review analysts (professional nurses) who are knowledgeable about issues involving utilization review or insurer internal appeal and grievance processes, as well as the clinical aspects of cases. In 2010, the HCR Program received 1,405 calls from consumers asking questions about external review service, as well as those from consumers and providers seeking assistance, information and counseling relating to utilization review or a health plan's appeals and grievance process. The number of calls received by the Program this year increased 12.3 percent from 2009.

The Program counseled 341 consumers during 2010, which is an increase of 6.2 percent over the number of consumers counseled in 2009.

HCR Program staff continues to refer consumers to appropriate resources if their concern cannot be addressed by Program staff. Consumers may be referred to the Department's Consumer Services Division, the Department's Seniors' Health Insurance Information Program (SHIIP), the

United States Department of Labor, other state insurance regulatory agencies, and Federal agencies (i.e., Centers for Medicare & Medicaid Services, Office of Personnel Management and Department of Defense).

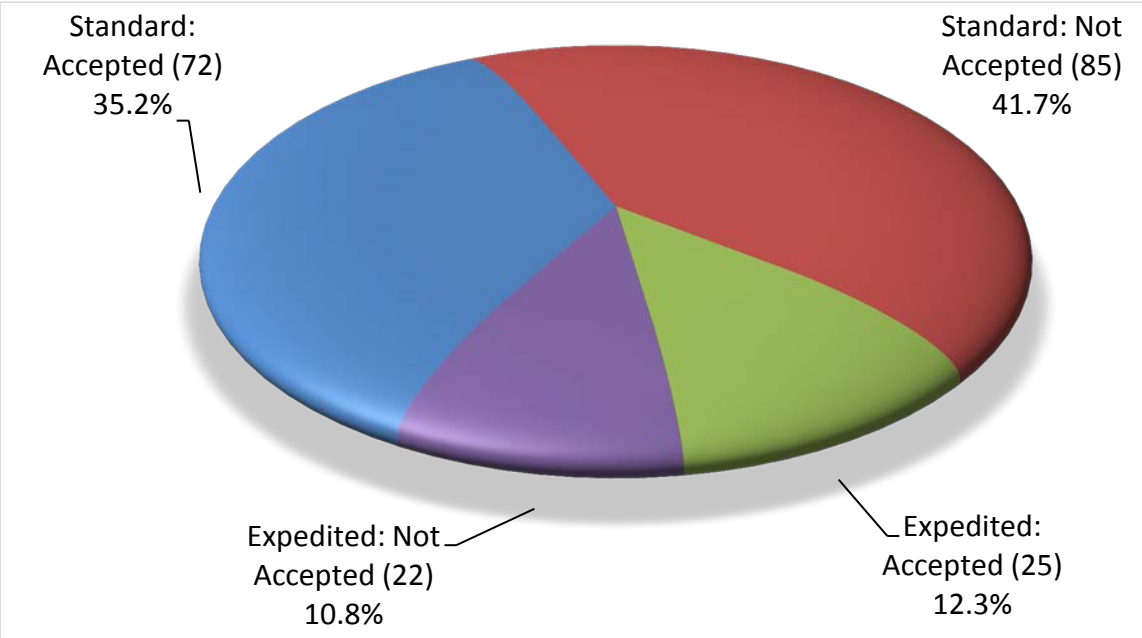
**External Review**

The HCR Program staff receives requests for external review from consumers or their authorized representative. In most cases, external review is available only after all appeals made directly to a health plan have failed to secure coverage. 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 a health plan’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 business days of the request.

**Eligibility**

During 2010, the HCR Program received 231 requests for external review. Of these requests, 27 involved a re-submission of a previously incomplete request by the same individual. Therefore, 204 individuals requested external review. Figure 1 shows the disposition of requests for external review made to the Program during 2010. During this time, 53.1 percent of the requests received by the HCR Program were determined to be eligible and were comprised of both standard and expedited requests.

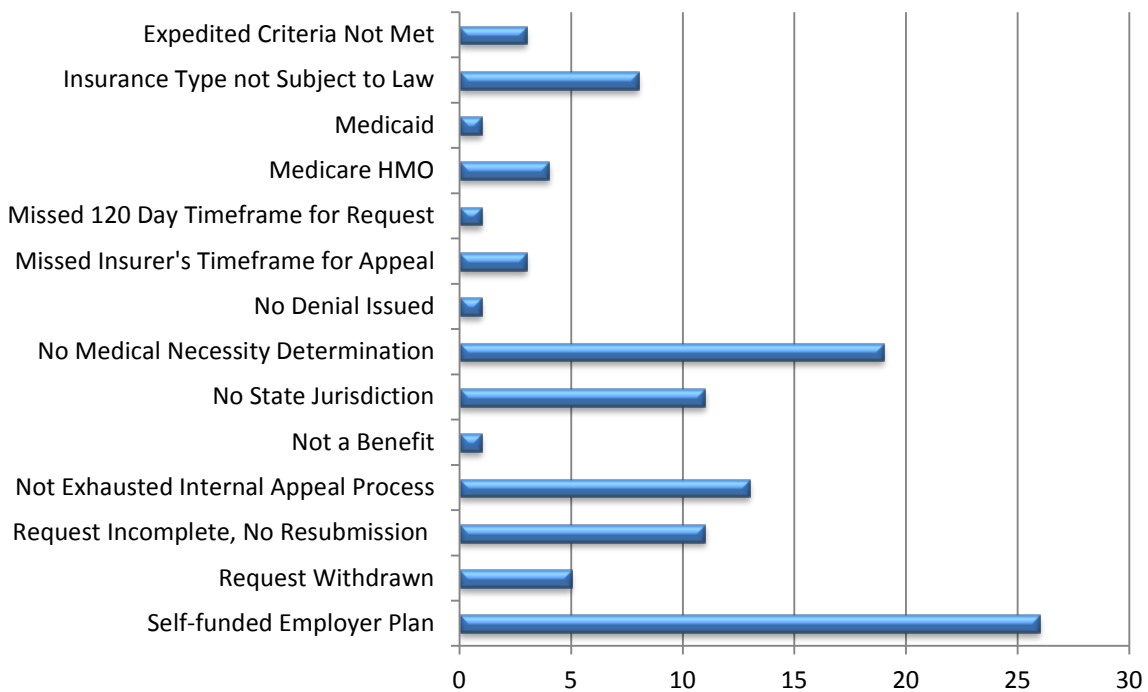
**Figure 1: Disposition of External Review Requests Received in 2010**



The reason why a case would not be accepted falls into any number of specific categories. Generally, however, a request may be deemed ineligible if the request does not meet the statutory requirements for eligibility or if the plan itself does not fall under North Carolina regulatory authority.

Figure 2 shows the number of cases that were not accepted for review and the reasons for which they were not accepted for the year 2010. During this time, of the 107 requests that were deemed to be not eligible, requests from consumers who were covered under a Self Funded employer plan were the largest group with 26 cases not accepted. Consumers who were not eligible for external review because the insurer’s denial did not represent a medical necessity denial made up the second largest group of ineligible requests with 19 cases not accepted. Requests that involved consumers who had not completed or exhausted the insurer’s internal appeal process made up the third greatest number of ineligible requests with 13 cases. These three reasons made up 54.2 percent of the cases not accepted for review.

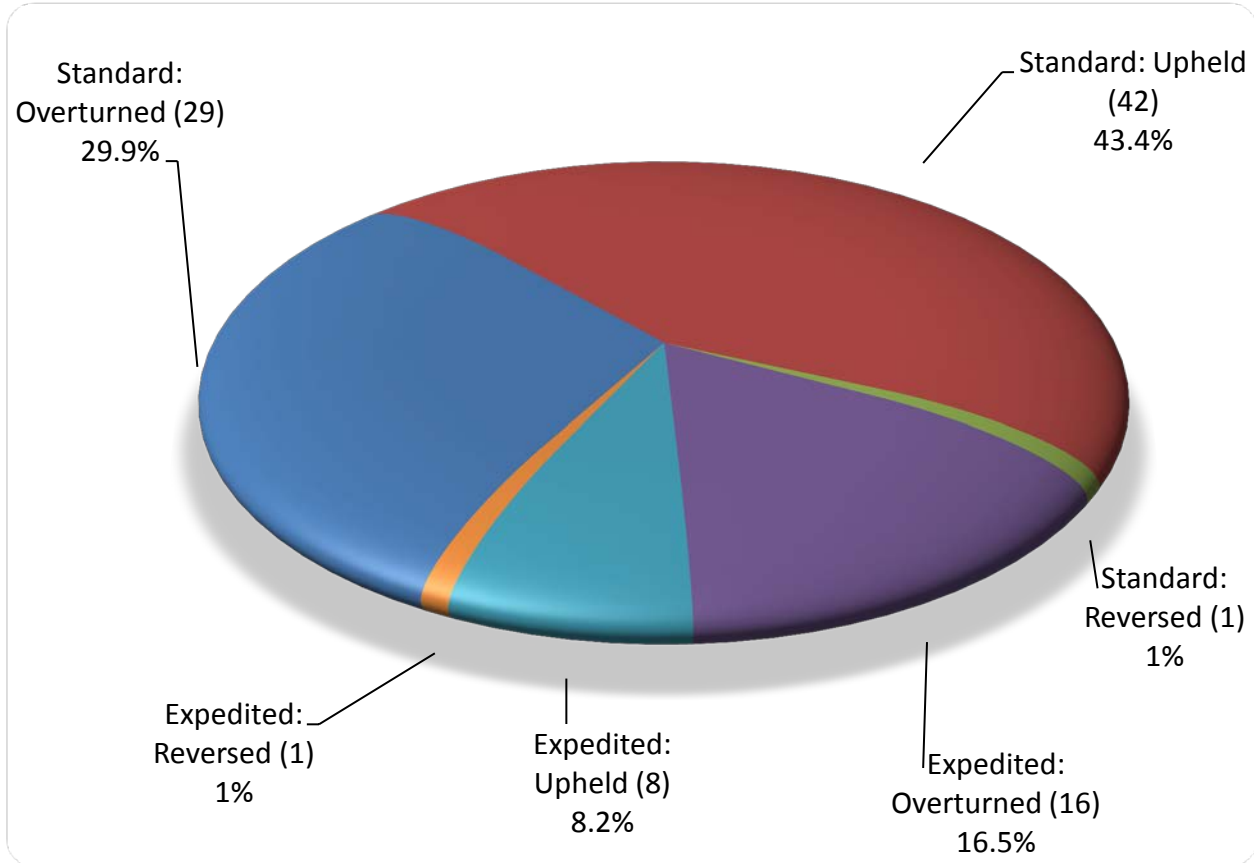
**Figure 2: Reasons for Non-Acceptance of an External Review Request in 2010**



**Outcomes**

In 2010, 97 cases were accepted for external review. Of those accepted, 72 were accepted to be processed on a standard basis. Twenty-five cases throughout the year were processed on an expedited basis. Figure 3 shows the outcomes of all cases that were accepted for review during the year 2010. Overall in 2010, cases that were accepted for external review were decided in favor of the consumer percent of the time.

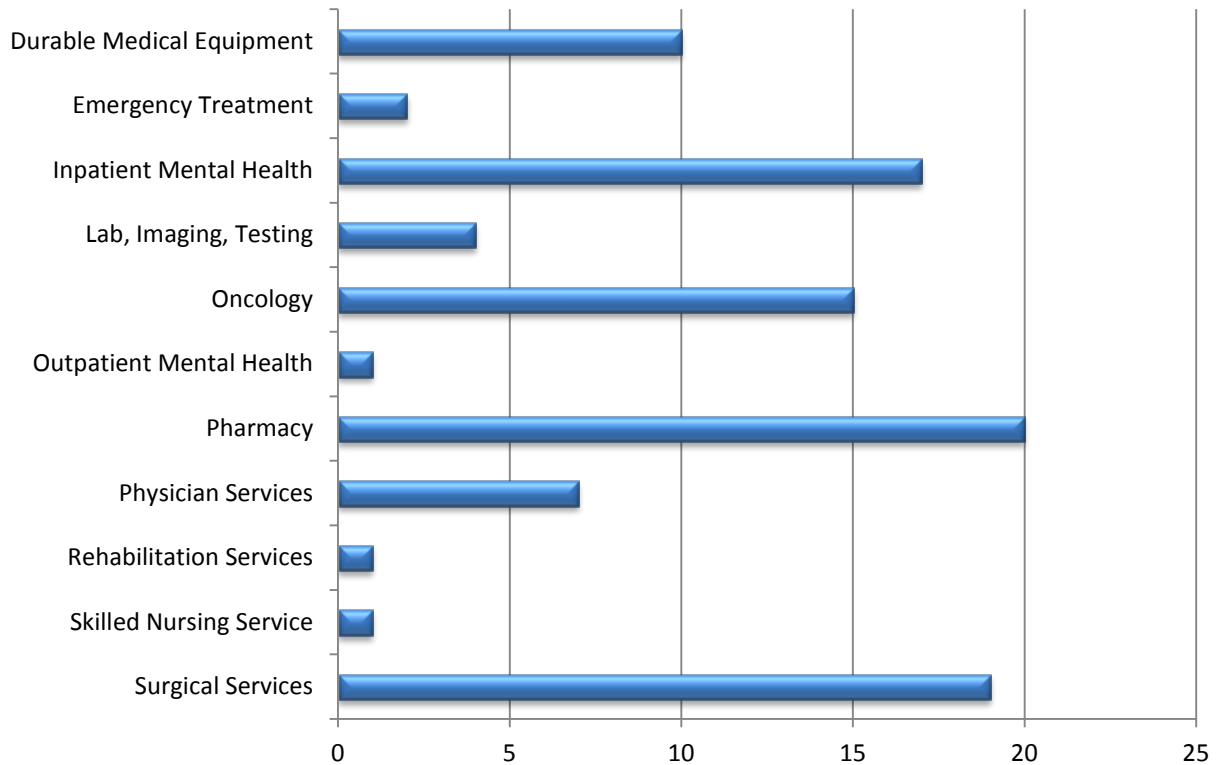
**Figure 3: Outcomes of Cases Accepted for External Review by Request Type in 2010**



**Activity by Type of Service Requested**

The HCR Program classifies accepted cases into “general” service categories. Figure 4 shows the number and percentage of accepted cases for each general service category for 2010. With 20 accepted cases, *Pharmacy* services had the largest number cases representing 20.6 percent of the cases. *Surgical Services*, representing a variety of different types of surgery, comprised 19.9 percent of the requests accepted in 2010 with 19 cases and *Inpatient Mental Health* was the third largest number of requests with 17 requests under this general category representing 17.5 percent of the requests. All together, these three general service types made up 57.7 percent of the accepted requests.

**Figure 4: Accepted Cases by Type of Service Requested in 2010**



Although the HCR Program reports primarily on the basis of the general types of services under dispute, data on specific service types relating to the request is also kept by the Program to analyze activity and identify trends. Information regarding the specific service types is available upon request to the HCR Program.

Table 1 shows the percentage of outcomes for all accepted cases by general service type as well as the percentage share of total outcomes for all services for 2010. *Pharmacy* services, the largest category of requests, was decided in favor of the consumer 50 percent of the time, due to either the IRO overturning the health plan's denial or to the health plan reversing their own denial. Requests involving *Surgical services* were decided in favor of the consumer 52.6 percent of the time. Requests made for *Inpatient Mental Health* services revealed outcomes in favor of the health plan 41.2 percent of the time.

**Table 1: Percentage of Outcomes by Type of Service Requested in 2010**

Type of Service	Percentage Overturned	Percentage Reversed	Percentage Upheld
Durable Medical Equipment	60.0	0.0	40.0
Emergency Treatment	0.0	0.0	100.0
Inpatient Mental Health	41.2	0.0	58.8
Lab, Imaging, Testing	25.0	0.0	75.0
Oncology	60.0	0.0	40.0
Outpatient Mental Health	0.0	0.0	100.0
Pharmacy	45.0	5.0	50.0
Physician Services	28.6	14.3	57.1
Rehabilitation Services	100.0	0.0	0.0
Skilled Nursing Facility	0.0	0.0	100.0
Surgical Services	52.6	0.0	47.4
<b>Percentage of Each Outcome for all Cases</b>	<b>46.4%</b>	<b>2.1%</b>	<b>51.5%</b>

Because of the types of services that are denied and the basis upon which the noncertification is issued, it is important to differentiate between a denial based solely on medical necessity and other types of noncertification decisions (i.e., experimental/investigational or cosmetic). For example, a health plan may base its denial decision only on the medical necessity of the procedure, evaluating whether the procedure meets its guidelines for appropriateness for the covered person’s condition. However, noncertifications may also include any situation where the health plan 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. Table 2 further analyzes the breakdown of case outcomes from decisions rendered by IROs as they relate to the service type and the nature of the noncertification for the year 2010.

**Table 2: Outcomes of Accepted External Review Requests by Service Type and Nature of Denial in 2010**

Service Type	Medical Necessity		Experimental / Investigational		Cosmetic Services	
	Overturned/ Reversed	Upheld	Overturned/ Reversed	Upheld	Overturned/ Reversed	Upheld
Durable Medical Equipment	3	2	3	2	0	0
Emergency Treatment	0	2	0	0	0	0
Inpatient Mental Health	7	10	0	0	0	0
Lab, Imaging, Testing	1	1	0	2	0	0
Oncology	0	0	9	6	0	0
Outpatient Mental Health	0	1	0	0	0	0
Pharmacy	6	8	4	2	0	0
Physician Services	1	1	2	3	0	0
Rehabilitation Services	1	0	0	0	0	0
Skilled Nursing Facility	0	1	0	0	0	0
Surgical Services	5	1	5	6	0	2
<b>Percentage of Outcomes</b>	<b>24.7%</b>	<b>27.8%</b>	<b>23.7%</b>	<b>21.6%</b>	<b>0.0%</b>	<b>2.0%</b>
<b>Percentage of All Cases:</b>	<b>52.6%</b>		<b>45.4%</b>		<b>2.0%</b>	

In 2010, 52.6 percent of the cases decided by IROs involved the medical necessity of the procedure. The remainder of the cases primarily involved whether the service was considered to be experimental or investigational for the patient’s condition, with 45.4 percent of the cases decided on the experimental or investigational nature of the treatment and only 2 percent decided on whether the services were considered to be cosmetic.

Almost all of the general service types, except *Oncology* involved a medical necessity determination by the insurer. Cases involving *Inpatient Mental Health* (17) and *Pharmacy* (14) represented the categories with the most number of cases decided on the merits of medical necessity. Cases involving a determination by the insurer that the service is experimental or investigational involved almost the entire spectrum of case types. *Oncology* service, with 17 cases, involved the highest number of cases with an experimental denial. *Surgical Services* with 11 cases and *Pharmacy*, with 6 cases, also were denied for experimental reasons. There were only two cases in 2010 that were denied due to the insurer’s decision that the service was cosmetic in nature and they both involved *Surgical Services*.

In 2010, the majority of cases that were accepted for review were those that were requested on a standard basis, with 74.2% of all cases falling into this 45 day time frame for processing cases.



Table 3 shows the outcomes of cases by the general type of service by type of review requested. The largest number of expedited cases fell into the general service type categories of *Oncology* with *Pharmacy* case types having the second largest number at eight. Standard cases involved all general service category types.

**Table 3: Outcomes of all Requests by General Service Type and Review Type in 2010**

Service Type	Standard Review		Expedited Review	
	Overturned/ Reversed	Upheld	Overturned/ Reversed	Upheld
Durable Medical Equipment	6	4	0	0
Emergency Treatment	0	2	0	0
Inpatient Mental Health	7	9	0	1
Lab, Imaging, Testing	1	3	0	0
Oncology	0	1	9	5
Outpatient Mental Health	0	1	0	0
Pharmacy	4	8	6	2
Physician Services	3	4	0	0
Rehabilitation Services	1	0	0	0
Skilled Nursing Facility	0	1	0	0
Surgical Services	8	9	2	0
Percentage of Case Volume	74.2%		25.8%	

### Health Plan Oversight

The external review laws place several requirements on health plans. Health plans are required to provide notice of external review rights to covered persons in their noncertification decisions and notices of decision on appeals and grievances. Health plans are also required to include a description of external review rights and external review process in their certificate of coverage or policy language. When the HCR Program receives a request for external review, the health plan is required to provide requested information to the Program within statutory time frames, so that an eligibility determination can be made. When a case is accepted for review, the health plan 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 health plan 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 health plan must provide notification that payment or coverage will be provided. This notice must be sent to the covered person and

their provider, as well as the Program, and is required to be sent within three business days in the case of a standard review decision and one calendar day in the case of an expedited review decision. The Program then monitors the payment status of the claims.

Additionally, the HCR Program acts as the liaison between health plans and IROs for invoicing and payment of IRO services. As set forth in N. C. Gen. Stat. § 58-50-92, the health plan whose denial decision is the subject of the review provides payment to the IRO for conducting the external review to the Department. This may include a cancellation fee for work performed by the IRO for a case that was terminated prior to the health plan notifying the organization of the reversal of its own noncertification decision, or when a review is terminated because the health plan failed to provide information to the review organization. As the entity that is contracted with the IROs, it is the responsibility of the Department to insure that IROs are paid in a timely manner for their services. Weekly auditing of health plan compliance with payment for IRO services is conducted by the Program.

The Program's experience to date has been that health plans are compliant with the handling of external review cases and are meeting their statutory obligations with respect to deadlines and payment notifications.

#### **External Review Activity by Health Plan and Type of Service**

Of the 97 cases that were accepted for external review in 2010, cases originating from Blue Cross Blue Shield of North Carolina (36), the North Carolina SHP-PPO Plan (31) and United Healthcare Insurance Company (12), comprised 81.4 percent of the external review activity. Ten other health plans made up the remaining 18.6 percent of cases. Of these remaining health plans, WellPath Select, Inc. had six cases and North Carolina Health Choice for Children had three cases. The North Carolina Health Choice for Children plan was removed from under the State Health Plan's administration and was placed under the administration of the Department of Medical Assistance as of October 1, 2010. At that time, they were no longer subject to North Carolina's external review laws.

The volumes for insurers and health plans are consistent with the numbers of accepted cases that the larger plans have had in past years. The percentage share of health plan activity for 2010 is depicted in Figure 5.

**Figure 5: Health Plans Share of Accepted External Review Requests in 2010**

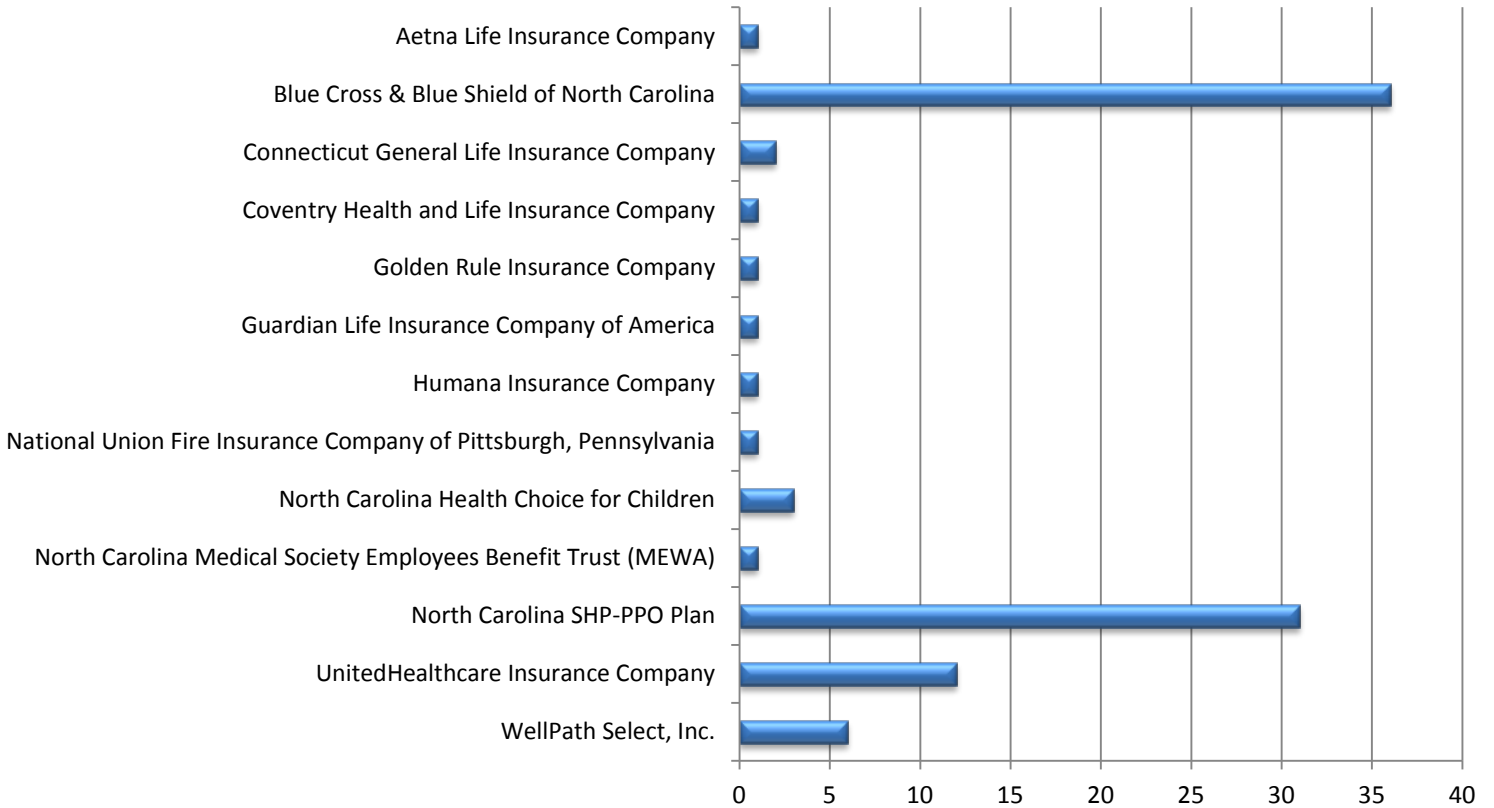


Table 4 demonstrates the outcomes of external review activity by the health plan whose decision is subject to review and the general type of service that the denial involved. This data is presented for informational purposes only. The number of requests per health plan is too small to draw any conclusions or identify trends as it relates to the health plan and the type of service that was denied. Blue Cross & Blue Shield of North Carolina’s decisions were decided in favor of the consumer by IROs 51.4 percent of the time with 18 cases overturned by an IRO. The North Carolina SHP PPO Plan’s decisions were decided in favor of the consumer by IROs 54.8 percent of the time and United Healthcare Insurance Company’s cases were decided in favor of the consumer 50 percent of the time.

Because an IRO is not involved in the outcome decision when a health plan reverses their own denial, this table only includes those 95 cases that were decided by an IRO.

**Table 4: Accepted Case Activity by Health Plan and Type of Service Requested in 2010**

Health Plan and Type of Service	Number of Requests	Percentage Overturned	Percentage Upheld
<b>Aetna Life Insurance Company</b>	<b>1</b>		
• Inpatient Mental Health	1	100.0	--
Total Percentage for Health Plan		<b>100.0</b>	--
<b>Blue Cross Blue Shield of North Carolina</b>	<b>35</b>		
• Durable Medical Equipment	6	50.0	50.0
• Inpatient Mental Health	4	25.0	75.0
• Oncology	3	100.0	--
• Pharmacy	6	50.0	50.0
• Physician Services	5	20.0	80.0
• Surgical Services	11	63.6	36.4
Total Percentage for Health Plan		<b>51.4</b>	<b>48.6</b>
<b>Connecticut General Life Insurance Company</b>	<b>2</b>		
• Inpatient Mental Health	1	100.0	--
• Lab, Imaging, Testing	1	--	100.0
Total Percentage for Health Plan		<b>50.0</b>	<b>50.0</b>
<b>Coventry Health and Life Insurance Company</b>	<b>1</b>		
• Oncology	1	--	100.0
Total Percentage for Health Plan		--	<b>100.0</b>
<b>Golden Rule Insurance Company</b>	<b>1</b>		
• Surgical Services	1	--	100.0
Total Percentage for Health Plan		--	<b>100.0</b>
<b>Guardian Life Insurance Company of America</b>	<b>1</b>		
• Inpatient Mental Health	1	--	100.0
Total Percentage for Health Plan		--	<b>100.0</b>
<b>National Union Fire Insurance Company of Pittsburgh, Pennsylvania</b>	<b>1</b>		
• Emergency Treatment	1	--	100.0
Total Percentage for Health Plan		--	<b>100.0</b>
<b>North Carolina Health Choice for Children</b>	<b>3</b>		
• Lab, Imaging, Testing	1	--	100.0
• Pharmacy	2	--	100.0
Total Percentage for Health Plan		--	<b>100.0</b>
<b>North Carolina Medical Society Employees Benefit Trust (MEWA)</b>	<b>1</b>		
• Surgical Services	1	100.0	--
Total Percentage for Health Plan		100.0	--

**Table 4: Accepted Case Activity by Health plan and Type of Service Requested in 2010  
(Cont'd.)**

Health Plan and Type of Service	Number of Requests	Percentage Overturned	Percentage Upheld
<b>North Carolina SHP-PPO</b>	<b>31</b>		
• Durable Medical Equipment	3	66.7	33.3
• Inpatient Mental Health	4	50.0	50.0
• Oncology	10	60.0	40.0
• Outpatient Mental Health	1	--	100.0
• Pharmacy	7	57.1	42.9
• Rehabilitation Services	1	100.0	--
• Skilled Nursing Services	1	--	100.0
• Surgical Services	4	50.0	50.0
Total Percentage for Health Plan		<b>54.8</b>	<b>45.2</b>
<b>UnitedHealthcare Insurance Company</b>	<b>12</b>		
• Durable Medical Equipment	1	100.0	--
• Inpatient Mental Health	5	40.0	60.0
• Pharmacy	4	50.0	50.0
• Physician Services	1	100.0	--
• Surgical Services	1	--	100.0
Total Percentage for Health Plan		<b>50.0</b>	<b>50.0</b>
<b>WellPath Select, Inc.</b>	<b>6</b>		
• Emergency Treatment	1	--	100.0
• Inpatient Mental Health	1	--	100.0
• Lab, Imaging, Testing	2	50.0	50.0
• Oncology	1	--	100.0
• Surgical Services	1	--	100.0
Total Percentage for Health Plan		<b>14.3</b>	<b>85.7</b>

### **IRO Oversight**

The Program currently contracts with four IROs-- MAXIMUS CHDR, Medwork of Wisconsin, Inc., Michigan Peer Review Organization (MPRO) and National Medical Review, Inc. (NMR). All IROs that are contracted with the Program to provide independent external reviews are companies that were determined via the solicitation and evaluation 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 an external review.

IROs are contracted to perform an independent medical review of contested health plan noncertifications. Specifically, the scope of service for the IRO is to:

- Accept assignment of cases from a wide variety of health plans 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 updates regarding their business relationships, as requested by the Department.

The HCR Program is responsible for monitoring IRO compliance with statutory requirements on a continual basis. HCR Program staff screens 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.

When a case is assigned to an IRO for a determination, the IRO must render a decision within the time frames mandated under North Carolina law. For a standard review, the decision must be rendered by the 45<sup>th</sup> calendar day following the date of the HCR Program's receipt of the request. For an expedited request, the IRO has until the 4<sup>th</sup> business day following the HCR Program's receipt of the request. The HCR Program audits 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. All decisions have been rendered within the required time frames.

### **External Review Activity by IRO**

Although 97 cases were accepted for external review during this period, two cases were reversed by the health plan prior to an IRO decision being rendered, so reporting on IRO activity will represent only those 95 cases actually reviewed by an IRO. Table 5 compares the number of cases assigned to each IRO that held a contract with the Program throughout the year, with the percentage of their review decisions for the year 2010. The outcome of cases reviewed by IROs was decided in favor of the consumer 47.4 percent of the time during 2010, which is consistent with outcomes measured in previous years.

**Table 5: IRO Activity Summary for 2010**

IRO	Number Assigned	Percentage Overturned	Percentage Upheld
Maximus CHDR	28	71.4	28.6
Medwork of Wisconsin, Inc.	20	30.0	70.0
MPRO	20	55.0	45.0
NMR, Inc.	27	29.6	70.4
<b>Total and Percentage of Outcomes for All Cases</b>	<b>95</b>	<b>47.4</b>	<b>52.6</b>

**IRO Decisions by Type of Service Requested and Health Plan**

During 2010, four IROs rendered 95 external review decisions for consumers: Maximus CHDR, Medwork of Wisconsin, Inc., MPRO, and NMR. External review cases are not assigned to an IRO if the IRO has a conflict of interest involving the health plan whose decision is the subject of the review or if the IRO does not have an appropriate reviewer available to whom they would assign the case. Table 6 breaks down the number of cases involving the general service type that each IRO reviewed for the calendar year 2010. This table only gives an accounting of the cases assigned and does not analyze outcomes by virtue of the type of noncertification issued. This data is presented as informational only as the overall number of cases does not allow for trends to be identified or assumptions to be made.

**Table 6: Accepted Case Activity by IRO and Type of Service Requested in 2010**

IRO and Type of Service	Number of Accepted Cases	Percentage Overturned	Percentage Upheld
<b>Maximus CHDR</b>	<b>28</b>		
• Durable Medical Equipment	2	100.0	--
• Emergency Treatment	1	--	100.0
• Inpatient Mental Health	3	66.7	33.3
• Lab, Imaging, Testing	2	50.0	50.0
• Oncology	10	90.0	10.0
• Pharmacy	5	60.0	40.0
• Physician Services	1	100.0	--
• Rehabilitation Services	1	100.0	--
• Surgical Services	3	33.3	66.67
<b>All Services:</b>		<b>71.4</b>	<b>28.6</b>

**Table 6: Accepted Case Activity by IRO and Type of Service Requested in 2010 (Cont.)**

<b>IRO and Type of Service</b>	<b>Number of Accepted Cases</b>	<b>Percentage Overturned</b>	<b>Percentage Upheld</b>
<b>Medwork of Wisconsin, Inc.</b>	<b>20</b>		
• Durable Medical Equipment	3	33.3	66.7
• Inpatient Mental Health	8	37.5	62.5
• Lab, Imaging, Testing	1	--	100.0
• Pharmacy	2	--	100.0
• Physician Services	2	50.0	50.0
• Surgical Services	4	25.0	75.0
<b>All Services:</b>		<b>30.0</b>	<b>70.0</b>
<b>MPRO</b>	<b>20</b>		
• Durable Medical Equipment	2	100.0	--
• Inpatient Mental Health	4	--	100.0
• Pharmacy	7	57.1	42.9
• Physician Services	2	--	100.0
• Surgical Services	5	100.0	--
<b>All Services:</b>		<b>55.0</b>	<b>45.0</b>
<b>NMR</b>	<b>27</b>		
• Durable Medical Equipment	3	33.3	66.7
• Emergency Treatment	1	--	100.0
• Inpatient Mental Health	2	100.0	--
• Lab, Imaging, Testing	1	--	100.0
• Oncology	5	--	100.0
• Outpatient Mental Health	1	--	100.0
• Pharmacy	5	40.0	60.0
• Physician Services	1	--	100.0
• Skilled Nursing Services	1	--	100.0
• Surgical Services	7	42.9	57.1
<b>All Services:</b>		<b>29.6</b>	<b>70.4</b>

Table 7 shows each IRO's decisions by health plan for the year 2010. The total number of cases for any IRO, and the number of assigned cases by health plan that were reviewed by an IRO is still too small to identify trends or make any evaluative statements.



**Table 7: IRO Decisions by Health plan in 2010**

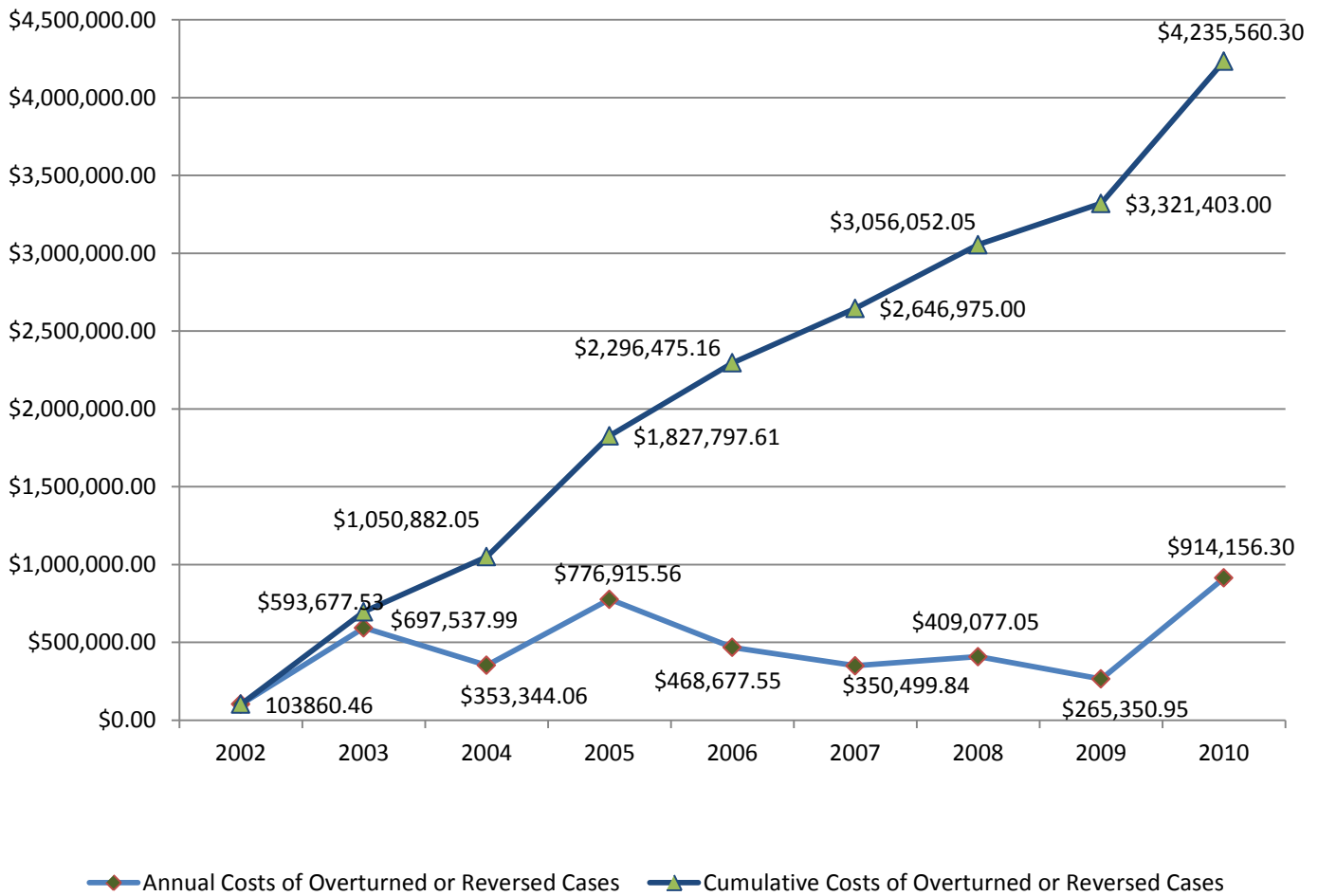
<b>IRO and Health plan</b>	<b>Number of Decisions</b>	<b>Percentage Overturned</b>	<b>Percentage Upheld</b>
<b>Maximus CHDR</b>	<b>28</b>		
• Blue Cross Blue Shield of North Carolina	6	100.0	--
• Guardian Life Insurance company of America	1	--	100.0
• North Carolina Health Choice for Children	2	--	100.0
• North Carolina SHP-PPO	12	66.7	33.3
• United Healthcare Insurance Company	5	80.0	20.0
• WellPath Select, Inc.	2	50.0	50.0
<b>All Health plans:</b>		<b>71.4</b>	<b>28.6</b>
<b>Medwork of Wisconsin, Inc.</b>	<b>20</b>		
• Aetna Life Insurance Company	1	100.0	--
• Blue Cross & Blue Shield of North Carolina	8	25.0	75.0
• Connecticut General Life Insurance Company	2	50.0	50.0
• North Carolina Medical Society Employees Benefit Trust (MEWA)	1	100.0	--
• North Carolina SHP-PPO	4	25.0	75.0
• United Healthcare Insurance Company	2	--	100.0
• WellPath Select, Inc.	2	--	100.0
<b>All Health plans:</b>		<b>46.2</b>	<b>53.8</b>
<b>MPRO</b>	<b>20</b>		
• Blue Cross Blue Shield of North Carolina	11	54.5	45.5
• North Carolina SHP-PPO	5	60.0	40.0
• United Healthcare Insurance Company	4	50.0	50.0
<b>All Health plans:</b>		<b>57.1</b>	<b>42.9</b>
<b>NMR</b>	<b>27</b>		
• Blue Cross & Blue Shield of North Carolina	10	40.0	60.0
• Coventry Health and Life Insurance Company	1	--	100.0
• Golden Rule Insurance Company	1	--	100.0
• National Union Fire Insurance Company of Pittsburgh, Pennsylvania	1	--	100.0
• North Carolina Health Choice for Children	1	--	100.0
• North Carolina SHP-PPO	10	40.0	60.0
• United Healthcare Insurance Company	1	--	100.0
• WellPath Select, Inc.	2	--	100.0
<b>All Health plans:</b>		<b>29.6</b>	<b>70.4</b>

## Captured Costs on Overturned or Reversed Services

Figure 6 shows the total 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. In 2010, consumers received \$914,156.30 worth of services that otherwise would have been

denied but for the Program’s assistance. While this amount alone may reflect the value that the HCR Program brings to consumers, the data presented in its cumulative form shows that North Carolina consumers have been provided with over \$4 million worth of services since the Program began and demonstrates the ongoing value that the Program provides. This chart is reflective of the concurrent and retrospective costs for services that were denied. It does not account for 11 cases from 2010 that have been overturned but the claims have not yet been captured due to the prospective nature of the services.

**Figure 6: Yearly and Cumulative Value of Allowed Charges for Overturned or Reversed 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.

The average cost of allowed charges per year from all cases that have been reversed by the health plan or overturned by an IRO since the Program began is \$470,618.

## Cost of External Review Cases for 2010

Table 8 shows the average cost of the IRO review and cost of allowed charges for cases that were reversed by the health plan or overturned (average and cumulative) in 2010, by type of service requested. The totals include the IRO charges for all 95 cases decided by an IRO, but the average and cumulative figures do not include the costs associated with three cases in 2009 whose costs have yet to be captured due to the prospective nature of the service.

**Table 8: Cost of IRO Review, Average and Cumulative Allowed Charges  
By Type of Service Requested in 2010**

Type of Service	Average Cost of IRO Review	Average Cost of Service	Cumulative Cost of Service
Durable Medical Equipment	\$608.50	\$ 2,552.75	\$ 15,316.51
Emergency Services	580.00	0.00	0.00
Inpatient Mental Health	617.06	22,933.92	137,603.50
Lab, Imaging, Testing	576.25	1,613.74	1,613.74
Oncology	818.00	27,079.01	243,711.05
Outpatient Mental Health	690.00	0.00	0.00
Pharmacy	680.00	54,497.26	381,480.79
Physician Services	593.33	944.54	2,833.62
Rehabilitation Services	470.00	3,583.80	3,583.80
Skilled Nursing Facility	690.00	0.00	0.00
Surgical Services	641.84	14,223.70	128,013.29
<b>Total for All Cases</b>	<b>\$661.00</b>	<b>\$21,765.63</b>	<b>\$914,156.30</b>

Currently, contracted fees for IRO services are between \$470 and \$690 for a standard review, and \$800 and \$895 for an expedited review. These fees are fixed per-case fees bid by each IRO; they do not vary by the type of service that is covered. The average cost to health plans for the 95 reviews performed during 2010 was \$661.

An IRO may charge a health plan a cancellation fee if the health plan reverses its own decision after the IRO has proceeded with the review. These charges range from \$150 to \$395 for a standard review and \$205 to \$395 for an expedited review.

## HCR Program Evaluation

The HCR Program continues to utilize its consumer satisfaction survey with all accepted cases in order to obtain feedback from consumers regarding the external review experience. A consumer satisfaction survey is mailed to the consumer or authorized representative at the completion of each accepted case. In 2010, 97 surveys were sent at the completion of an external review, of which 48.5 percent were completed and returned. Overall, responders were generally pleased with the customer service they receive while contacting the HCR Program. Consumers reported satisfaction with the HCR Program staff and information about the external review process. Survey results also showed that 95.7 percent of individuals responding to the survey 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.

## Community Outreach and Education on External Review and HCR Program Services

The HCR Program began 2010 with a new look and verbiage on the Department's web site to inform and educate consumers about the availability of external review services. The new verbiage posed the questions: **HEALTH CLAIM DENIED?** This question was accompanied by the Program's toll-free number for consumers to call in on the External Review Helpline to request a review or to seek assistance with their insurer's internal appeals process. Other changes to the Program's web site information included adding a new icon to the consumer external review home page titled "Request A Speaker". HCR staff are available to speak with groups about health insurance coverage and what to do if their insurance company denies their claim.

The HCR Program continued to use the Department's HCR Facebook page as a vehicle for posting health care articles, program updates, participation in health fairs and program successes to consumers. In 2010, data collected on the HCR Facebook page showed that there were 4990 views. Other outreach activities in 2010 included a DVD mailing project to approximately 100 health care organizations and advocacy groups informing them about the services available through the HCR Program. The HCR Program also completed a targeted mailing to 600 mental health and substance abuse providers informing them of the availability of HCR Program services. The mailing included a letter detailing program services, a program brochure and bookmark. The HCR Program also has information about external review and consumer counseling posted on the NC Medical Society web site; this provides a vehicle for informing providers and their staff about the availability of these services for their patients. Additional outreach and education initiatives included presentations to professional groups, radio interviews and participation in the Department's employee health benefit fair.

The HCR staff continues to promote consumer and provider awareness of external review and consumer counseling services through a variety of outreach and education strategies. While insurers' are statutorily required to notify consumers of their right to external review whenever

the insurer issues a noncertification decision, an appeal decision upholding a noncertification, and a second-level grievance review decision upholding the original decision, HCR staff seek opportunities to participate in events that will promote awareness of Program services.

## **Conclusion**

Since the Program's inception nine years ago, consumers and authorized representatives acting on behalf of consumers have accessed the HCR Program seeking information or counseling on utilization review and internal insurer appeal and grievance procedures or external review services. Feedback we receive from consumers and providers is very positive regarding their external review experience, and interaction with the Healthcare Review staff. The Department believes that public faith in the integrity of the external review process is absolutely essential; the very foundation of an external review is to provide an unbiased way to resolve coverage disputes between a covered person and their health plan. While not all consumers receive the outcome they hoped for, their feedback regarding the external review process remains favorable.

The Program remains an important resource for North Carolina consumers and has provided measurable value to the lives of North Carolinians. To date, the Program has provided services that have resulted in consumers obtaining over \$4,235.560 worth of services that had been denied by their health plan.

The HCR Program will continue to track external review results and trends. The Department and HCR Program staff will also continue to monitor developments on the state and federal level which could impact patient protections in North Carolina. The Department is committed to assuring that consumers are informed and are able to access the critical protections that North Carolina's external review law provides.