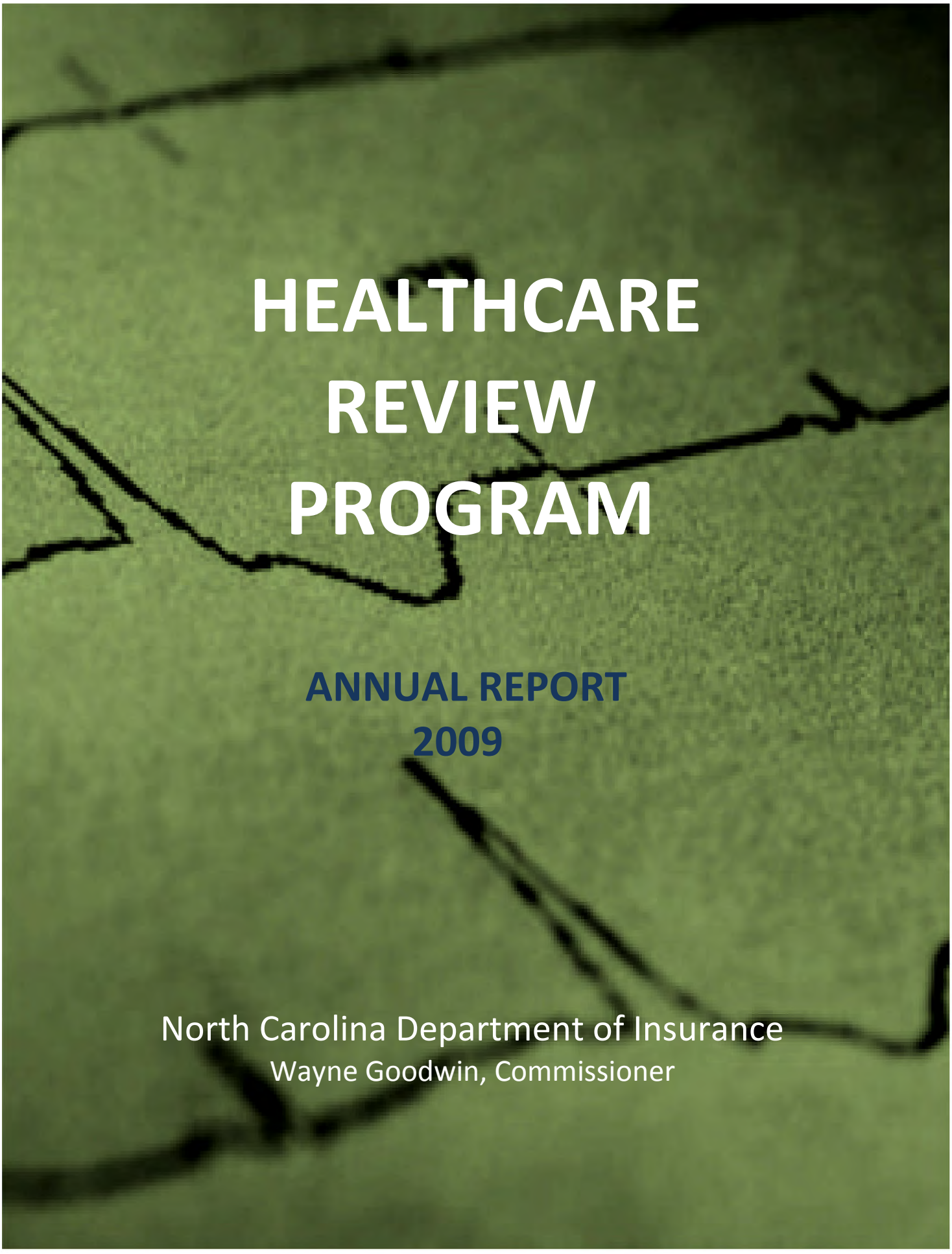

HEALTHCARE REVIEW PROGRAM

ANNUAL REPORT 2009

North Carolina Department of Insurance
Wayne Goodwin, Commissioner

A REPORT ON EXTERNAL REVIEW REQUESTS IN NORTH CAROLINA

Healthcare Review Program

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All Healthcare Review Program reports are available on the N. C. Department of Insurance web site at: www.ncdoi.com

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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 321 consumers during 2009.

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 2009, 147 individuals requested an external review and 78 cases were accepted. Of those accepted, 67 cases were processed on a standard basis and 11 cases were processed on an expedited basis. Overall, outcomes of accepted cases were decided in favor of the consumer 44.9 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 2009, the average cost of allowed charges from all cases that were reversed by the health plan or overturned by an IRO was $7,753.35 with a cumulative total for the year of $248,107.22, with the costs of three 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 $3,304,160.27.

The HCR Program continues to promote consumer and provider awareness of external review services through a variety of community outreach and education initiatives. In 2009, HCR Program staff, working with the Department's Public Information Office, produced a web-based video about external review and consumer counseling services available through the HCR Program. The Program staff also created a Facebook page as another vehicle to communicate program updates, post consumer comments and announce upcoming community events where HCR staff will be available to discuss program services. Other

outreach activities included a letter from the Commissioner of Insurance to members of the North Carolina Senate and House of Representatives regarding the availability of consumer counseling on the health insurer appeals process and external review services through the HCR Program. An electronic letter detailing HCR Program services was emailed to the legislative assistants of the North Carolina General Assembly and to the health benefit representatives of North Carolina state agencies.

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 2009, 76 surveys were sent at the completion of an external review, of which 44.7 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 81.1 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.

Entering its eighth year of 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, 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 2009, 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 provide 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 2009, the HCR Program received 1,251 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 15.5 percent from 2008.

The Program counseled 321 consumers during 2009, which is an increase of 8 percent over the number of consumers counseled in 2008. Of those individuals, 75.1 percent involved direct or indirect consumer counseling on appeals and grievance issues. The remainder of the calls involved:

- Health plan's handling of claim payment.
- Issues relating to insurance other than a health benefit plan.
- Denials made by self-funded employer plans regulated under the Employee Retirement Income Security Act (ERISA).
- Network access.
- Health plans regulated by states other than North Carolina.
- Insurance coverage issues.
- Pre-existing condition issues.
- Coordination of benefits issues.
- Insurance policy benefits and premium concerns.
- General information regarding external review services.
- Legislative referrals made to the HCR Program from the offices of state and federal elected officials.

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

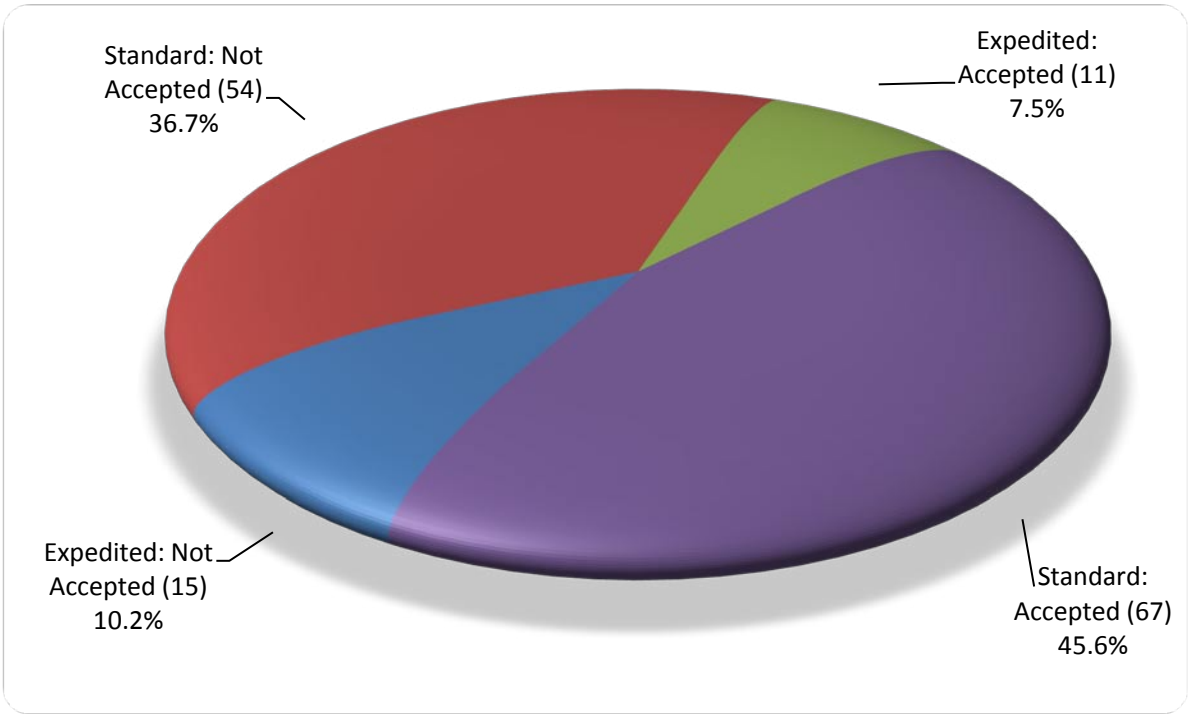
The HCR Program staff receives requests for external review from consumers or their authorized representative. In most cases, external review is available only after all appeals made directly to a health plan have failed to secure coverage. Through September 30, 2009, requests for an external review of a health plan's decision had to be made to the Program within 60 days of receiving a denial decision from the health plan. Changes to N.C. Gen. Stat. § 58-50-80 (a), allows for a request to be made within 120 days after receiving a denial letter after the effective date of October 1, 2009. 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 2009, the HCR Program received 166 requests for external review. Of these requests, 19 involved a re-submission of a previously incomplete request by the same individual. Therefore, 147 individuals requested external review. Figure 1 shows the disposition of requests for external review made to the Program during 2009. 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.

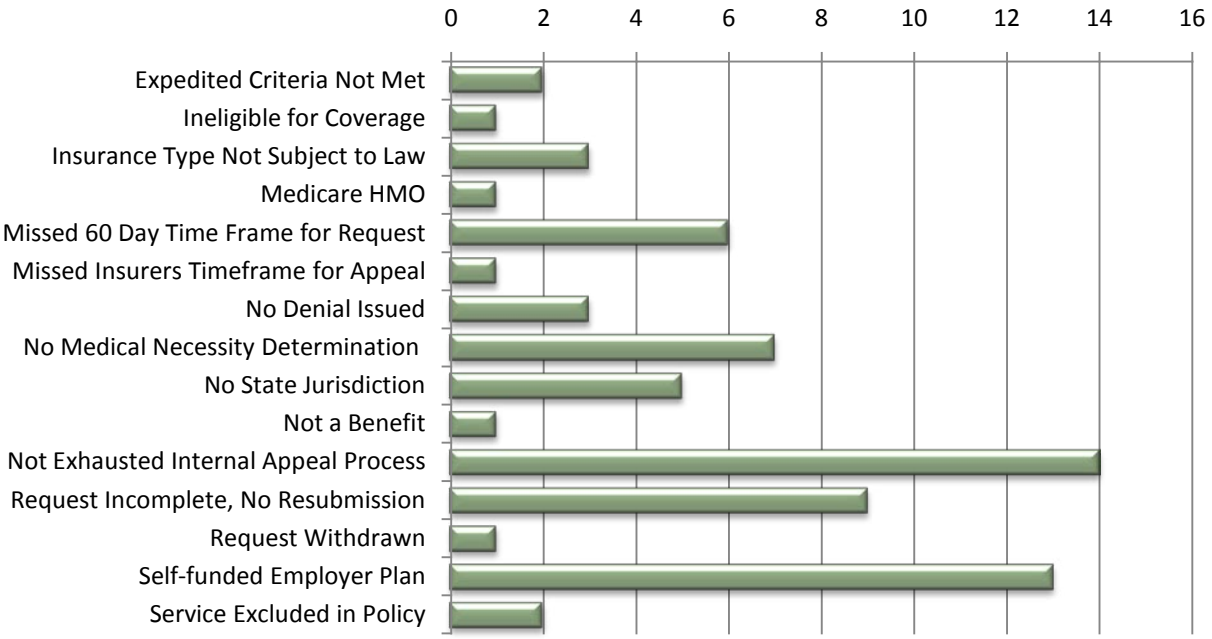
Figure 1: Disposition of External Review Requests Received in 2009



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 2009. During this time, of the 69 requests that were deemed to be not eligible, requests from consumers who had not fully exhausted the health plan's internal appeals process prior to requesting external review were the largest group with 14 cases not accepted. Consumers who were not eligible for external review because they were covered under a self-funded employer plan made up the second largest group of ineligible requests with 13 cases not accepted. Requests that involved an incomplete request with no subsequent resubmission of a complete request made up the third greatest number of ineligible requests with 9 cases. These three reasons made up 52.2 percent of the cases not accepted for review.

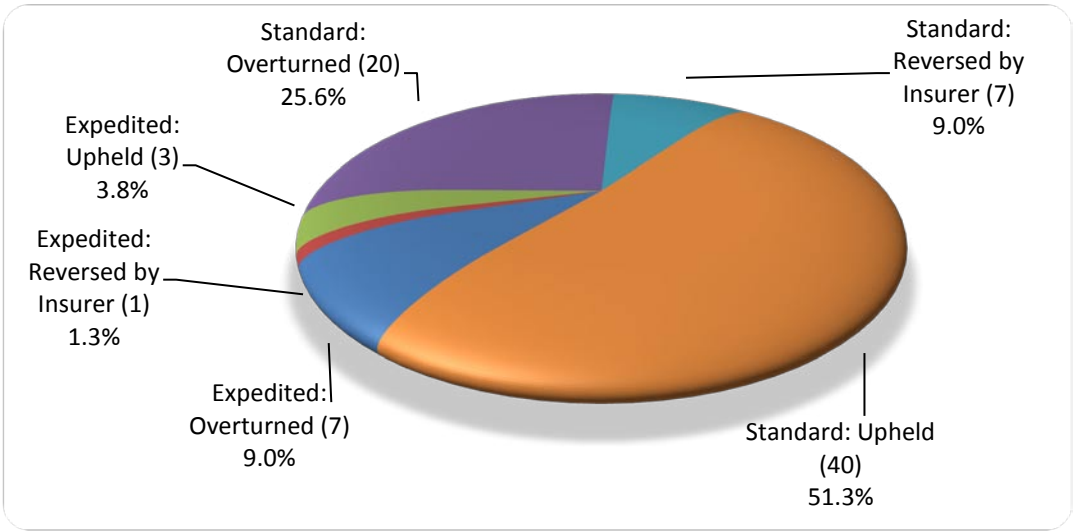
Figure 2: Reasons for Non-Acceptance of an External Review Request in 2009



Outcomes

In 2009, 78 cases were accepted for external review. Of those accepted, 67 were accepted to be processed on a standard basis. Eleven 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 2009. Overall in 2009, cases that were accepted for external review were decided in favor of the consumer 44.9 percent of the time.

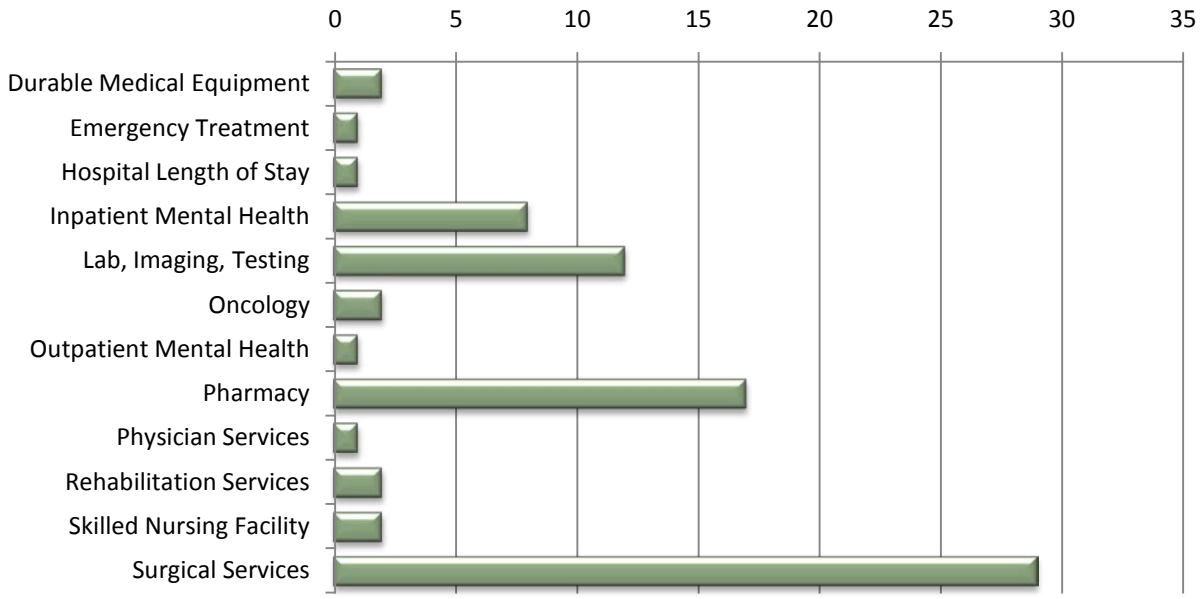
Figure 3: Outcomes of Cases Accepted for External Review by Request Type in 2009



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 2009. With 29 accepted cases, representing a variety of procedures, *Surgical Services* comprised 37.2 percent of the requests accepted in 2009. *Pharmacy* had 17 accepted cases representing 21.8 percent of the cases and *Lab, Imaging, Testing* was the third largest number of requests with 12 requests under this general category representing 15.4 percent of the requests. All together, these three general service types made up 74.4 percent of the accepted requests.

Figure 4: Accepted Cases by Type of Service Requested in 2009



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 2009. *Surgical Services*, the largest category of requests, was decided in favor of the consumer 55.2 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 *Pharmacy* services were decided in favor of the consumer 41.2 percent of the time. Requests made for *Lab, Imaging, and Testing* services revealed outcomes in favor of the health plan 66.7 percent of the time.

Table 1: Percentage of Outcomes by Type of Service Requested in 2009

Type of Service	Percentage Overturned	Percentage Reversed	Percentage Upheld
Durable Medical Equipment	100.0	0.0	0.0
Emergency Treatment	0.0	100.0	0.0
Hospital Length of Stay	0.0	0.0	100.0
Inpatient Mental Health	25.0	0.0	75.0
Lab, Imaging, Testing	25.0	8.3	66.7
Oncology	50.0	0.0	50.0
Outpatient Mental Health	0.0	0.0	100.0
Pharmacy	23.5	17.7	58.8
Physician Services	100.0	0.0	0.0
Rehabilitation Services	50.0	0.0	50.0
Skilled Nursing Facility	0.0	0.0	100.0
Surgical Services	44.8	10.4	44.8
Percentage of Each Outcome for all Cases	**34.6%**	**10.3%**	**55.1%**

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 2009.

Table 2: Outcomes of Accepted External Review Requests by Service Type and Nature of Denial in 2009

Service Type	Medical Necessity		Experimental / Investigational		Cosmetic Services	
	Overturned/ Reversed	Upheld	Overturned/ Reversed	Upheld	Overturned/ Reversed	Upheld
Durable Medical Equipment	1	0	0	0	1	0
Emergency Treatment	1	0	0	0	0	0
Hospital Length of Stay	0	1	0	0	0	0
Inpatient Mental Health	2	6	0	0	0	0
Lab, Imaging, Testing	0	3	4	5	0	0
Oncology	0	0	1	1	0	0
Outpatient Mental Health	0	0	0	1	0	0
Pharmacy	4	8	3	2	0	0
Physician Services	0	0	1	0	0	0
Rehabilitation Services	1	1	0	0	0	0
Skilled Nursing Facility	0	2	0	0	0	0
Surgical Services	7	4	7	6	2	3
Percentage of Outcomes	20.5%	32.1%	20.5%	19.3%	3.8%	3.8%
Percentage of All Cases:	52.6%		39.8%		7.6%	

In 2009, 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 39.8 percent of the cases decided on the experimental or investigational nature of the treatment and only 7.6 percent decided on whether the services were considered to be cosmetic.

Medical necessity cases involved almost all of the general service types, except *Oncology* and *Outpatient Mental Health*. Cases involving *Pharmacy* (12), *Surgical Services* (11) and *Inpatient Mental Health* (8) represented the categories with the most number of cases decided on the merits of medical necessity alone. Almost all of the cases involving experimental / investigational denials involved *Surgical Services* with 13 cases and *Lab, Imaging, Testing* with 9 cases. *Surgical Services* comprised almost all of the cases determined on whether the service was considered to be cosmetic.

In 2009, the majority of cases that were accepted for review were those that were requested on a standard basis, with 85.9% 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. Expedited cases fell into only three of the general service type categories: *Oncology, Pharmacy*,

and *Surgical Services*. Standard cases involved all general service category types except for *Oncology*.

Table 3: Outcomes of all Requests by General Service Type and Review Type in 2009

Service Type	Standard Review		Expedited Review	
	Overturned/ Reversed	Upheld	Overturned/ Reversed	Upheld
Durable Medical Equipment	2	0	0	0
Emergency Treatment	1	0	0	0
Hospital Length of Stay	0	1	0	0
Inpatient Mental Health	2	6	0	0
Lab, Imaging, Testing	4	8	0	0
Oncology	0	0	1	1
Outpatient Mental Health	0	1	0	0
Pharmacy	4	9	3	1
Physician Services	1	0	0	0
Rehabilitation Services	1	1	0	0
Skilled Nursing Facility	0	2	0	0
Surgical Services	12	12	4	1
Percentage of Case Volume	**85.9%**		**14.1%**	

Health Plan Oversight

The external review law places 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.

Overall, 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 78 cases that were accepted for external review in 2009, cases originating from Blue Cross Blue Shield of North Carolina (22), the North Carolina SHP-PPO Plan (20) and United Healthcare Insurance Company (16), comprised 74.4 percent of the external review activity. Ten other health plans made up the remaining 25.6 percent of cases. Of these remaining health plans, WellPath Select, Inc. had four cases; UnitedHealthcare of North Carolina, Inc. had four cases and Aetna Life Insurance Company had three cases. These figures are consistent with the volumes that the state's larger insurers have had in past years. The percentage share of health plan activity for 2009 is depicted in Figure 5.

Figure 5: Health Plans Share of Accepted External Review Requests in 2009

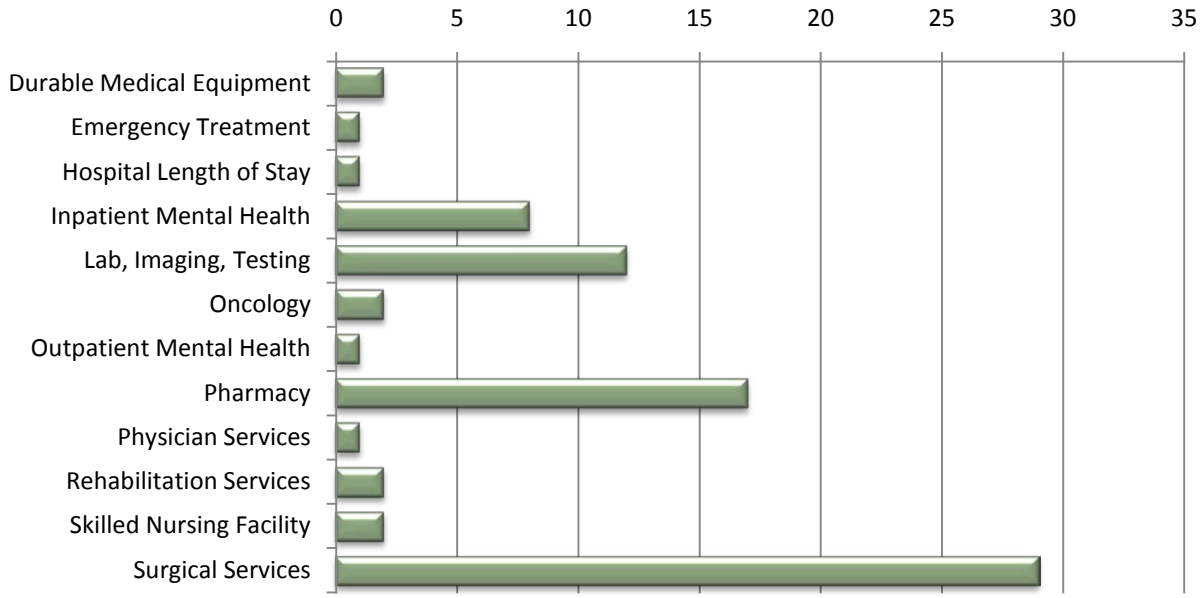


Table 4 demonstrates the outcomes of external review activity by the health plan whose decision is subject to review and the general type of service that the denial involved. This data is presented for informational purposes only. The number of requests per health plan is too small to draw any conclusions 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 9.5 percent of the time. The North Carolina SHP PPO Plan's decisions were decided in favor of the consumer by IROs 60 percent of the time and United Healthcare Insurance Company's cases were decided in favor of the consumer 58.3 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 70 cases that were decided by an IRO.

Table 4: Accepted Case Activity by Health Plan and Type of Service Requested in 2009

Health Plan and Type of Service	Number of Requests	Percentage Overturned	Percentage Upheld
Aetna Life Insurance Company	**3**		
• Pharmacy	2	--	100.0
• Rehabilitation Services	1	--	100.0
Total Percentage for Health Plan		**--**	**100.0**
Blue Cross Blue Shield of North Carolina	**21**		
• Inpatient Mental Health	1	--	100.0
• Lab, Imaging, Testing	4	--	100.0
• Oncology	2	50.0	50.0
• Outpatient Mental Health	1	--	100.0
• Pharmacy	4	--	100.0
• Surgical Services	9	11.1	88.9.
Total Percentage for Health Plan		**9.5**	**90.5**
Celtic Insurance Company	**1**		
• Surgical Services	1	--	100.0
Total Percentage for Health Plan		**--**	**100.0**
Connecticut General Life Insurance Company	**2**		
• Lab, Imaging, Testing	1	--	100.0
• Surgical Services	1	100.0	--
Total Percentage for Health Plan		**50.0**	**50.0**
John Alden Life Insurance Company	**1**		
• Inpatient Mental Health	1	--	100.0
Total Percentage for Health Plan		**--**	**100.0**
North Carolina Health Choice for Children	**1**		
• Surgical Services	1	--	100.0
Total Percentage for Health Plan		**--**	**100.0**
North Carolina SHP-Indemnity	**1**		
• Inpatient Mental Health	1	--	100.0
Total Percentage for Health Plan		**--**	**100.0**
North Carolina SHP-PPO	**20**		
• Durable Medical Equipment	1	100.0	--
• Inpatient Mental Health	3	33.3	66.6
• Lab, Imaging, Testing	3	100.0	--
• Pharmacy	1	--	100.0
• Rehabilitation Services	1	100.0	--
• Skilled Nursing Facility	2	--	100.0
• Surgical Services	9	66.6	33.3
Total Percentage for Health plan		**60.0**	**40.0**
Principal Life Insurance Company	**1**		
• Lab, Imaging, Testing	1	--	100.0
Total Percentage for Health plan		**--**	**100.0**
Union Security Insurance Company	**1**		
• Durable Medical Equipment	1	100.0	--
Total Percentage for Health Plan		**--**	**100.0**

Table 4: Accepted Case Activity by Health plan and Type of Service Requested in 2009 (Cont.)

Health Plan and Type of Service	Number of Requests	Percentage Overturned	Percentage Upheld
United Healthcare Insurance Company	**12**		
• Inpatient Mental Health	2	50.0	50.0
• Lab, Imaging, Testing	1	--	100.0
• Pharmacy	5	40.0	60.0
• Physician Services	1	100.0	--
• Surgical Services	3	100.0	--
Total Percentage for Health Plan		**58.3**	**41.7**
UnitedHealthcare of North Carolina, Inc.	**3**		
• Pharmacy	2	100.0	--
• Surgical Services	1	100.0	--
Total Percentage for Health Plan		**100.0**	**--**
WellPath Select, Inc.	**3**		
• Hospital Length of Stay	1	--	100.0
• Lab, Imaging, Testing	1	--	100.0
• Pharmacy	1	100.0	--
Total Percentage for Health Plan		**33.3**	**66.7**

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). Maximus CHDR, Medwork of Wisconsin, Inc., and NMR were contracted with the Program throughout 2009. The fourth IRO, MPRO, began providing independent review services for the Program on July 1, 2009. 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 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. 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 78 cases were accepted for external review during this period, eight cases were reversed by the health plan prior to an IRO decision being rendered, so reporting on IRO activity will represent only those 70 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 2009. The outcome of cases reviewed by IROs was decided in favor of the consumer 38.6 percent of the time during 2009, which is consistent with outcomes measured in previous years.

Table 5: IRO Activity Summary for 2009

IRO	Number Assigned	Percentage Overturned	Percentage Upheld
Maximus CHDR	23	52.2	47.8
Medwork of Wisconsin, Inc.	13	46.2	53.8
MPRO	7	57.1	42.9
NMR, Inc.	27	18.5	81.5
Total and Percentage of Outcomes for All Cases	**70**	**38.6**	**61.4**

IRO Decisions by Type of Service Requested and Health Plan

During 2009, four IROs rendered 70 external review decisions for consumers: Maximus CHDR, Medwork of Wisconsin, Inc., MPRO, and NMR. The contract for MPRO initiated on July 1, 2009. Because the four IROs were not all effective for the same 12 month period, the number of cases assigned to each IRO is dissimilar. External review cases are also 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 2009. 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 2009

IRO and Type of Service	Number of Accepted Cases	Percentage Overturned	Percentage Upheld
Maximus CHDR	**23**		
• Durable Medical Equipment	1	100.0	--
• Inpatient Mental Health	3	33.3	66.7
• Lab, Imaging, Testing	4	50.0	50.0
• Oncology	1	100.0	--
• Pharmacy	6	50.0	50.0
• Skilled Nursing Facility	1	--	100.0
• Surgical Services	7	57.1	42.6
All Services:		**52.2**	**47.8**
Medwork of Wisconsin, Inc.	**13**		
• Durable Medical Equipment	1	100.0	--
• Inpatient Mental Health	2	50.0	50.0
• Lab, Imaging, Testing	2	--	100.0
• Pharmacy	1	--	100.0
• Physician Services	1	100.0	--
• Rehabilitation Services	1	100.0	—
• Surgical Services	5	40.0	60.0
All Services:		**46.2**	**53.8**

Table 6: Accepted Case Activity by IRO and Type of Service Requested in 2009 (Cont.)

IRO and Type of Service	Number of Accepted Cases	Percentage Overturned	Percentage Upheld
• **MPRO**	**7**		
• Hospital Length of Stay	1	--	100.0
• Lab, Imaging, Testing	1	100.0	--
• Pharmacy	2	50.0	50.0
• Surgical Services	3	66.7	33.3
All Services:		**57.1**	**42.9**
NMR	**27**		
• Inpatient Mental Health	3	--	100.0
• Lab, Imaging, Testing	4	--	100.0
• Oncology	1	--	100.0
• Outpatient Mental Health	1	--	100.0
• Pharmacy	5	--	100.0
• Rehabilitation Services	1	--	100.0
• Skilled Nursing Services	1	--	100.0
• Surgical Services	11	45.5	54.5
All Services:		**18.5**	**81.5**

Table 7 shows each IRO's decisions by health plan for the year 2009. 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 2009

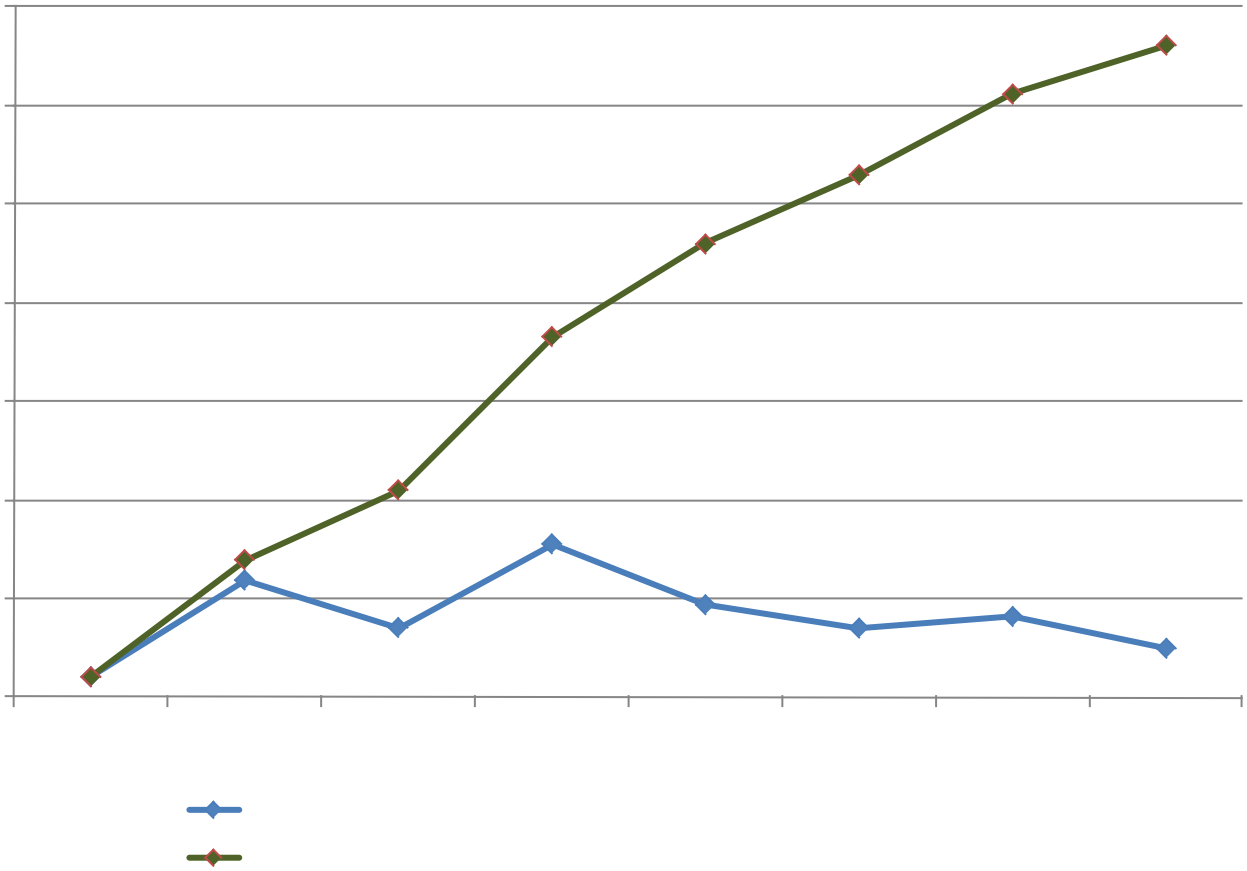
IRO and Health plan	Number of Decisions	Percentage Overturned	Percentage Upheld
Maximus CHDR	**23**		
• Aetna Life Insurance Company	1	--	100.0
• Blue Cross Blue Shield of North Carolina	5	20.0	80.0
• North Carolina SHP-PPO	6	50.0	50.0
• Union Security Insurance Company	1	100.0	--
• United Healthcare Insurance Company	7	57.1	42.9
• UnitedHealthcare of North Carolina, Inc.	3	100.0	--
All Health plans:		**52.2**	**47.8**
Medwork of Wisconsin, Inc.	**13**		
• Aetna Life Insurance Company	1	--	100.0
• Blue Cross & Blue Shield of North Carolina	4	25.0	75.0
• John Alden Life Insurance Company	1	--	100.0
• North Carolina SHP-PPO	4	100.0	--
• United Healthcare Insurance Company	2	50.0	50.0
• WellPath Select, Inc.	1	--	100.0
All Health plans:		**46.2**	**53.8**
MPRO	**7**		
• Blue Cross Blue Shield of North Carolina	1	--	100.0
• Connecticut General Life Insurance Company	1	100.0	--
• North Carolina SHP-PPO	1	100.0	--
• United Healthcare Insurance Company	3	66.7	33.3
• WellPath Select, Inc.	1	--	100.0
All Health plans:		**57.1**	**42.9**
NMR	**27**		
• Aetna Life Insurance Company	1	--	100.0
• Blue Cross & Blue Shield of North Carolina	11	--	100.0
• Celtic Insurance Company	1	--	100.0
• North Carolina Health Choice for Children	1	--	100.0
• North Carolina SHP-Indemnity	1	--	100.0
• North Carolina SHP-PPO	9	44.4	55.6
• Principal Life Insurance Company	1	--	100.0
• WellPath Select, Inc.	1	100.0	--
All Health plans:		**18.5**	**81.5**

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 2009, consumers received $248,107.22 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 $3 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 five cases from 2009 and previous years that have been overturned but the services have not yet been provided 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 $413,020.

Cost of External Review Cases for 2009

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 2009, by type of service requested. The totals include the IRO charges for all 70 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 2009

Type of Service	Average Cost of IRO Review	Average Cost of Service	Cumulative Cost of Service
Durable Medical Equipment	$572.50	$12,517.56	$25,035.12
Emergency Services	N/A	147.76	147.76
Hospital Length of Stay	525.00	0.00	0.00
Inpatient Mental Health	603.75	1,993.55	3,987.10
Lab, Imaging, Testing	560.00	1,219.02	4,876.08
Oncology	847.50	35,579.08	35,579.08
Outpatient Mental Health	690.00	0.00	0.00
Pharmacy	621.75	5,302.51	37,117.55
Physician Services	675.00	73.27	73.27
Skilled Nursing Facility	580.00	0.00	0.00
Surgical Services	653.33	10,092.23	141,291.26
Total for All Cases	**$627.00**	**$7,753.35**	**$248,107.22**

N/A –Decision reversed by insurer prior to IRO review.

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 70 reviews performed during 2009 was $627.

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. For cases that were accepted for review in 2009, 76 surveys were sent at the completion of an external review. Only 44.7 percent of consumers or authorized representatives completed the survey and returned it to the HCR Program. Of those cases that were overturned by the IRO, 16 of 27 persons responded (59.3%) and of those cases that were upheld by the IRO, 16 of 43 persons responded (30.2%). In cases where the health plan reversed its own decision, five of six persons responded.

Overall, responders are generally pleased with the customer service they receive after contacting the Healthcare Review Program. Most responders report satisfaction with the HCR Program staff and information about the external review process. 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?" Of the responders whose decision was overturned, 100 percent stated they would tell a friend about external review. For those persons whose outcome was upheld by the IRO, 69.2 percent would also tell a friend about external review. As shown in Table 9, 81.1 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 9: Consumer Satisfaction Survey Analysis for 2009

Outcome of External Review	Number of Surveys Sent	Number of Surveys Received	Percentage of Respondents	Percentage of Respondents who would "Tell a Friend"
Overturned	27	16	59.3	100.0
Upheld	43	16	30.2	69.2
Reversed	6	5	83.3	100.0
Total	**76**	**37**	**44.7**	**81.1**

Community Outreach and Education on External Review and HCR Program Services

The HCR Program continues to identify new and innovative strategies to heighten consumer and provider awareness of external review services. In 2009, strategies used to inform and educate consumers and providers included creating web-based video, a Facebook page, participation in health benefit fairs and the North Carolina State Fair, radio interviews, group presentations, and utilizing email to communicate information about the HCR Program to state agencies.

In 2009, HCR Program staff collaborated with the Department's Public Information Office to produce a consumer friendly web-based video which provides an overview of the external review process and describes the consumer counseling services provided by Program staff.

The addition of a Facebook page as part of the Program's outreach efforts has been very successful. The Facebook page was launched in April, 2009, and by the end of the year, the total number of views was 5,176, with an average monthly viewing of 576. The Program uses the Facebook wall to post Program updates, pictures of Program staff at community outreach events, health care articles and to receive and respond to consumer inquiries.

In 2009, a letter from the Commissioner of Insurance was sent to members of the North Carolina Senate and House of Representatives highlighting HCR services and how these services can be of assistance to their constituents when they have received a health claim denial. The HCR Program receives inquiries and requests for assistance from legislative staff at the state and federal level when they have a constituent who has received a health claim denial from their insurance company. Legislative assistants contact the HCR Program seeking guidance and assistance in resolving the constituent's concern. As a service to their constituents, we encourage legislative staff to include a link to the HCR Program on their home web page. Also during this period, an electronic letter about HCR services was sent to state agency health benefit representatives, informing them of the availability of HCR services if an employee receives a health claim denial from their insurer.

The HCR staff continues to promote consumer and provider awareness of external review and consumer counseling services through community based events. 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. In 2009, HCR staff participated in the North Carolina State Wellness Fair, North Carolina State Fair, and made presentations to provider groups and participated in radio interviews.

Conclusion

Since the Program's inception almost eight years ago, consumers and providers 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 $3 million 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.