Medical Peer Review and PSRO (2)

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SECTION VIII. REACTION OF SPECIFIC GROUPS TO THE PSRO PROGRAM

This Section will briefly relate the reactions of various professional, accreditation, and trade associations to the passage and the initial implementation of the PSRO program. This Section is not meant to be all inclusive; however, it will cover the major interests involved in the PSRO program.

A. American Medical Association

The American Medical Association (AMA) has taken a very critical stand against the PSRO legislation. Their primary objection is to the method by which the program is being implemented. As indicated in the historical section of this report, the AMA had originally approached Senator Bennett on the idea of a PSRO program. Based upon these suggestions, Senator Bennett introduced his amendment to the Social Security law which established the PSRO program.

The AMA testified at the hearings before the amendment was passed. They presented Senator Bennett with certain objections to the legislation. He countered with some very good answers as indicated in our earlier analysis.

The AMA also objected to certain ways in which the PSRO program is being implemented. Of course, the most notable objection can be found in the AMA lawsuit against DHEW, which attempted to have the Medicare-Medicaid utilization review (UR) regulations scheduled to go into effect on July 1, 1975, declared illegal. Some of the major arguments put forth by the AMA were examined by a three-judge court on the
PSRO case and found lacking in merit—particularly the plaintiff's reliance on the Supreme Court's abortion rulings to show an unconstitutional interference with the relationship between physicians and patients. In addition, inasmuch as the Court based its PSRO ruling solely on the legitimacy of the government efforts to control cost of Federal health programs, the opinion may give some ammunition to PSRO opponents who are seeking either repeal or an amendment to the existing provisions.

In a statement accompanying the announcement of the suit, AMA's president, Dr. Malcolm C. Todd, commented on its underlying legal arguments. Said Todd:

"The Supreme Court has ruled that any governmental interference with medical decisions made by a patient and his doctor violate the right of privacy and personal autonomy on the right of life guaranteed by the Constitution. And Section 1801 of the Medicare Law states, 'Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided', and, moreover, these regulations...exceed the (specific UR) authority granted by the Social Security Act to the Secretary of HEW...and are adopted in violation of the Administrative Procedure Act."

Todd also said that the major motivation for the UR regulations was their sole objective—"cost cutting. The only way to cut costs in most programs is to deny care to patients."

However, the AMA has generally accepted the concept of UR. In fact, it has supported UR many times in the past as indicated by the write-up in the history section of this report. Also, the AMA has developed a model screening criteria format to be used specifically for PSRO review. The criteria will help PSROs to implement the Government's utilization review requirements.
The model screening criteria project was funded by the Department of Health, Education and Welfare, and was carried out in conjunction with over thirty national specialty societies. The model format has a list of key questions which each specialty society addressed. Under the format, six elements common in the actual criteria sets developed by specialty societies were distributed to all state and local medical societies; all conditional and planning PSROs; and all U.S. hospitals, specialty societies and, on request, from individual physicians. The model screening criteria are intended to serve as reference points which local physician groups can utilize in developing and refining criteria for local PSRO review systems. The screening criteria sets also are supposed to assist local hospitals in meeting HEW requirements and in carrying out utilization review according to the regulations.

The model screening criteria formula was designed to assist in the specific review processes of certification admissions, continued stay review, and medical care evaluation studies. Although the format is a model, local physician groups have been encouraged to adopt and use it and allow for a definitive feedback in subsequent revision. According to Claude Welch, M.D., chairman of the AMA's Project Policy Committee, the model criteria sets were developed in a "manner that would ensure usefulness in the process of screening large numbers of cases, to select for a period of review those cases involving potential misutilization of services or substandard delivery of medical care".

The AMA emphasizes that the criteria should be reviewed by the local PSROs and hospitals, and they should then adapt, adopt or develop
criteria themselves based on the model format. The AMA is also very careful to point out that the model criteria sets are not final and should be reviewed periodically. The AMA will perform this periodic review and will be coordinating the updating and refinement by specialty societies. All the criteria sets will then be widely circulated so that necessary changes can be shared with all physician organizations. Examples of the criteria sets may be found in the Appendices.

The AMA provided some educational material to its physicians who were quite negative toward the PSRO program. On April 19, 1975, DHEW issued its own rebuttal to AMA's "deleterious effects" of PSRO packet by saying:

"The materials in the AMA package are totally negative in tone. Aside from our concern that much of the information provided is factually inaccurate and misleading, we do not believe that the majority of American physicians share the views expressed in the package. Indications of support for the program have come to us from a number of individual physicians--many of whom are members of the AMA--and from physician organizations, including a number of medical societies, medical specialty societies and state and county medical societies."

It is interesting to note that one month after President Nixon signed the bill into law, the Association's House of Delegates passed "Report E", which directed the AMA to assume a dominant leadership role in the implementation of PSRO. In carrying out that directive, the AMA established a PSRO Advisory Committee, with representation from all organized medicine which formed eight working task forces to make recommendations on the important facets of PSRO.
B. Medical Subspecialty Organizations

The PSRO program has received considerable support from subspecialty societies as evidenced by the desire to develop the criteria sets and norms described above. The largest medical specialty society, The American Academy of Family Physicians, has modified its original hard-line position to PSRO-funded activities.

The AMA has recommended that the National Specialty Society (NSS) develop a committee on peer review; that the state specialty societies should have committees on peer review; and that the local specialty societies should have committees on peer review. The role of the NSS has been primarily educational--provided through booklets, pamphlets, brochures, and audio-visual aids. The continued recommended role of the state specialty societies would be consultative--to assist in establishing peer review organizations with guidelines for handling issues and involving specialists' interests; they would provide appellate jurisdiction to serve as a court of appeals for particular instances involving individual member specialists; and they would also provide a medical educational objective to help establish methodology for use in results of peer review and continuing medical education of medical specialists. The local specialty society would provide actual peer review activity by the local practitioners.

The second major reaction to the PSRO program by the specialty groups was the effort of the major specialty societies in reviewing the proposed model format for PSRO screening criteria related to hospital admissions.
A meeting of DHEW, AMA, and the PSRO National Council in October of 1974 laid the groundwork for the specialty societies' review activity. The end result of this meeting was agreement on a sixfold diagnostic-based format, consisting of the following items:

1. Justification for admission.
2. Length of stay to be established locally on the basis of local data.
3. Validation of diagnosis.
4. Critical diagnostic and therapeutic services.
5. Discharge status.
6. Complications.

Some of the other specialty societies that deserve mention are:

The American Psychiatric Association, which acknowledges the crucial role of peer review.


The American College of Obstetrics and Gynecology (ACOG), which merely refers to education and peer review (statement, 1974).

The American Academy of Pediatrics (AAP), which has as yet no formal position.

The American Society of Internal Medicine (ASIM), which in its Resolution No. 28 in 1973 and Statement on Peer Review in 1970, supports peer review.

The American College of Physicians and The American Medical Association in statements issued in 1969, like the APA, simply acknowledge the "primary role of education". As the ASIM puts it, "...none of the three (organizations) finds it primary enough to merit further exploration".

The American College of Surgeons (statement, 1974) simply supports the position of the AMA.
C. Independent Surveys of Private Practice Physicians

During the last two years, there have been a considerable number of surveys that sought the attitude of the private practitioner toward the PSRO legislation as well as the techniques and methods by which the Federal Government is seeking to implement the legislation.

A survey conducted by Medical World News in a publication dated October 25, 1974, noted that one-fifth of the nation's practicing GPs indicated that they would not provide medical care to Medicare and Medicaid patients if they had to go through the PSRO monitor activity; one-fourth of the physicians feared an income reduction as a result of PSRO; about one-third of the doctors felt that PSROs would actually stimulate more malpractice suits; more than half of the doctors were opposed to PSROs; most doctors who are either hospital-based, under forty-five years of age, or live in the Northeast sector of the country favor PSROs.

Another survey performed by Decision Making Information of Santa Ana, California, in the Chicago area indicated that most doctors fear that the Federal Government would sooner or later use the program to force "cookbook" medicine and enforce description of allowable services, thus making doctors the pawn of the Government. Only about 32% of the doctors felt that the threat of Federal Government domination is being over-emphasized.
It is interesting to note the doctors' impressions as to the motivation and reasons for passing the law. About 90% felt that cutting Medicare/Medicaid costs by making the physicians accountable for patient care and preventing them from providing unneeded services were major motivations. 78% credited the formulators of the law with an intention to improve the quality of care. Only a slightly smaller number (73%) suspected the intentions of issuing a standard format of allowable services. 67% thought the objective was to dominate physicians. Half of the respondents saw the desire to fragment organized medicine.

Seventy-four percent of the responding doctors felt that medical care review organizations would eventually have to be established by the government because the local doctors would not take the initiative. 66% believed that individual physicians would not have much opportunity to enforce the norms and standards adopted by the review organizations. About 86% thought that the Government would need the cooperation of physicians who are essential to make the review system work. 69% felt that the rules and regulations written under a new law can be changed.

D. Federal Congressmen

The reaction to Federal Congressmen has been extremely wide and variable. Senator Kennedy is disappointed in the speed of program implementation, indicating he feels that the program would be much more effective if it were placed under the Social Security Administration. Other more conservative legislators are possibly pleased with the many
problems which confront the program. In the recent months, there have been committee hearings to examine the implementation process. These hearings do not tell much about the attitude of individual congressmen. There have been no formal polls of Congressmen on this subject to our knowledge.

E. Federal Governmental Agencies

The BQA and the "health" component of the Department of Health, Education and Welfare have the following general reactions to implementation of the PSRO program at this time:

(1) Lack of adequate funding is the major sentiment.
(2) Medical groups are not accepting the responsibility as laid down in the law.
(3) The turnover of administrators in the program has weakened the program.
(4) Not enough support from Congress.
(5) Need for more sophisticated techniques to monitor existing PSROs.
(6) Too much intradepartmental political maneuvering.

The Social Security Administration at one time was thinking of trying to seize control of the PSRO program from the BQA and the OPSR. Their claim was that they could more effectively manage a program of this nature, while the BQA was a young, inexperienced and ineffective agency. However, there does not appear to be any serious discussion to indicate a change in that direction at this time.

Most other Federal agencies involved in health care favor the PSRO program. Any activity that will result in less Federal health care costs and improvement in services will find a great deal of favor among these agencies.
F. Health Insurance Companies

The health insurance companies are vitally interested in the PSRO program and the peer review process. Most notable of the carriers is obviously Blue Cross, which covers a great deal of the U.S. population. The Blue Cross plans would very much like to have control over the data processing of claims, since they are already in this type of business in relation to Medicare and Medicaid. There is additional discussion of Blue Cross interest below.

The Federal Government would like the private health care insurance carriers to support the development of PSRO activity. It would like the carriers to use the PSRO organizations for reviewing the appropriateness of medical claims. The Federal Government believes that the private carriers want one system of review for all patients. It feels the PSRO system will, in fact, become that system. The Federal Government is exploring whether a conditionally designated but unfunded PSRO could undertake privately-financed review in advance of receiving Federal funds to review the carrier and the recipient of Federal benefits. The Bureau of Health Insurance of the Social Security Administration has held many meetings with significant health insurance carriers. These meetings have been organized primarily through the Health Insurance Association of America to discuss the methods of monitoring for peer review under the PSRO program.

The Blue Cross Association (BCA) has developed Plan Utilization Review (PUR), which is an assistance program for Blue Cross plans aimed at supporting their provider organizational review efforts. This includes a variety of systems such as a computer-assisted claims screening mechanism;
an automated program for statistical reporting of patient discharges in development of physician data and profiles; development of methodology for concurrent peer review; and establishment of a set of guidelines for evaluating hospital plan utilization review and medical order practices.

The program is headed up by Mr. H. G. Pearce, BCA Senior Vice President. Pearce indicates that review of cost and quality is part of the system and that PUR is designed to support the review effort wherever it is being performed. The Blue Cross Association realizes that most PSROs think Blue Cross is trying to take over their functions; however, the BCA denies any such intention and indicates that the needs of the emerging PSROs have been considered. The PUR was designed based upon these perceived needs.

Mr. Paul S. Boulis is the BCA PUR Director of Implementation and the primary author of the Patient Care Coordinator Manual. He states that PUR's concurrent peer review program uses physician-determined diagnosis and specific length-of-stay standards as the basis for the review process. According to Boulis, the most efficient way to handle concurrent review is to allow the program to be administered by the medical staff in each hospital.

G. **Data and Systems Consulting Firms**

Data systems and consulting firms are vitally interested in the PSRO program from the PSRO Management Information Systems (PMIS) standpoint. The PMIS will require considerable systems effort in development of data processing capability to monitor the program.
There have been considerable numbers of firms represented at the meetings of the NPSRC. In addition, a considerable number of firms have responded to Requests for Proposals which are submitted by the Federal Government in anticipation of the systems needed in implementing the program.

H. Hospitals

The hospitals have been affected primarily by Section 1155(E)(1) of the PSRO law. This provision allows for in-house "delegated" review with local PSRO approval. According to the Manual on Hospital Review Duties, a hospital conducting such a review is required to:

1. Perform admission certification, continued-stay review, and retrospective medical care evaluation studies.
2. A hospital may be allowed, for elective admissions, to exempt physicians, diagnoses or procedures from admission certification and continued-stay review—if approved by the local PSRO.
3. Perform admission certification of emergency admissions on a random sample or selected basis.
4. Perform at least one MCE study at any given time for which it may develop the criteria or standards and select the norms to be used.
5. Use the PSRO's norms, criteria and standards for admission certification, continued state review, and profile analysis until the hospital can present the PSRO with valid reasons why these parameters should be modified for their institution.

The hospitals have been affected by the PSRO program, primarily through the utilization review (UR) regulations. The American Hospital Association has represented the hospitals and has expressed great concern over the ability of the hospitals to implement the UR regulations and have placed considerable pressure upon the PSRO administrative agencies as well as Congress to revise the regulations.
In addition, hospitals are affected by the delegated review status that each of them is encouraged to achieve under the program. In this status, they would be given authority to perform the utilization review and peer review activities at the institution, reporting to and being monitored by the local PSRO in their area.

The hospitals have had to respond to the PSRO requirements by hiring additional clerical staff and people who have the ability to accept training for medical chart auditing and transforming information from the medical records onto the appropriate medical care review abstract forms required by the Federal Government.

Some additional hospital-PSRO reactions deserve mention.

Many hospital administrators feel that a sharp decrease in hospital admissions could result from PSRO operations. The Hospital Financial Management Association has studies which indicate that the PSROs, in combination with emphasis on use of outpatient facilities and HMOs, could result in a 20 to 50% drop in hospital inpatient admissions. At the same time, hospitals could experience increases in length of stay, as short-stay cases are treated in outpatient departments and surgical centers, while only the more critically ill patients are admitted. This factor apparently will need to be watched by hospitals if reimbursement formulas are on a per-admission basis.

In addition, many administrators feel that PSRO could emerge to challenge many hospital management practices in medical records, medical education, in-service training, planning, service and other programs.
I. Hospital Accreditation Agencies

The Joint Commission on Accreditation of Hospitals (JCAH) has prepared a program that can be used by institutions to help them meet the peer review and audit capabilities required by the PSRO program. Known as Performance Evaluation Procedure (PEP), it is not a system for examining physician behavior, but a system for examining patient outcomes. JCAH does not have nor intend to have its own set of clinical standards or criteria as many physicians initially thought. PEP emphasizes criteria for medical audit systems, not criteria for clinical diagnoses. The outcomes of the audit system should have the following characteristics:

1. Valid, objective criteria for process and outcome;
2. Valid comparison of performance to criteria;
3. Appropriate peer review to determine justification for variations;
4. Analysis of deficiencies as to source and type (i.e., knowledge, motivation, facilities, personnel administration);
5. Corrective action (training, counselling, consultation, policy change);
6. Reaudit to measure effectiveness of corrective action.

J. Consumer Groups

Many consumer groups are vitally concerned about the PSRO program. Among these are Ralph Nader's group. Nader wants to be assured that the PSROs are going to be implemented on the basis of their legislative intent. Secondly, there are groups that are concerned about confidentiality of medical data and conservation of medical records. In addition, there are a number of other consumer and advisory groups that are interested in one way or another in the PSRO program. The National Advisory Council
has formally endorsed encouraging PSROs to open their boards to non-provider members. The Council has encouraged PSROs to establish "advisory groups" composed of consumers and others as distinct from the statutory-required advisory groups to statewide councils and to then seek reimbursement for their operation from HEW. There is an obvious move for public accountability.

K. Non-Physician Professional Medical Care Providers (i.e., Pharmacists, Nurses, and Others)

The Professional Standards Review Organization legislation will affect all health professionals in one way or another. Yet, apprehension and a lack of understanding persist among many of the professionals about the program. This lack of understanding is due primarily to its complexity and controversial aspects. On the other hand, pharmacists, nurses, and some other paramedical groups are becoming very active in the PSRO effort. The American Society of Hospital Pharmacists is publishing a routine newsletter which describes PSRO; is becoming very active in implementing drug utilization review systems; and is making an effort to convince the medical profession that they need to rely more upon the clinical pharmacist for input in determining drug prescribing and to assure that this is done on a rational basis.

The American Nurses Association is also interdigitating with the American Hospital Association and other organizations to subcontract for norms development to the Bureau of Quality Assurance. These subcontracts involve development of standards for review within their own specific professions. The major issue involved in paramedical professionals
is the PSRO requirement that the physician be responsible for reviewing all medical care. The other types of professionals feel that they should have as much of an input and as much of an approval as the physicians in reviewing the care.

During March, 1974, the OPSR met with the Coalition of Independent Health Professions, an organization representing eleven non-physician health care groups. At that meeting, it was pointed out that the PSRO Manual spells out the role of non-physician practitioners in the PSRO process and structure. The PSRO law mandates advisory groups and provides that they must consist of from seven to eleven members representing "health care practitioners other than physicians and hospitals and other health care facilities".

The Manual also states that approximately one-half of such advisory groups should represent practitioners, with at least one nurse and one pharmacist routinely included. A dentist is also contemplated if outpatient dental services are reviewed by the PSRO in a particular state. The remaining members in this category will represent those non-physician practitioners who provide the greatest amount of service, or whose services represent special problem areas under the programs reviewed.

The ultimate authority for review is with the physician, and this obviously presents some conflict with the non-physician practitioners. The Manual states that "while the PSRO retains all the responsibility for the decisions made under its aegis, it should seek the participation of all health care practitioners in all aspects..."
The American Dental Association stated before the Senate PSRO hearings that "nothing less than inclusion of dentists as members of PSROs" would satisfy the dental profession.

L. American Hospital Association

Most hospitals recognize that there would be a problem in the phasing of PSROs into the state programs of medical care. They are therefore reluctant to sign the memoranda of understanding with the conditional PSROs which carry out the medical assistance review functions. The problem is made more difficult by the allegation that the Social and Rehabilitative Service in Washington is dragging its feet on accepting PSRO authority to do its monitoring, reflecting a strong feeling in many state governments against turning over to any independent physicians' organizations such an important matter as control of the Medicaid programs. However, the American Medical Association has emphasized to its membership that the hospitals should stimulate hospital medical staffs to seek review authority under Section 1155(E) of the PSRO law.

Utilization review and medical audit programs, according to the AHA News Bulletins:

"should be implemented and operated primarily by the organized medical staff of the health care institution; the hospital medical staff should have primary responsibility for developing criteria for effectiveness and quality of care....Findings of utilization review and medical audit programs should be used primarily for medical staff education....Most important....hospitals should take steps immediately to establish or strengthen these programs in institutions".

The AHA also stated in regard to the UR committee relationship to the PSRO that:
"In order to take full advantage of opportunities for hospitals and hospital medical staffs to have the fullest possible impact on the initial development of the PSRO in your area, we strongly urge that hospitals encourage and support local physicians' active participation in the formation and development of PSROs."

In summary, the American Hospital Association is fostering peer review programs with primary emphasis on the institution having the primary responsibility for stimulating the physicians to set up peer review organizations within their geographic service area.

M. Medical Care Foundations

Basically, the medical care foundations (MCF) have supported the peer review and quality assurance concept. As Senator Bennett indicated in his introduction to HR-1, the Amendment to the Social Security Law, the concept embodied in his amendment came from the foundation movement. Many of the conditional PSROs are currently an outgrowth or are actually the foundation for medical care in their area.

A comprehensive MCF by definition is concerned with the benefit packages involved in health insurance carried by its patients, and, as a result, becomes an active participant in designing health care programs that are both high in quality and cost effective. The MCF is a management system for community health services, according to the American Association of Foundations for Medical Care.

MCFs are set up and run by physicians. "Claims review" foundations for medical care restrict themselves to peer review activities consisting of reviewing payment claims that fall outside the established norms and are referred by fiscal intermediaries. "Comprehensive" foundations for
medical care, on the other hand, set minimum benefits packages and process all patient services and payment claims for peer review in an appropriate period. Some comprehensive foundations have assumed a portion of the underwriting risk for a defined population and have provided comprehensive health services for a fixed annual sum on a capitation basis, thereby qualifying as health maintenance organizations. MCFs certainly have a potential as a cost effective management mechanism for the delivery of health services with a high level of quality assurance.

The first FMC was formed in San Joaquin County, California, in 1954, to provide comprehensive health services to labor groups dissatisfied with their previous medical care arrangements. A key feature of the FMC movement is its dedication to an incentive reimbursement system for participating physicians in which income is received in direct proportion to the amount of medical services delivered. By virtue of their corporate charters, county medical societies are not permitted to carry out a wide range of health service activities. The societies therefore set up separate corporations, which were the first FMCs.

Many of the FMCs' review procedures are geared to utilization of prescription drugs. The San Joaquin Medical Care Foundation has, from 1970 until recently, operated peer review under a Drug Utilization Review Committee, which consists of four pharmacists and one physician. Profiles provided by computers indicate physician drug utilization patterns. According to the group, drug peer reviews led to an average FMC prescription drug cost of $4.50, compared with a statewide average of $5.00 in 1972. In addition, usage patterns involving unusually large numbers of barbiturate and amphetamine prescriptions,
suggesting possible serious drug abuse, were apparently easily
detected. Incorrect dosages or other inappropriate usage patterns
were frequently detected by the computer profile and made available
to the Peer Review Committee for personal transmission to the prescribing
physician. Projection of a premium savings of 12% in San Joaquin to the
national drug bill of $8.5 billion suggests that an approximate total of
$1.03 billion of unnecessary expenditures in the cost of medications
might have been saved by effective drug surveillance programs and peer
review.

However, there are some foundations which are currently—and have in
the past—violently opposed the regulations developed by HEW for the
PSRO program. Typical of these is the Northern Virginia Foundation for
Medical Care. Dr. Harry Z. Kuykendall is President of this foundation
and wrote the following letter with regard to certain of the DHEW guidelines:

"You will correctly gather from the letter (to HEW)," Kuykendall
told his fellow PSROs, "that we have been informed by DHEW, in
writing, that they will sign no contract with us until we have
altered five of our foundation bylaws to suit DHEW 'guidelines'...
We are outraged that the HEW would be so heavy-handed in demanding
changes in this organization where it has absolutely no authority
whatever to do so. Likewise, we are aware that the same abusiveness
has already been applied to many of you and will be applied to many
more. We are mounting a full-scale battle with HEW over this issue,
involving Virginia's Governor, Senators, Representatives, local and
state medical societies, AAPAC, VAMPAC, the National Review Council,
AMA, and as many as 10,000 letters from Virginia physicians alone.
We do not intend to lose this battle."

Five bylaw changes required by HEW would establish membership eligibility
for Federally licensed physicians and mail balloting for members of the
Board of Trustees, prohibit mandatory dues, and the termination of PSRO
membership for failure to pay dues, and forbid the "slotting" of physicians
for the board. In these instances, Kuykendall wrote to the Foundation's
Project Officer, "We've found not only no merit, but a rather startling profligate degree of perfidy instead."

N. Local Medical Societies

Local and state medical societies have reacted in different ways to the implementation of the PSRO law. Initially, there was sharply divided reaction from the medical groups after DHEW released its first major proposal for implementing the PSRO law. In the December 20 Federal Register, there was an indication that there would be 182 professional standards review organizations nationwide. If several state medical societies were given carte blanche to rewrite the proposals, it would seem that the total number of PSRO-operating areas would probably fall below 150. The strongest negative comment that the societies have is that the statewide PSRO area designations in their particular states could not be represented by the medical society itself. Rather, the PSRO must be an independent organization within the state. As an example, the PSRO guidelines state that areas should not cross state lines or divide counties; PSRO areas generally should not include more than 2500 practicing physicians; and medical referral patterns in existing peer review organizations should be taken into account when drawing boundary lines.

Several state medical societies--among them Florida, Ohio, Texas, Virginia and Washington--found detailed objections to the geographical area designations. These societies had hoped for statewide PSROs, and at least two of them--Texas Medical Association and Washington State Medical Association--apparently were successful in convincing regional HEW offices to recommend statewide designation.
The AMA has, through its advisory committee on PSRO, offered to assist medical societies which have legitimate complaints about the HEW proposals. Several states have expressed interest and, in fact, used AMA's offer of assistance.

0. Miscellaneous

There have been some reactions from various groups outside the official organizations indicated above to the PSRO program.

For example, there is a group of physicians in Ohio who have created their own PSRO without the support of government funding. Their primary motive was to develop a peer review system that would not be designed by bureaucrats. The core of the system is the Medical Advances Institute Criteria of Care. The criteria were developed by physicians from all specialties located throughout the state of Ohio. Apparently, the doctors cross-checked and challenged one another's ideas until they had firm models.

The system has some rather unique features:

(1) The criteria, written for a computer by a team of computer scientists and clinicians working together, eliminated a common drawback: systems that start with medical criteria and then cannot adapt themselves to the computer.

(2) The standards can be modified to fit local hospital facilities and medical customs, rather than forcing everyone to follow a rigid set of rules.

(3) The computer makes sure that peer review acts on our problem after it is revealed. The computer also steers the problem to the proper authorities—physicians, nursing administrators who are clinical administrators—depending upon where the trouble arose.

(4) The system covers all patients, not just those on Medicare and Medicaid, so it really could be adaptable to any national health insurance program.
Review isn't retrospective, but rather ongoing: it begins with admissions and continues through discharge.

The American Association of Councils of Medical Staffs of Private Hospitals criticized the PSRO law. They charged it would eliminate the private practice of medicine. The President of the Council indicated that the fundamental constitutional question of freedom is involved and every physician's office is faced with a threat of a "third chair" representative--control by the Federal Government.

The Association of American Physicians and Surgeons was very critical of the PSRO program, citing an Arthur D. Little report criticizing PSROs. The Little report contended that peer review would be repressive, violate patient's rights, and ration care.

In Texas, the PSRO program was originally opposed. However, the doctors reacted by founding the Texas Institute for Medical Assessment (TIMA). The major objective of TIMA is to see that the law is carried out. The group felt it would be better to operate as a private group on a statewide basis and could therefore do the job much less expensively than the nine designated PSRO areas for the state of Texas.

The American College of Physicians, in general, supported PSRO "as an opportunity for the profession to monitor itself".

The American Society of Internal Medicine said it would assist in the orderly implementation of PSRO and seek to modify those portions of the law it finds objectionable.

The American Association of Foundations for Medical Care supported PSRO, urging that the National PSRO Council be allowed to act as an independent agency in control of its staff and budget.
Certain reservations about PSRO were expressed by the American Dental Association, but they said if dental services are to be reviewed, dentists should have policy roles.

The American Public Health Association asked for greater consumer participation in the peer review process.

Another reaction to the PSRO law was an attempt to set up a national system of private programs for PSRO. The most notable among the private programs is "Private Initiative in PSRO" (PIP), which was founded by the American Association of Foundations for Medical Care, the American College of Physicians, the American Hospital Association, the American Medical Association, and the American Society of Internal Medicine.

The PIP is wholly funded by the W. K. Kellogg Foundation of Battle Creek, Michigan. The purpose of the project is to use private resources in influencing and developing PSROs, so that it emphasizes quality assurance and provides more ample opportunity for active participation and contribution by representatives of the general public. The project is directed by a Management Committee, consisting of two representatives from each of the sponsoring organizations, plus two representatives of the general public. The policies of this Management Committee are implemented through the efforts of a Project Director and a Project Manager.

The objectives of the project, which began in late 1974 and extends through calendar 1976, are to carry out a prospective demonstration, tests and evaluations centering on five major areas:

1. The feasibility and the impact of incorporating quality assurance into the continued stay review required by PSRO;
The type and magnitude of contributions made to PSRO by representatives of the general public serving on local hospital boards, advisory committees to the PSRO, and the state PSR council;

The operating costs of PSRO in relation to the type of organization performing the review;

The impact of Private Initiative's quality assurance program on the content, utilization and cost of medical care;

Other important issues, such as confidentiality of data, incidence of malpractice and other legal suits, the relationship of PSROs and fiscal intermediaries in pre-existing data systems, use of non-physician personnel in key roles, and other smaller issues.

PSROs currently participating in the PIP program include:

(1) PSRO of New York, Inc., Purchase, New York;
(2) Baltimore City PSRO, Inc., Baltimore, Maryland;
(3) Colorado Foundation for Medical Care, Denver, Colorado;
(4) Foundation for Medical Care Evaluation of Southeastern Wisconsin, Milwaukee, Wisconsin;
(5) Multnomah Foundation for Medical Care, Portland, Oregon;
SECTION IX. OUTLOOK FOR OPPORTUNITIES AS OUTGROWTHS OF PEER REVIEW

This section of the report will describe the opportunities we project as outgrowths of the PSRO program in the following areas: related to national health insurance; drug utilization review; medical malpractice; relationship to comprehensive health planning; relation to supplies and equipment manufacturing; relation to insurance claims; systems and equipment requirements; educational service requirements; consulting services; physician recruitment services; government-sponsored R & D funds related to PSRO; provision of baseline data; and consumer education.

A. Key Element of National Health Insurance

There appears to be little doubt that peer review will become a key element of the national health insurance program. The current PSRO program is a type of peer review which will be included in evaluating the quality, quantity and cost of care rendered under the national health insurance program.

The PSROs represent a gearing up for national health insurance. Many governmental officials feel that the concept seems compatible with both the Kennedy and the Administration's previous health insurance programs. Whether or not national health insurance absorbs PSROs is yet to be seen. They may be replaced by something else—perhaps a program to measure medical care quality by assessment outcomes.
Table 26.

FOUR MAJOR COST CONTROL MEASURES TO BE IN PLACE PRIOR TO ENACTMENT OF NATIONAL HEALTH INSURANCE

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Logical distribution and funding of capital intensive health programs, i.e. buildings, equipment, major new programs</td>
<td>(National Health Planning and Resource Development Act of 1974)</td>
</tr>
<tr>
<td>2. Logical production and assignment of health manpower</td>
<td>(Bill pending in both houses)</td>
</tr>
<tr>
<td>3. Assurance of the medical necessity, optimum quality, and appropriateness of setting in which health care is delivered</td>
<td>(PSRO - Peer Review Programs)</td>
</tr>
<tr>
<td>4. Maximum allowable costs to be reimbursed for specific products and services</td>
<td>(Already have started through MAC - Drugs and Pharmaceutical Regulations)</td>
</tr>
</tbody>
</table>
Therefore, despite the current fiscal problems for the PSRO program, the program is an extremely important element of peer review as an experimental way of ensuring that care is rendered on a quality at reasonable cost.

B. **Drug Utilization Review**

Drug utilization review by the peer review organization will be one of the top priorities when reviewing ancillary services.

It has been estimated that 10% of the national health care expenditures in 1974 was devoted to drug utilization. In addition, the interactions and adverse reactions in the use of drugs has been highly publicized in the last two years. Consumers are becoming extremely involved in the push for generic versus brand name prescribing and other issues that impinge upon drug utilization review. Therefore, there certainly are opportunities for various groups to develop ways in which drug utilization review can be better monitored.

A number of contracts have been let by the Bureau of Quality Assurance which relates specifically to developing models for testing drug utilization review systems; to document all existing drug utilization review systems; and to suggest ways in which area wide PSRO drug utilization review systems can be established and monitored over a long-term basis. In addition, norms and criteria for proper drug utilization and rational drug prescribing are being set up and developed by various groups with the idea of using these as methods for monitoring health care activities in the
The opportunities are tremendous for a number of various groups to interact and influence and impinge upon the drug use policy issues.

C. Medical Malpractice Insurance

There is an opportunity to utilize the PSRO program and peer review in general to set up proper review mechanisms and to establish satisfactory norms for use by the courts in considering malpractice cases. Although this is a very controversial subject at the moment with the AMA violently opposed to having PSRO norms and criteria being used as criteria in a court case because this would tend to establish cookbook medicine standards. We believe it is fairly recognized by the insurance companies and by the courts that for once we may have some standards by which to objectively judge whether a physician has malpracticed or whether the patient and his representatives are merely attempting to seek redress for damages that are unwarranted.

D. Relation to Comprehensive Health Planning

The relationship of the PSRO program to comprehensive health planning lends all kinds of opportunities to various groups to see that there is a proper working relationship between these two groups.

The comprehensive health planning agencies, which are now represented by the Health Systems Agencies (HSA) are a conglomeration of the Regional Medical Program, the Hill-Burton Program, and the comprehensive health planning agencies to review all capital expenditures for health
care in a specified geographic region. The HSA's will rely upon PSRO's to secure advice on whether or not a facility or a physician provider is indeed rendering quality and appropriate care within the appropriate settings. There is therefore an opportunity for the PSROs to assist these agencies in this regard.

In addition there are opportunities for the institutions to convince the HSA's via the PSROs, that they are practicing medicine on an appropriate basis. There is an opportunity for vendors to provide the institutions with information related to their specific products as they relate to how the care should be rendered to patients in those institutions and then channel this further to the PSRO and then on to the HSA. In essence, comprehensive health planning agencies, the institutions, the manufacturers', and the PSROs will all be working together to monitor the care that is rendered within an area.

E. Relation To Supplies and Equipment Manufacturers

Manufacturers of equipment and supplies will have an opportunity to influence the way in which the PSRO, the national health insurance program, the hospitals, and the HSAs review the care rendered within a region. A good point can be made that the PSROs may find underutilization of certain services. If this happens, the PSRO may cause an increase in the quantity of supplies and equipment of a particular type in a particular area. These and other factors need to be analyzed in greater depth by the manufacturers.
F. Relation To Insurance Claims

There will be a need to develop a review capability to analyze the claims under a third-party payment program. Systems will need to be developed for the insurance carriers and the PSROs which will enable review, not only of the cost of the care and to prevent fraud, but also to review the medical care that is rendered to assure that it is of proper quality and that it is rendered in an appropriate setting. The opportunities for performing this review function is really "up for grabs" by a number of organizations, including third-party payers, medical care foundations and other non-profit organizations. The opportunity for a profit-making organization to capture this opportunity is also a firm possibility.

G. Systems and Equipment Requirements

The PSRO program, (or any peer review program, for that matter) will require an extensive systems and data processing capability in order to adequately monitor all the transactions that are passed through the system. There will be need for systems and data processing equipment at the local PSRO level, at the State Support Center level and at the Federal level. Third-party carriers will require system support to adequately cover the review function and manipulate and massage the data before it is fed into the review system for national health insurance.
H. Educational Service Requirements

There will be a great deal of educational requirements as a result of PSRO. The typical peer review and utilization review loop that should be followed in the ideal system would be as follows:

1. Establishment of norms, criteria, and standards.
2. Development and implementation of a system to monitor actual practice and to compare actual practice against norms, criteria and standards.
3. Educational effort to modify behavior.
4. Follow up monitoring to determine effect of educational effort.
5. Reassessment of criteria, norms, and standards to determine if modifications are in order based on experience.

There is not one aspect of this review cycle that will not require extensive educational and training effort in the development as well as in the implementation and ongoing stages. The opportunity is there for those who would pursue it.

As can be seen from review process, there is a very strong need to educate the physicians on the proper utilization of specific drugs and other diagnostic services.

I. Consulting Services

Consulting services will be required in a wide variety of areas as they apply to the peer review process. Some of these services will include the following:
J. Physician Recruitment Services

There will be need to provide adequate health manpower as a result of the PSRO program. Specifically, there appears to be a maldistribution of medical manpower, with the rural areas being underpopulated with physicians, and the urban areas being overpopulated with physician manpower. If someone could provide adequate recruitment services for physicians, or could devise systems to attract physicians to an underserviced area, the someone's services would be in great demand. This ability would assist a PSRO greatly by enabling the hospitals within a PSRO area to meet PSRO quality standards and criteria. This need could well become the basis for a new service to provide physician recruitment services and other related health manpower recruitment services to a PSRO area.

K. Government-Sponsored R & D Funds Related To PSRO

There is expected to be additional funds for R&D efforts related to development, monitoring, and operation of PSRO and peer review activities on a national basis. The opportunity here is for organizations to develop standards, to develop data systems, to develop data bases, to develop
methods and procedures for monitoring care. The opportunities here are for both non profit as well as commercial organizations.

L. Provision Of Base Line Data

By base line data is meant data which reflects delivery of medical care services within a geographic area over a period of time. The base line data is used to make comparisons with the data generated after a PSRO has been implemented. It is also used to develop standards, norms and criteria for specific diagnosis before the PSRO is implemented; and it has a number of other uses in connection with retrospective review of care, medical care evaluation studies, and applications for a select period.

The opportunity for a number of data base publishing firms and organizations to provide data to PSROs on a local basis, to the Federal PSRO data processing activity, to Congress, to insurance carriers, and to medical speciality organizations would seem to be very great.

M. Consumer Education

Consumers are becoming much more sophisticated in the appropriate methods, proper medical procedures, and their legal rights to receive quality medical care.

The consumer movement can represent a problem as well as an opportunity. An obvious opportunity here would be to establish a service to the consumer informing him of alleged proper medical care procedures. There is also the opportunity to influence the consumer, and to suggest ways in which he can modify his behavior related to
<table>
<thead>
<tr>
<th></th>
<th>ACCESSIBILITY</th>
<th>ACCURACY</th>
<th>ADEQUACY</th>
<th>TIMELINESS</th>
<th>COST</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sample patient records from national sample of hospitals</td>
<td>Likely to pose significant problems</td>
<td>Good</td>
<td>Good for utilization; Good (with reservations) for quality of care; Good for cost</td>
<td>Good</td>
<td>Very high</td>
</tr>
<tr>
<td>2</td>
<td>Individual PSROs sample records from national sample of hospitals</td>
<td>Likely to pose some problems</td>
<td>Good</td>
<td>Good for utilization; Good (with reservations) for quality care; Good for cost</td>
<td>Good</td>
<td>Very high</td>
</tr>
<tr>
<td>3</td>
<td>Use abstract service data (PAS and other abstract services)</td>
<td>Likely to pose some problems</td>
<td>Questionable</td>
<td>Good for utilization; Fair for quality; No cost data</td>
<td>Very good</td>
<td>Moderate</td>
</tr>
<tr>
<td>4</td>
<td>Use MADOC data</td>
<td>Good</td>
<td>Questionable</td>
<td>Fair for utilization; (no Medicaid data); Poor for quality of care; Good for cost</td>
<td>Fair, available for both new and existing PSROs but with delay of 1 to 2 years</td>
<td>Very low</td>
</tr>
<tr>
<td>5</td>
<td>Use UHDA data</td>
<td>Good</td>
<td>Questionable but somewhat better than PAS</td>
<td>Good for utilization; Poor for quality of care; Good for cost</td>
<td>Fair, may not be implemented nationally until 1976</td>
<td>Low</td>
</tr>
<tr>
<td>6</td>
<td>Collect retrospective data on quality of care as part of National Medical Care Evaluation Studies</td>
<td>Good</td>
<td>Good</td>
<td>Good for quality of care</td>
<td>Good</td>
<td>Unknown</td>
</tr>
<tr>
<td>7</td>
<td>Individual PSROs sample patient records prior to quality assurance effort*</td>
<td>Good</td>
<td>Good</td>
<td>Good for quality care</td>
<td>Good</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

*This option assumed to be used in conjunction with options 4, 5 or 6

Source: Bureau of Quality Assurance
Table 28.
PHASES OF APPLICATION OF PSRO

<table>
<thead>
<tr>
<th>PHASE NO.</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>NECESSITY FOR ADMISSION TO GENERAL ACUTE COMMUNITY HOSPITALS CONTINUED STAY REVIEW FOR INPATIENTS</td>
</tr>
<tr>
<td>II</td>
<td>MEDICAL CARE EVALUATION STUDIES (INPATIENT)</td>
</tr>
<tr>
<td>III</td>
<td>ANCILLARY SERVICES (DRUGS AND PHARMACEUTICALS WILL BE THE FIRST ANCILLARY SERVICE FOR REVIEW)</td>
</tr>
<tr>
<td>IV</td>
<td>NECESSITY FOR ADMISSION AND CONTINUED STAY IN EXTENDED CARE FACILITIES</td>
</tr>
<tr>
<td>V</td>
<td>REVIEW OF MEDICAL CARE PROVIDED IN OUTPATIENT DEPARTMENTS AND IN PHYSICIANS' OFFICES</td>
</tr>
</tbody>
</table>
delivery of health care services.

In summary, this section has detailed a number of opportunities for a number of different types of organizations and groups that directly and indirectly stem from PSRO program and peer review activity.
Table 29.

SPECIAL ISSUES OF IMPORTANCE TO FUTURE SUCCESS OF PSRO PROGRAMS

1. SUPPORT OF PHYSICIANS AND OTHER INTERESTED GROUPS

2. EXPANSION OF PSRO REVIEW TO NON-FEDERAL PAYMENT PATIENTS

3. NATIONAL HEALTH INSURANCE

4. MALPRACTICE

5. RELATIONSHIP OF PSRO WITH OTHER HEALTH LEGISLATION
   (HMO, END STAGE RENAL DISEASE---LOCAL MEDICAL REVIEW
   BOARDS, P.L. 92-603, NATIONAL HEALTH PLANNING AND
   RESOURCES DEVELOPMENT ACT OF 1974)
SECTION X. RECOMMENDATIONS ON HOW TO TAKE ADVANTAGE OF THE OPPORTUNITIES

This section will detail certain recommendations and other strategy for taking advantage of the opportunities as outlined in the last section. It is geared particularly to the pharmaceutical firms; manufacturers of medical equipment; insurance companies; management consultants; and financial institutions including investment houses and banks.

A. Pharmaceutical Firms

The pharmaceutical firms should take advantage of the opportunities presented by the PSRO - peer review program in the following areas:

(a) Development of a more thorough ongoing and updated knowledge of the implications of PSRO review procedures for specific products.

(b) Develop medical justifications for use of their products in particular medical situations.

(c) Develop cost justifications for use of their products in particular medical situations.

(d) Provide a program for effectively disseminating information to various groups or the medical and cost justifications for use of their product.

The reasons for taking advantage of the program in the above areas and some suggested approaches as to how these areas can be developed as follows.

1. Development of a More Thorough Ongoing and Updated Knowledge of the Implications of PSRO Review

The PSRO program changes rapidly in terms of new objectives, strategy, major personnel changes, legal problems affecting implement-
tation, available budget, and utilization review procedures. Certainly a manufacturer would want to be alert to these changes, primarily where the changes affect his product.

How can this knowledge be acquired and interpreted? Public documents will reveal much of this information. Congressional hearing minutes, draft regulations, Departmental policy statements, and Departmental procedure guidelines will prove very helpful. However, selecting the appropriate information and making a proper analysis and interpretation may require outside professional assistance.

Secondly, the alert firm will need to maintain close personal contact with the individuals who are responsible for determining new directions. These people include DHEW bureaucrats, legislators, outside interest groups, and educational institutions to name but a few. There needs to be attendance at public meetings where the policy issues are discussed. As in the case of developing updated information through written documentation, the close personal contact discussed above may be more effectively carried out through the advice and guidance of outside professional assistance.

All of the organizations described in this report should be contacted by the manufacturer.

2. Develop Medical Justifications for Use of Their Products in Particular Medical Situations

Eventually, there will be norms, criteria and standards for
appropriate medical use of specific pharmaceutical preparations. These parameters will cover at least the following minimal areas: maximum and minimum dosages for each drug related to diagnosis; maximum and minimum duration of therapy; contraindications for therapy based upon interactions and reactions to other drugs, allergies, inconsistencies with diagnosis, specific diets, and specific laboratory tests.

Standards will be developed along the same patterns as those developed for patient admission and continued stay by the AMA through the speciality medical societies. The method for developing these standards will be similar to the admission criteria also. The Federal government (most likely through the BQA, FDA, and other agencies concerned with medical standards), will cooperatively develop the standards with academic and research organizations; with trade associations (e.g. American Society of Hospital Pharmacists and American College of Clinical Pharmacology); and hopefully with the manufacturers. The latter group should take the initiative in this effort.

In essence, each disease entity will have its recommended drug therapy as part of the total standards and criteria. There will be competition among manufacturers for having their drug as "the drug of choice" for each diagnosis. In effect, there will be a national formulary of acceptable drugs for each therapy regime.
Where two competing drugs are in fact of equal potency, efficacy and acceptability, then the people responsible for developing the standards will turn to the costs of the drug. Once quality has been satisfied, then a purely economic decision needs to be made. This is discussed below.

3. Develop Cost Justifications for Use of Their Products When Competing Products are Medically Similar

When the issue of "drug of choice" develops into a cost decision, the manufacturer will be required to justify his product on a cost basis. The Maximum Allowable Cost Program (MAC) is somewhat a step in this direction. Charges for drugs are currently being analyzed on a historical basis by the Federal government to determine how "comparable" drugs compare in cost. From this analysis, price ceilings will be placed on all drugs. If a manufacturer wants to object to this ceiling, he has recourse through administrative agency appeal and then to the courts. However, it would be much easier for the manufacturer to present a plan for justifying proposed ceilings, rather than to file objections on prices developed after the fact.

Similarly, under a peer review program, the manufacturer would be well advised to plan now for justifying his costs where the drug competes with other drugs of equal efficacy.
4. **Develop a More Effective Program for Educating Physicians And Pharmacists on Proper Use of the Product**

Responsibility and opportunity for the pharmaceutical firm to take advantage of the PSRO program is also in the area of physician and pharmacist education.

It is recognized that the drug industry currently does provide extensive information on proper drug use through detail-men, journal advertising, tapes, and films. However, the fact remains that most physicians are not thoroughly familiar and do not always use the information available to them on proper use and contraindications to use of a specific drug.

The pharmacist, as well as the physician, have a prime responsibility under PSRO to assure the appropriateness and quality of the prescriptions they prescribe and dispense. In order to accomplish this assurance they must be aware of the contraindications for use of the drug, adverse reactions and side effects, as well as the conditions under which the prescription should be given. Where drugs are inappropriately prescribed by physician ignorance, the adverse reactions, etc., are still a reflection upon the pharmaceutical industry in the final analysis.

The pharmaceutical industry is defined very broadly in this context. The basic elements of the industry include ethical drug manufacturers, pharmacists (both community and institutionally based), nurses and physicians. The hospitals, pharmacologists,
and the Federal regulatory agencies are also included in a secondary role. However, the first group of elements are the primary targets of public criticism when improper drug utilization is the subject of ridicule.

It is interesting to note that the development of hospital drug information systems now will facilitate the task of PSROs, which ultimately will have to spell out drug standards for their communities. Chairman and Staff Director of the late 1960's HEW Task Force on Prescription Drugs, Philip R. Lee, M.D., in his book, *Pills, Profits and Politics*, emphasizes the importance of these emergency systems. Dr. Lee is the former DHEW Assistant Secretary for Health and is now a Professor of Social Medicine at the University of Southern California, and Milton Silverman, Ph.D. who co-authored the book, is a research pharmacologist at the University of California School of Medicine and Pharmacy and who for many years was Science Editor of the "San Francisco Chronicle". PSRO drug guidelines could not only serve as an information aid to prescribing physicians but could also offer some guarantee to the physician that if he follows locally accepted rules he cannot justifiably be charged with malpractice. The drug firms have a definite responsibility for activity to educate the physician on appropriate prescribing habits.

In summary, the firms should have a greater impact on the education of the physician. In addition, they should also be more thoroughly involved in drug labeling requirement legislation and other
facets of Federal regulations of health care delivery. Specific recommendations as to how this can be accomplished are as follows:

1. Active participation in development of norms, standards, and criteria for drug use;

2. Attendance at the National PSRO Review Council Meetings;

3. Conferences with individual Senators related to specific legislative measures;

4. Frequent meetings with the FDA and BQA officials on the proposed regulations.

5. Assistance to specialty societies on developing norms and criteria;

6. Assistance in funding review monitoring activities outside of the governmental funding activity.

B. Manufacturers of Medical Equipment and Supplies

Manufacturers of medical equipment and supplies have an opportunity to influence the PSRO's attitude of the utilization of selected products. If the medical procedure can be justified, it will be much easier to justify use of the supplies and equipment necessary to perform the procedure.

Then PSROs turn their attention from hospital admissions and length of stay to actual medical practice, medical peer review could impose strict guidelines on the use and evaluation of medical procedures which depend upon utilization of devices. Dr. Theodore Cooper, currently Assistant Secretary for Health of the Department of Health, Education and Welfare, has publically indicated that he could foresee the day when
the following types of questions could be asked of a medical device and/or supply manufacturer:

1. What are the specific conditions and indications for the use of a certain piece of medical equipment?
2. What will it replace?
3. What is the objective data as to its real advantages over current devices and techniques?
4. Is there a role for post-marketing review?
5. What are the cost benefits of this new device?
6. What are the potential hazards?

If a manufacturer can answer these types of questions in an honest and comprehensive manner, he will be well prepared for the implications of peer review. If he combines this preparedness with an aggressive educational campaign in both the development of standards and the use of the product, he will have taken maximum advantage of the opportunities available to him under PSRO.

C. Insurance Companies

It is hoped by the Federal government that private health care insurance carriers will support the development of PSRO activity by deciding to use PSRO organizations to meet the carrier's review needs. Henry Simmons, M.D., former Deputy Assistant Secretary for Health and Director of the Office of Professional Standards Review, once said, "We believe that the private carriers will want a system of review for all patients and that the PSRO system will in effect become that system."
To push this development, we are exploring whether a conditionally designated but unfunded PSRO could undertake privately financed review in advance of receiving Federal Funds to review the care given to the recipients of Federal benefits."

Insurance companies should work actively through the Health Insurance Association of America to assure that data processing services and EDP support services are being covered adequately. It will become increasingly important for them to assure there is adequate data and adequate review of services. There is opportunity to develop systems to accomplish these objectives.

D. Consulting Firms

Consulting firms should capitalize upon the many different types of services that are currently needed. Specific recommendations on how to accomplish this are the following:

1. Keep in constant communication with the Federal PSRO staff to determine near term needs of the government in operating the PSRO program.

2. Suggest RFPs and contract services that the Federal government should consider.

3. Determine from Federal sources the probable current and future needs of the local PSROs, the hospitals, the trade organizations, and the medical groups.

4. Meet with all of the prospective clients mentioned in number 3 above, to assure an awareness of the needs for services.

5. Determine how, in combination with other consulting firms, a particular firm's services could benefit a client.
6. Operate seminars, develop newsletters, and prepare tape cassettes regarding various aspects of the PSRO program.

E. Financial Institutions

Investment houses and banks have an opportunity to analyze the decisions reached by the PSROs, to determine what products and services are likely to be acceptable to a PSRO. This information can be used as part of the total information available to the financial institution in reaching recommendations on specific investment decisions. The financial institution can also use this information to obtain an early warning of future trends in a particular subset of the health care industry.

F. Opportunities for Miscellaneous Groups

Opportunities - Pharmacists - PSROs will affect every pharmacist eventually according to a joint statement of the American Pharmaceutical Association and the American Society of Hospital Pharmacists. Professional Standard Review Organizations will first affect the practice of pharmacy in hospitals, and then the community pharmacist and others who provide service in nursing homes.

The statement stated specifically:

"Pharmaceutical service will be subject to review by PSROs to the extent that drugs provided and services rendered are reimbursed under Federal programs.

Pharmaceutical service provided in acute care hospitals will be subject to immediate PSRO review. Service provided in long term care facilities will be subject to review somewhat later. Service provided in an ambulatory environment will be reviewed
when systems of review have been developed and when PSROs have satisfied the HEW secretary that they have the capacity of reviewing Health Care Services provided in this environment."

**Opportunity - Consumer Satisfaction** - Peer review has usually been professionally oriented. There is no reason to believe that the consumers of medical care have the training required to evaluate the technical proficiency or technical appropriateness of medical services. However, patients do make judgements which influence their compliance with recommended medical regimens, and whether or not they return for further care. Patients are competent to make judgements about the non-professional aspects of medical care which is cost, convenience, and personal satisfaction. These factors, and patient judgements concerning them, often determine whether or not adequate care is actually delivered to the population.

Studies of consumer satisfaction with medical care have taken place as evidenced by increased patient understanding of disease, increased compliance with medical regimens, rate of return for treatment. Various groups have conducted surveys to gather specific opinions. For this reason there is a tremendous opportunity for the manufacturers of supplies and equipment to influence buying decisions and pronouncements of the local PSROs through influences placed upon the consumer.
SECTION XI. CONCLUSIONS

This section of the report will list the conclusions with regard to opportunities in the PSRO program. After a thorough indepth analysis of the growth of the health care field, a review of the concept of medical peer review, an analysis of the current status of PSRO, and the opportunities that emanate as a result of that program, the following conclusions are reached:

1. Peer review is a concept that appears to be accepted by all major parties concerned.

2. The growth of the health care industry in the last decade seems to be a mandate for some form of control over the cost and quality of medical care.

3. The Federal government is the largest single purchaser of medical care. It is therefore logical to expect the Federal government to take the lead in controlling the cost and quality of medical care.

4. The government would prefer to have local physicians be responsible for reviewing the necessity and appropriateness of medical care delivered at the local level.

5. The amendments to the Social Security Act establishing the PSRO program reflected the government's desire to have the physicians themselves operate a system of controlling cost and quality of medical care.

6. The PSRO program has been very slow in being implemented.

7. The reasons for lack of efficient implementation are:
   (a) inadequate funding; (b) turnover in staff at the Federal level; (c) lack of complete acceptance of the method of implementation by various provider groups; and (d) interdepartmental DHEW political battles over jurisdiction, etc.

8. There are opportunities available to pharmaceutical firms, manufacturers of medical equipment and
supplies, insurance companies, consulting firms and financial institutions as a result of the PSRO program.

9. The major advantage of the program to these groups stems from the strong need to educate and instruct the providers of medical care on the appropriate use of the several supply and equipment items.

10. There are a multitude of new needs created as a result of the PSRO programs.

11. The groups outlined in "9" can take advantage of these needs and opportunities by remaining diligent in the contemporary status of the PSRO program implementation.

12. A PSRO-type of medical peer review program will become the basis for monitoring delivery of health care under a national health insurance program.

13. Each vendor of a service or product will need to become more aware of the peer review movement.

14. Each vendor of a service or product will need to justify the medical necessity and cost of his product or service.

15. Each vendor of a service or product will need to become more efficient in instructing the physicians and other providers on the use of the product.
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<td>Public Law 92-603, Title XI - General Provisions and Professional Standards Review (Establishing the PSRO Program.)</td>
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<td>H.</td>
<td>Excerpts from the American Medical Association's Project on Model Screening Criteria to Assist PSRO</td>
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<tr>
<td>I.</td>
<td>Project Directory, Effective July 1, 1975, of Local PSROs and DHEW Regional Office Focal Points for PSRO Assistance (Organized by State; by Organizational Status - i.e., Planning, Conditional or Operational Phase; and by Health Services Administration Contract Number.)</td>
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<tr>
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<td>Statistical Reports Illustrating Cost Savings Result of MCF Review Activity</td>
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GLOSSARY OF SELECTED TERMS
APPENDIX A. GLOSSARY OF SELECTED TERMS

ADMISSION CERTIFICATION (AC)

A form of concurrent health care review in which an assessment is made of the medical necessity of a patient's admission to a hospital.

ADVISOR

A lay person with particular expertise in administration, financing, or delivery of medical care. The peer review committee relies upon advisors for additional resources in their areas of knowledge.

AMBULATORY CARE REVIEW

A function of the medical society or other organization authorized by the medical society, which is concerned with peer review to assure quality of medical care rendered to ambulatory patients in a geographically defined locality.

BQA

Acronym for Bureau of Quality Assurance; this is the administrative unit of the Federal government within the Department of Health, Education, and Welfare that has the operational responsibility for the PSRO program.

CARRIER

A private financing organization or government agency which underwrites and/or administers programs that pay for health services.

CLAIMS ADMINISTRATION

A function of insuring organizations involving the review of health insurance claims submitted for payment by individual claim or in the aggregate. Claims administration, as it relates to professional review programs, is an identification procedure, screening treatment or charge patterns, for subsequent referral to peer review for adjudication.

CLAIMS REVIEW

A retrospective process which begins with the initiation of a claim for payment after the completion of a service. The claims process, from receipt to payment, usually includes:
A check for the completion of all necessary items on the form;

A determination that the beneficiary is indeed eligible and that the contract covers the services provided; and

A check that charges are consistent with usual and customary individual fees or published institutional rates.

**CLERICAL GUIDELINES**

Minimal criteria to enable non-professional review and indicate cases in which professional review is required.

**CONCURRENT REVIEW**

That review of patient services which is performed while the patient is hospitalized.

**CONSULTANT**

A practicing physician to whom the peer review committee can refer questions for additional evaluation. For the most part, consultants will represent specialty areas of medicine, serving as a reference for particular situations involving a physician practicing in the same specialty.

**CONTINUED OR EXTENDED STAY REVIEW**

A form of concurrent medical care review which occurs during a patient's hospitalization and consists of an assessment of the medical necessity of a patient's need for continued confinement at a hospital level of care and may also include a detailed assessment of the quality of care being provided.

**CRITERIA**

(Dictionary: "Standards on which judgments or decisions may be based.") A statement of preferred treatment modalities established by a peer review committee for use in identifying situations for review. In review discussions, the terms "criteria" and "guideline" are frequently used interchangeably. The DHEW definition is: Predetermined elements of health care against which aspects of the quality of a medical service may be compared (i.e., a laboratory examination which generally would be performed for every patient with a given diagnosis). They are developed by professionals relying on professional expertise and on the professional literature.
CRITICAL CRITERIA

Those anticipated to best discriminate among physicians or thought most important to good care.

CURRENT EVALUATION (OF UTILIZATION OF MEDICAL SERVICES)

In contrast to medical audit, which retrospectively reviews utilization, current evaluation involves the periodic review of services during the course of treatment.

DATA

Statistical information which is employed in the peer review process to identify patterns of health service utilization. Data can be used to verify that peer review criteria actually reflect community practice patterns. Converseley, data can be screened through previously established criteria to point out situations for further peer analysis.

DATA SOURCES

Organizations collecting information on patterns of medical practice or charges. Presently, data sources include federal agencies collecting broad demographic data, national or local organizations which compile information on hospital discharges, and health insurance carriers.

EPISODES OF CARE

A specified period of time during which health services were rendered to a patient.

FOUNDATION FOR MEDICAL CARE

An organization of doctors of medicine, sponsored by a local or state medical association. It is a separate and autonomous corporation with its own board of directors. Every physician member of the medical society may apply for membership in the Foundation and, upon acceptance, may participate in all programs and activities.

A Foundation for Medical Care is concerned with the development and delivery of medical services and maintenance of reasonable costs. It believes in the free choice of a personal physician and hospital by the patient; the fee-for-service concept; and local implementation of peer review.

GOVERNMENT FINANCED PROGRAMS

Any health care program funded through public sources; for example, Medicare and Medicaid.
GUIDELINE

(Dictionary: "An indication or outline of future policy or conduct.") Applied to a discussion of peer review, guidelines suggest a range of acceptable treatment patterns.

MEDICAL CARE EVALUATION

The educational function of the medical staff designed to assure the quality of care in the hospital or other health care institution. Medical care evaluation is concerned with two dimensions of quality:

Utilization Review: examination of the efficiency of institutional use, and the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices, both on a current and a retrospective basis.

Medical Audit: retrospective examination of the clinical application of medical knowledge, advancing the level of medical care in the institution through an educational process.

MEDICAL CARE EVALUATION STUDIES (MCEs)

A form of retrospective health care review in which in-depth assessment of the quality and/or nature of the utilization of health care services is made.

MEDICAL PRACTICE ANALYSIS

A function of the medical society or other organization authorized by the medical society, designed to coordinate all peer review efforts of a community. Medical practice analysis focuses on the development and application of criteria for optimal medical care, and evaluates the individual and collective quality, volume, and cost of medical care, wherever provided.

NORMS

Empiric measures of performance such as length of stay by diagnosis. Norms of health care services are used as principal points of evaluation and review in the operation of the PSRO hospital review system.

NORMATIVE CRITERIA

Criteria determined by the consensus of selected committees.

OUTCOME APPRAISAL

Evaluation of the results or consequences of disease or medical intervention. Outcomes may be either intermediate or final. Outcomes with regard to individual patients or population groups may be subclassified as:
Patient Outcomes, such as mortality or survival, physical or psychological morbidity, and the level of function;

Process Outcomes, including patient satisfaction, understanding of disease, compliance with medical regimens, and altered level of risk;

Administrative Outcomes, including the utilization of services, workloads, waiting time intervals, and other volumetric measures of managerial interest;

Economic Outcomes specifying the costs generated by services provided.

PARAMETER

(Dictionary: "A quality which may have various values, each fixed within the limits of a stated case.") In common usage, "parameter" is frequently used to suggest a range and as such, can be properly interchanged with "criteria" or "guideline" when discussing peer review. The precise definition of "parameter", however, does not connote the flexibility of the other two terms and thus is not recommended.

PHDDS

The UHDDS, as expanded for the PSRO program, with the approval of the Secretary of HEW.

PEER REVIEW

Evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians. Peer review is the all-inclusive term for medical review efforts. Medical practice analysis, inpatient hospital and extended care facility utilization review; medical audit; ambulatory care review; and claims review are all aspects of peer review.

PEER REVIEW COMMITTEE

The body of practicing physicians appointed by the medical society which is responsible for Medical Practice Analysis.

POPULATION-BASED DATA

Refers to health measures or the utilization of services per unit of population defined by geographic or demographic characteristics.

PRE-ADMISSION CERTIFICATION

Review of the medical necessity of admission to a hospital prior to the admission.
PRIVATE FINANCING ORGANIZATIONS

Blue Shield plans, Blue Cross plans, and insurance companies.

PROCESS APPRAISAL

Evaluation of health services actually provided to patients or the operation of institutional mechanisms designed to effect health services.

PROFESSIONAL REVIEW

Can be prospective, concurrent, or retrospective. It is designed to evaluate both the quality and the economics of medical care. Professional review generally includes an evaluation of the:

- Relevance of individual services to each patient's specific needs, as determined by his diagnosis;
- Appropriateness of the level of care to each patient's particular medical needs;
- Volume of services provided in each instance;
- Appropriateness of the outcome, including complications, indications for discharge, and the provision of follow-through services; and
- Appropriateness of the services provided to populations as a measure of the accuracy of diagnosis and the adequacy of case finding.

PROFILE

A presentation of selected information which identifies patterns of health care delivery during a defined period of time.

PROFILE ANALYSIS

A form of health care review which examines patterns of practice to identify problem areas in the delivery of health care and to evaluate the effects of peer review.

PSRO DATA AND INFORMATION

Data and information acquired, generated and used for purposes of carrying out the objectives of the PSRO legislation.

REGIONAL

Refers to any designated geographic area rather than the specific geography of the Federal health regions.
REVIEW COORDINATION

The process by which the various components of a health care review program are integrated.

REVIEW PROCESS

A general term used to describe all aspects of review, including those which are not performed by physician peers. This involves supportive activities of lay individuals and organizations as well as peer review itself.

ROUTINE DATA

Data required on each episode of care required.

SCREENING

Screening is a process in which norms and criteria are used to analyze large numbers of items, activities or transactions in order to select a smaller number for study in depth.

STANDARDS

The desired level of compliance with criteria or norms. Standards sometimes refer to criteria which have been validated by outcomes evaluation. The DHEW definition is: "professionally developed expressions of the range of acceptable variation from a norm or criterion (i.e., the minimally and maximally acceptable percentages of patients who should receive a particular service, given a particular diagnosis)."

STRUCTURAL APPRAISAL

Evaluation of the preparation of an individual professional or the adequacy of a facility or organization to provide specific health services at a stated level of quality. Structural appraisal often includes licensure and/or certification.

UNIFORM HOSPITAL DISCHARGE (UHDDS)

A discharge data set based on the work done by the Uniform Abstract Sub-committee of the United States National Committee on Vital and Health Statistics, the Uniform Hospital Discharge Data Demonstration, and the work group on Uniform Hospitalization Data for HEW programs.
USUAL, CUSTOMARY, REASONABLE

As adopted by the American Medical Association House of Delegates at the 1966 Clinical Convention:

"Usual is defined as the 'usual' fee which is charged for a given service by an individual physician in his personal practice (i.e., his own usual fee);

Customary is defined as that range of usual fees charged by physicians of similar training and experience for the same service within a given specific limited geographic or socioeconomic area;

Reasonable is defined as a fee which meets the above two criteria, or, in the opinion of the responsible local medical association's review committee, is justifiable in the special circumstances of the particular case in question."
APPENDIX B

BIBLIOGRAPHY
APPENDIX B

BIBLIOGRAPHY

1. General Information


ASIM Guidelines for Medical Care, ASIM Aids, no. 317, American Society of Internal Medicine, 703 Market Street, Room 535, San Francisco, California 94103.

Brook, Robert H. M.D., A Study of Methodologic Problems Associated with Assessment of Quality of Care, Dept. of Medical Care and Hospitals, the Johns Hopkins University, Baltimore, Maryland, May 1972.


Essentials of Approved Programs in Continuing Medical Education, prepared by the Council on Medical Education, American Medical Association, June 1970.


Goodman, Raymond D. M.D., (ed.), Monograph-Medical Care Audit, Dept. of Continuing Education in Health Sciences, School of Public Health, UCLA, July, 1974.

Hospital Utilization Project, Focus on Utilization Review, 3530 Forbes Avenue, Pittsburgh, Pennsylvania, published from November 1968 to date on select ed topics.

Howard, Rutledge W. M.D., "Medical Education in the Community Hospital," The Hospital Medical Staff, Vol. 1, January 1972.


Schonfeld, H.K., "The Development of Standards for the Audit and Planning of Medical Care; Pathways Among Primary Physicians and Specialists for Diagnosis and Treatment," Medical Care 6:101-114, March - April 1968.


2. Information About PSRO

(a) Development of a PSRO


PSRO: A Guide to its Implementation Through Peer Review, ASIM Aids, order no. 315, American Society of Internal Medicine, San Francisco, California.

"PSRO's and Norms of Care, A report by the Task Force on Guidelines of Care," AMA Advisory Committee on PSRO, JAMA 228:2, July 8, 1974.

"Summary of Project to Develop Model Sets of Criteria for Screening the Appropriateness, Necessity and Quality of Medical Services in Hospitals," American Medical Association, July 1974.


(b) Hospital Review Programs in Operation

Certified Hospital Admission Program (CHAP). Developed by the Medical Care Foundation of Sacramento County, 5380 Elvas Avenue, Sacramento, California 95819.

Certified Hospital Extension of Care (CHEC). Developed by Georgia Medical Care Foundation, 1100 Spring Street, N.W., Atlanta, Georgia 30309.

Concurrent On-Site Evaluation and Review Effort (CONSERVE). Developed by Multnomah Experimental Medical Care Review Organization, 5319 S.W. Westgate Drive, Portland, Oregon 97721.

Hospital Admission and Surveillance Program (HASP). Developed by Illinois Foundation for Medical Care, 360 N. Michigan Avenue, Chicago, Illinois 60601.

Hospital Admission Precertification Program (HAPP). Developed by New Mexico Foundation for Medical Care, 1009 Bradbury, S.E., Albuquerque, New Mexico 87106.
Hospital Utilization Project (HUP). Developed by Alleghany County (Penn) Medical Society Foundation, 713 Ridge Avenue, Pittsburgh, Pennsylvania 15212.

Medical Advances Institute (MAI) PSRO Review Process Function and Organization. Developed by Ohio State Medical Association, 17 S. High Street, Columbus, Ohio 43215.

On-Site Concurrent Hospital Utilization Review (OSCHUR). Developed by Utah Professional Review Organization, 555 E. Second Street South, Salt Lake City, Utah 84102.

(c) Resource Material


3. Information About Utilization Review


Griffith, J.R. "It Utilization Review Worth It? Hospital Administration 14:4-9, Fall, 1969.

Handbook: The Extended Care Facility and Utilization Review, Rochester, Regional Utilization and Medical Review Project.


Stephen, Sr., M.A. Evolution of a Utilization Review Committee at the University of Illinois Research and Educational Hospitals. Program in Hospital Administration, School of Public Health, University of Chicago, 1966. 68pp.


4. Information About Medical Audit


Sanazaro, P.J., Williamson, J.W. "End Results of Patient Care: a Provisional Classification Based on Reports by Internists," Medical Care, 6:123-130, March/April, 1968.


Schonfeld, H.K. "Standards for the Audit and Planning of Medical Care: a Method for Preparing Audit Standards for Mixtures of Patients," Medical Care, 8:287-296, July/August, 1970.

Shapiro, S. "End Result Measurements of Quality of Medical Care," Milbank Memorial Fund Quarterly, 45:7-30, April 1967.

5. Publications Providing Information About the Current Status of the PSRO Program.

American Association of Foundations for Medical Care News Letter, published monthly by AAFMC, 540 East Market Street, P.O. Box 230, Stockton, California 95201. $75.00 per year.

American Medical News - Published weekly by American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. $5.00 per year.
American Nursing Home Association Weekly Notes, published weekly by ANHA, 1200-15th Street, N.W., Washington, D.C. 20005. $2.00 per year for members only.

Group Practice Newsletter, published weekly by American Association of Medical Clinics, 20 South Quaker Lane, Alexandria, Virginia 22313. Free to members and selective health organizations.


Hospital Week, published weekly by American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611. $5.00 per year.


Washington Developments, published semi-monthly by American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611. $5.00 per year for members; $15.00 for non-members.

6. Additional Information Related to PSRO

Patient Care Coordinator Program - (A Program of Concurrent Admission Certification and Continued Stay Review), Blue Cross Association, 840 North Lake Shore Drive, Chicago, Illinois 60611; June, 1974; Attention: Richard B. Stuckey; Price $3.00.

APPENDIX C

DRAFT POLICY STATEMENT OF DHEW ON THE
USE OF NORMS, CRITERIA
AND STANDARDS OF MEDICAL CARE
Use of the Review Process

Norms, criteria and standards shall be utilized in the conduct of admission certification, continued-stay review, medical care evaluation studies, and profile analysis as described in regulations governing PSRO hospital review and applicable guidelines. These norms, criteria and standards shall be utilized for screening to select from a large number of cases under review those which require closer professional scrutiny. Screening review, using norms, criteria and standards may be performed by non-physicians employed by the PSRO or by a delegated hospital. Those cases not meeting the norms, criteria and standards shall be subject to peer review by physician members of the PSRO. In addition, a sample of cases meeting the norms, criteria and standards shall periodically be reviewed in order to validate the norms, criteria and standards currently employed by the PSRO.

PSRO Responsibilities and Procedures

Each PSRO shall, as part of its written formal plan for operation as a PSRO, specify the organizational structure and procedures which it will utilize to develop or select, disseminate, update and modify norms, criteria and standards. The formal plan shall specify that all norms, criteria and standards used in the hospital review process must be disseminated to each hospital in the area and to the Secretary. All norms, criteria and standards used in the hospital review process shall be available at the
principal office of the PSRO for public inspection. All norms, criteria and standards employed by a PSRO for use in concurrent review shall be forwarded to the Secretary prior to their use by the PSRO. All revisions in these norms, criteria and standards shall be forwarded to the Secretary prior to their use by the PSRO.

Each PSRO shall, as part of its formal plan for operation as a PSRO, specify a methodology for developing criteria and standards for selecting norms to be used in the review process. Procedures to be employed for such development and selection must be approved by the Secretary.

The PSRO shall assure that uniform norms, criteria and standards are utilized in the hospital concurrent review process throughout its area, except as specified below. Where a hospital can demonstrate that there is good cause (i.e., patient mix characteristics, etc.) for variation from the PSRO norms, criteria and standards for concurrent review, exception to this requirement may be granted by the PSRO for that hospital. Such exception may be reversed by the Secretary if not granted for a good cause. The formal plan of each PSRO must include a methodology for reviewing and acting upon such requests for exception. Such plan must be approved by the Secretary.

Norms, criteria and standards developed by the PSRO for use in medical care evaluation studies, as well as selected norms, criteria and standards developed by delegated hospitals for such studies, shall be kept on file at the principal office of the PSRO. Examples of such norms, criteria and standards shall be forwarded to the Secretary to the extent specified in Federal reporting requirements (q.v.). The PSRO shall provide these norms,
criteria and standards, on request, to hospitals in the area who wish to conduct similar medical care evaluation studies.

**National PSR Council Responsibilities**

The National Professional Standards Review Council shall make available to each PSRO regional norms and model sets of criteria and standards which should serve as principal points of reference in the development of norms and criteria and standards, respectively, for use in concurrent review in the area. Regional norms may include those developed by regional or national organizations which abstract hospital data; intermediaries; carriers; or state governmental agencies so long as the region within which such norms are developed includes a sufficient geographic area to assure that the norms are based on no less than five (5) percent of the annual hospital discharges in the United States and so long as the region includes more than one PSRO area. In the case of criteria and standards, the National Professional Standards Review Council shall provide to each PSRO a model set of such criteria and standards developed by national medical professional organizations. Such set of criteria and standards shall serve as one of the principal points of reference in developing criteria and standards suitable for use in each PSRO area.

Where significant differences occur between the actual norms, criteria and standards employed by a PSRO and the regional norms, or, in the case of criteria and standards, the model set provided by the Council, the National Professional Standards Review Council shall review such actual norms, criteria and standards to determine if there is a reasonable basis for the difference. Where this review, after appropriate consultation
and discussion, indicates a reasonable basis for the difference, the Council shall approve the use of such norms, criteria and standards. Where the Council makes a determination that such differences are not justified, appropriate modifications must be made by the PSRO and the revised norms, criteria and standards submitted to the Secretary. No PSRO may employ norms, criteria and standards which have been disapproved by the National Professional Standards Review Council.

The National Professional Standards Review Council shall provide for the preparation and distribution to each PSRO of data indicating those regional norms, including model criteria and standards which are to be employed as principal points of reference in developing actual norms, criteria and standards for use in concurrent review in the area. The National Professional Standards Review Council and the Secretary shall provide to each PSRO such technical assistance as is necessary to assure that norms, criteria and standards are effectively and efficiently employed in the review process.
APPENDIX D

SAMPLE FORMS FOR REPORTING PSRO ACTIVITY - REQUIRED BY FEDERAL GOVERNMENT
# QUARTERLY PSRO FUNCTION COST SUMMARY

<table>
<thead>
<tr>
<th>Cost Components</th>
<th>Concurrent Review</th>
<th>Medical Care Evaluation Study</th>
<th>Criteria and Standards</th>
<th>Profile</th>
<th>Administration of Plan</th>
<th>Long Term Care Review</th>
<th>Ambulatory Care Review</th>
<th>Quarterly Total for QR</th>
<th>Cumulative Total ($)</th>
<th>Annual Budget ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Direct Personnel Costs</strong></td>
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<td></td>
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</tr>
<tr>
<td>1. Physicians</td>
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<td>200</td>
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<td></td>
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<tr>
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<td></td>
<td></td>
<td></td>
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| **B. Support Costs** |                   |                               |                        |         |                        |                       |                        |                        |                     |                  |
| 8. Office Space     |                   |                               |                        |         |                        |                       |                        |                        | 1,250               | 2,500            |
| 9. Rent             |                   |                               |                        |         |                        |                       |                        | 1,250                  | 2,500               | 5,000             |
| 10. Repairs & Maintenance | 102             |                               |                        |         |                        |                       |                        | 102                    | 154                | 1,000             |
| 11. Utilities       | 189               |                               |                        |         |                        |                       |                        | 189                    | 309                | 700               |
| 12. Insurance       |                   |                               |                        |         |                        |                       |                        | 290                    | 350                |                  |
| 13. Office Furniture & Equipment | 522           |                               |                        |         |                        |                       |                        | 522                    | 6,211              | 7,500             |
| 14. Office Supplies | 239               |                               |                        |         |                        |                       |                        | 239                    | 827                | 1,000             |
| 15. Mail & Related | 295               |                               |                        |         |                        |                       |                        | 295                    | 522                | 1,200             |
| 16. Postage        | 430               |                               |                        |         |                        |                       |                        | 430                    | 967                | 1,400             |
| 17. Subscriptions   | 21                |                               |                        |         |                        |                       |                        | 21                     | 40                 | 200               |
| 18. Educational Material | 629            |                               |                        |         |                        |                       |                        | 629                    | 629                | 1,000             |
| 19. Telephone       | 140               |                               |                        |         |                        |                       |                        | 140                    | 200                | 600               |
| 20. Travel          |                   |                               |                        |         |                        |                       |                        | 75                     | 23                | 128               |

| **Total**          | 75                | 23                            | 128                    |         | 235                    | 428                   | 1,200                  |                        |                     |                  |
### QUARTERLY PSRO FUNCTION COST SUMMARY (continued)

<table>
<thead>
<tr>
<th>COST COMPONENTS</th>
<th>FUNCTIONAL COST CENTER</th>
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<tbody>
<tr>
<td></td>
<td>CONCURRENT REVIEW (M)</td>
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<td>16b. PENSION</td>
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<td>19b. PHYSICIANS</td>
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<td>19f. ACCOUNTING</td>
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<td>19g. OTHER</td>
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<td><strong>20. ALIGNMENT COSTS</strong></td>
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<td><strong>21. SUPPORT COSTS</strong></td>
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<td><strong>22. TOTAL</strong></td>
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# QUARTERLY DELEGATED HOSPITALS

## FUNCTION COST SUMMARY

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<td>(2) REVIEW COORDINATORS</td>
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<td>(3) OTHER</td>
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<tr>
<td>B SUPPORT</td>
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</tr>
<tr>
<td>(1) PHYSICIAN ADVISORS</td>
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<tr>
<td>(2) OTHER PERSONNEL</td>
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<tr>
<td>(3) OTHER</td>
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<tr>
<td>C TOTAL</td>
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</table>
## Uniform Hospital Discharge Abstract (UHDA) with Added PSRO Data Elements

### Patient Information
- **Name:** Isabelle Q. Archer
- **Address:** 912 Main St., Albany, N.Y. 12221
- **Date of Birth:** 08.12.02
- **SSN:** 09-04-74:11 / 10-15-74
- **Medicare:** Yes

### Diagnosis
1. **Principal Diagnosis:**
   - Hip Fracture
2. **Other Diagnoses:**
   - Atherosclerotic Heart Disease
   - Diabetes Mellitus

### Procedure
- **Principal Procedure:**
  - Total Hip Replacement

### Certification Status

<table>
<thead>
<tr>
<th>Area for Additional Data</th>
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</thead>
</table>

### Areas for Additional Data
- **PSRO Required:**
- **Certification Status**
  - I. Admission Certification (check one)
    - A. Preadmission
    - B. Concurrent
    - C. Concurrent after referral
    - D. Concurrent denial
  - II. Continued Stay Review (indicate number in each box)
    - A. No. Extensions granted
    - B. No. Extensions granted after referral
    - C. No. Extensions denied
  - III. Days Certified (indicate number in each box)
    - A. Days certified at admission
    - B. Days of stay certified as medically necessary
    - C. Days of stay certified for other reasons
1. IDENTIFICATION OF ORIGINAL STUDY
   a. TOPIC OF NCE STUDY: Management of Pts. with Acute Myocardial Infarction in CCU
   b. DATE NCE STUDY COMPLETED: 3/1/75

2. RE-STUDY METHODOLOGY
   a. TYPE OF STUDY (Check One)
      (1) RETROSPECTIVE
      (2) PROSPECTIVE
      (3) MIXED
   b. SAMPLE
      (1) NUMBER OF SUBJECTS: 30
      (2) OTHER DESCRIPTION: First 30 MI discharges in 2nd quarter 1975.
   c. DATA COLLECTION
      (1) SPECIAL DATA ELEMENTS
      (2) ROUTINE DATA ELEMENTS
      (3) ELEMENTS USED
      (4) ELEMENTS TO BE INCORPORATED IN ROUTINE DATASET
   d. CRITERIA AND STANDARDS (Check One)
      (1) SUBSET OF ORIGINAL
      (2) ORIGINAL SET
      (3) NEW SET
      (4) OTHER (Specify)

3. FINDINGS
   a. ORIGINAL FINDINGS
      (1) ACTIONS CORRECTED DEFICIENCIES
      (2) ACTIONS PARTIALLY CORRECTED DEFICIENCIES
      (3) ACTIONS PRODUCED NO CHANGE
      (4) ACTIONS NOT IMPLEMENTED
   b. NEW PROBLEM IDENTIFIED (Specify)

4. RECOMMENDATIONS (Check all that apply)
   a. SAME EDUCATION PROGRAMS
   b. NEW EDUCATION PROGRAMS
   c. SAME ADMINISTRATIVE CHANGE
   d. NEW ADMINISTRATIVE CHANGE
   e. RE-STUDY
   f. NCE STUDY
   g. CHANGE IN CONCURRENT REVIEW
   h. OTHER REVIEW MODIFICATION
   i. NO ACTION NECESSARY
   j. OTHER (Specify)

5. PERSONNEL UTILIZED (Enter in whole hours)
   a. PHYSICIAN: 2
   b. OTHER: 2
   c. TOTAL: 4

ADDITIONAL EXPLANATORY REMARKS (USE ADDITIONAL PAPER IF NECESSARY)
4. Recommendations (continued): Change in Concurrent Review to begin immediately: 3 physicians must have cardiology consultation before admitting patients to CCU.
## MCE Study Status Report

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<th>PSRO</th>
<th>Delegated Hospital</th>
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**Management of Patients With Acute Myocardial Infarction in CCU**

1. **STUDY TOPIC**
   - Mode (s):
     - Management of Patients
     - With Acute Myocardial Infarction in CCU

2. **METHOD FOR SELECTING STUDY (Check one)**
   - A. PROFILE ANALYSIS
   - B. CONCURRENT REVIEW
   - C. OTHER MCE STUDY
   - D. ANALYSIS OF MEDICAL RECORDS
   - E. HIGH VOLUME
   - F. PERCEIVED NEED
   - G. PSRO PREARRANGED PLAN
   - H. OTHER (Specify) 

3. **SELECTION OF STUDY (Check one)**
   - A. PSRO (COMMITTEE)
   - B. HOSPITAL
   - C. MEDICAL AUDIT COMMITTEE
   - D. UN COMMITTEE
   - E. OTHER (Specify) 

4. **DERIVATION OF CRITERIA (Check one)**
   - A. SELF GENERATED
   - B. NATIONAL ORGANIZATION
   - C. OTHER PSRO
   - D. OTHER HOSPITAL
   - E. OTHER (Specify) 

5. **SETTING OF CRITERIA AND STANDARDS (Check one)**
   - A. PSRO (COMMITTEE)
   - B. HOSPITAL
   - C. MEDICAL AUDIT COMMITTEE
   - D. UN COMMITTEE
   - E. OTHER (Specify) 

6. **STUDY SITE (Check One)**
   - A. PSRO-WIDE
   - B. PSRO SUB-AREA
   - C. INDIVIDUAL HOSP.
   - D. SERVICE DEPT. OF HOSP.
   - E. OTHER (Specify) 

7. **TYPE OF STUDY (Check One)**
   - A. COGNITIVE
   - B. PROSPECTIVE
   - C. RETROSPECTIVE
   - D. MIXED

8. **SAMPLE SIZE**
   - A. # OF SUBJECTS
     - 118 D. STAFF
     - 113 OTHER ISPECIFY)

9. **DATA SOURCE AND COLLECTION (Check One)**
   - A. SPECIAL ABSTRACT
   - B. ROYAL ABSTRACT
   - C. OTHER (Specify) 

10. **DATA QUALITY CONTROLS (Check One)**
    - A. VERIFIED
    - B. VERIFIED - SOURCE INADEQUATE
    - C. VERIFIED - DATA INACCURATE
    - D. OTHER

11. **DATA PROCESSING (Check One)**
    - A. MANUAL
    - B. ED
    - C. COST: $ 

12. **FINDINGS (Check One)**
    - A. COMPLIANCE WITH STANDARDS
    - B. VARIATION FROM STANDARDS
    - C. VARIATION JUSTIFIED
    - D. DEFICIENCY

13. **DEFICIENCY ANALYSIS (Check One)**
    - A. KNOWLEDGE
    - B. PERFORMANCE
    - C. OTHER

14. **ATRIBUTION (Check all that apply)**
    - A. MORE THAN ONE DEFICIENCY
    - B. INDIVIDUAL PHYSICIAN
    - C. GROUP OF PHYSICIANS
    - D. HOSPITALS
    - E. OTHER

15. **TYPE OF ACTION RECOMMENDED (Check all that apply)**
    - A. MEDICAL EDUCATION PROGRAM
    - B. MEDICAL STAFF (COMMITTEE)
    - C. HOSPITAL BOARD OF TRUSTEES
    - D. OTHER

16. **IF EDUCATION IS RECOMMENDED, IS THERE LINKAGE WITH EXISTING CONTINUING MEDICAL EDUCATION PROGRAMS?**
    - A. YES
    - B. NO

17. **ACTION RECOMMENDED (Check one)**
    - A. REGULAR MONTHLY PROGRAM FOR MEDICINE DEPT.
    - B. NURSING STAFF

18. **PERSONNEL UTILIZED (Check in whole hours the hours spent on this study)**
    - A. SELECTION AND DESIGN
      - PHYSICIAN: 1
      - OTHER: 1
      - TOTAL: 7
    - B. SETTING CRITERIA AND STANDARDS
      - PHYSICIAN: 3
      - OTHER: 4
      - TOTAL: 7
    - C. DATA COLLECTION AND DISPLAY
      - PHYSICIAN: 3
      - OTHER: 5
      - TOTAL: 5
    - D. INTERPRETATION AND ANALYSIS OF FINDINGS
      - PHYSICIAN: 1
      - OTHER: 1
      - TOTAL: 2

**RESERVED FOR PROCESSING CONTROL**
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### SUMMARY OF GENERAL INSTRUCTIONS FOR REPORT PREPARATION AND SUBMISSION

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APPENDIX E

PSRO AREA DESIGNATIONS - STATE BY STATE LISTING

AND

STATISTICAL SUMMARIES

(From PSRO Program Manual)
F. The designation of a PSRO area should take into account the need to allow effective coordination with Medicare/Medicaid fiscal agents. This principle is stated in the statute and the Senate Finance Committee Report. Since the PSRO is involved in the Medicare and Medicaid programs, it will have a significant effect on the claims process.

203 PROCEDURE FOR REQUESTING CHANGES IN AREA DESIGNATIONS

The Senate Finance Committee Report states that "tentative area designsations could be modified if, as the system was placed into operation, changes seemed desirable." Therefore, as operating experience is gained consideration will be given to possible modifications of the areas.

Organizations desiring changes in the PSRO areas as designated by the Secretary should submit their request to the Department's Regional Health Administrator for their State (see list of Regional Health Administrators in Appendix A). The request should contain the following information:

A. Identification by State and, if applicable, area numbers of the areas that would be affected.

B. A listing of counties or the political subdivisions describing the proposed realignment. Where political subdivisions are to be divided, use postal zones, streets, highways, etc.

C. The reason(s) for requesting the change. Examples of valid reasons that could form the basis for a change are:

1. Changes have occurred in medical service area configurations.

2. The workload of an operating PSRO(s) is either too low or high to operate effectively.

3. A peer review organization is already in operation and its service area does not coincide with a designated PSRO area.

4. Changes have taken place in political subdivisions.

5. The physician population in an area(s) has changed substantially.

The Regional Health Administrator will submit his recommendation to the Assistant Secretary for Health who will transmit it to the Secretary with a statement of his concurrence or rejection. If the Secretary approves the change
it will be published in the Federal Register as a Notice of Proposed Rulemaking with an invitation for public comment.

It should be noted that all changes must be consistent with the PSRO Area Designation Guidelines as spelled out in Section 202 of this chapter.

204 AREA DESIGNATIONS--STATE-BY-STATE LISTING AND STATISTICAL SUMMARIES

204.1 The Individual Area Designations, As Published in the Federal Register Are As Follows:

ALABAMA: The State of Alabama is designated as a single Professional Standards Review Organization area.

ALASKA: The State of Alaska is designated as a single Professional Standards Review Organization area.

ARIZONA: Two Professional Standards Review Organization areas are designated in Arizona, composed of the following counties:

AREA I: Mohave, Coconino, Navajo, Apache, Yavapai, Maricopa, Gila

AREA II: Yuma, Pinal, Graham, Greenlee, Pima, Santa Cruz, Cochise

ARKANSAS: The State of Arkansas is designated as a single Professional Standards Review Organization area.

CALIFORNIA: Twenty-eight Professional Standards Review Organization areas are designated in California, composed of the following counties, with the exception of Areas XVIII through XXV which are composed of cities and parts of Los Angeles denoted by postal zone:

AREA I: Del Norte, Mendocino, Lake, Sonoma, Humboldt

AREA II: Siskiyou, Modoc, Trinity, Shasta, Tehama, Plumas, Glenn, Butte, Colusa, Sutter, Yuba, Sierra
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(Continued) 90035 90042 90059
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90003 90055 90004
90057 90020 90039
90037 90001 90010
90017 90065 90054
90047 90026 90019
90021 90011 90063
90061 90015 90051
90032 90044

AREA XXV: Beverly Hills
Los Angeles Postal Zones:
90027 90028 90029
90036 90038 90046
90048 90058 90069

AREA XXVI: Orange

AREA XXVII: Riverside

AREA XXVIII: San Diego Imperial

COLORADO: The State of Colorado is designated as a single Professional Standards Review Organization area.

CONNECTICUT: Four Professional Standards Review Organization areas are designated in Connecticut, composed of the following counties:

AREA I: Fairfield
AREA II: Litchfield New Haven
AREA III: Hartford
AREA IV: Tolland Middlesex New London Windham

DELAWARE: The State of Delaware is designated as a single Professional Standards Review Organization area.

DISTRICT OF COLUMBIA: The District of Columbia is designated as a single Professional Standards Review Organization area.

FLORIDA: Twelve Professional Standards Review Organization areas are designated in Florida, composed of the following counties:
AREA I: Santa Rosa, Liberty, Holmes, Jefferson, Wakulla, Taylor
          Gadsden, Walton, Leon, Jackson, Bay, Escambia
          Okaloosa, Franklin, Washington, Madison, Calhoun, Gulf

AREA II: Hamilton, Marion, Union, Gilchrist, Citrus
          Levy, Columbia, Dixie, Alachua, Hernando
          Suwannee, Lafayette, Bradford, Putnam, Sumter

AREA III: Nassau, St. Johns
          Clay, Duval
          Baker, Flagler

AREA IV: Pinellas

AREA V: Pasco
          Hillsborough

AREA VI: Polk
          Highlands
          Hardee

AREA VII: Lake, Osceola
          Orange, Seminole

AREA VIII: Volusia
          Brevard

AREA IX: Manatee, Glades
          Charlotte, De Soto
          Sarasota, Lee

AREA X: Indian River, Martin
          Okeechobee, Palm Beach
          St. Lucie, Hendry

AREA XI: Collier
          Broward

AREA XII: Monroe
          Dade

GEORGIA: The State of Georgia is designated as a single Professional Standards Review Organization area.

HAWAII, GUAM, THE TRUST TERRITORY OF THE PACIFIC ISLANDS AND AMERICAN SAMOA:
          Hawaii, Guam, the Trust Territory of the Pacific Islands and American Samoa are designated as a single Professional Standards Review Organization area.

IDAHO: The State of Idaho is designated as a single Professional Standards Review Organization area.
ILLINOIS: Eight Professional Standards Review Organization areas are
designated in Illinois, composed of the following counties:

AREA I: Jo Daviess
       De Kalb
       Boone

       Ogle
       Winnebago
       Carroll

       Stephenson
       Whiteside
       Lee

AREA II: McHenry
         DuPage

         Kane
         Lake

AREA III: Cook

AREA IV: Kendall
          Will
          Grundy

AREA V: Rock Island
        Marshall
        McDonough
        La Salle
        Tazewell
        Knox

        Stark
        Henry
        Putnam
        Peoria
        Warren

        Mercer
        Bureau
        Fulton
        Henderson
        Woodford

AREA VI: Livingston
        Iroquois
        Edgar
        Piatt
        Cumberland
        Moultrie

        Macon
        Douglas
        De Witt
        Coles
        Vermillion

        Ford
        McLean
        Shelby
        Champaign
        Clark

AREA VII: Adams
         Schuyler
         Christian
         Mason
         Jersey
         Pike

         Morgan
         Sangamon
         Cass
         Greene
         Logan
         Montgomery

         Hancock
         Brown
         Calhoun
         Menard
         Macoupin
         Scott

AREA VIII: Madison
          Williamson
          Effingham
          Union
          Randolph
          Washington
          Hamilton
          Edwards
          Monroe
          Hardin
          Marion
          Massac

          Richland
          Fayette
          Gallatin
          Crawford
          Lawrence
          Franklin
          Wayne
          Jackson
          Pope
          Clinton
          Pulaski

          Bond
          Saline
          Jasper
          Johnson
          Perry
          Jefferson
          White
          Wabash
          St. Clair
          Alexander
          Clay
INDIANA: Seven Professional Standards Review Organization areas are designated in Indiana, composed of the following counties:

AREA I: Lake, La Porte, Porter

AREA II: St. Joseph, Cass, Elkhart, Newton, Wabash, Marshall, Starke, Tippecanoe, Newton, Starke, Wabash

AREA III: Lagrange, Allen, Steuben, Huntington, Noble, Wells, De Kalb, Adams, Whitley

AREA IV: Grant, Fayette, Blackford, Union, Jay, Madison, Franklin, Delaware, Randolph, Ripley, Dearborn, Henry, Jefferson, Wayne, Ohio, Switzerland, Rush

AREA V: Boone, Morgan, Jackson, Hamilton, Johnson, Jennings, Putnam, Shelby, Washington, Hendricks, Brown, Scott, Marion, Bartholomew, Clark, Hancock, Decatur, Floyd, Orange, Crawford, Harrison

AREA VI: Vermillion, Sullivan, Parke, Greene, Vigo, Monroe, Lawrence, Clay, Owen

AREA VII: Knox, Gibson, Daviess, Pike, Martin, Dubois, Posey, Warrick, Vanderburgh, Spencer, Perry

IOWA: The State of Iowa is designated as a single Professional Standards Review Organization area.

KANSAS: The State of Kansas is designated as a single Professional Standards Review Organization area.
KENTUCKY: The State of Kentucky is designated as a single Professional Standards Review Organization area.

LOUISIANA: Four Professional Standards Review Organization areas are designated in Louisiana, composed of the following parishes:

**AREA I**
- Caddo
- Bossier
- Webster
- Claiborne
- Lincoln
- Union
- Morehouse
- West Carroll
- East Carroll
- Bienville
- Quachita
- Richland
- Madison
- De Soto
- Red River
- Natchitoches
- Winn
- Caldwell
- Franklin
- Jackson
- Grant
- La Salle
- Catahoula
- Concordia
- Vernon
- Rapides
- Avoyelles
- Sabine
- Tensas

**AREA II**
- Beauregard
- St. Landry
- Acadia
- Cameron
- St. Mary
- Allen
- Calcasieu
- Lafayette
- Vermilion
- Iberia
- Evangeline
- Jefferson Davis
- St. Martin
- Iberia

**AREA III**
- Point Coupe
- St. Helena
- Iberville
- Livingston
- West Feliciana
- Tangipahoa
- West Baton Rouge
- Ascension
- East Feliciana
- Washington
- East Baton Rouge

**AREA IV**
- Assumption
- St. Tammany
- Orleans
- Lafourche
- St. James
- St. Charles
- St. Bernard
- Plaquemines
- St. John the Baptist
- Jefferson
- Terrebonne

MAINE: The State of Maine is designated as a single Professional Standards Review Organization area.

MARYLAND: Seven Professional Standards Review Organization areas are designated in Maryland, composed of the following counties:

**AREA I**
- Garrett
- Frederick
- Allegany
- Washington

**AREA II**
- Baltimore City

**AREA III**
- Montgomery

**AREA IV**
- Prince Georges
### MASSACHUSETTS

**MASSACHUSETTS** : Five Professional Standards Review Organization areas are designated in Massachusetts, composed of the following cities and townships:

<table>
<thead>
<tr>
<th>AREA</th>
<th>Cities and Townships</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monroe, Yale, Columbia, Hadley, Northfield, West Stockbridge, Orange.</td>
</tr>
<tr>
<td></td>
<td>Rowe, Amherst, Greenfield, Lee, Hadley, Northfield.</td>
</tr>
<tr>
<td>VI</td>
<td>Ann Arbor, Carroll, Harford.</td>
</tr>
<tr>
<td></td>
<td>Carroll, Howard.</td>
</tr>
<tr>
<td></td>
<td>Anne Arundel, Charles.</td>
</tr>
<tr>
<td></td>
<td>Howard, Carroll, Harford.</td>
</tr>
<tr>
<td>VII</td>
<td>Cecil, Kent, Talbot, Queen Annes, Dorchester.</td>
</tr>
<tr>
<td></td>
<td>Caroline, Kent.</td>
</tr>
<tr>
<td></td>
<td>Wicomico, Somerset, Worcester.</td>
</tr>
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### DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
<table>
<thead>
<tr>
<th>AREA II:</th>
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<td>Winchedon</td>
<td>Ashby</td>
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<td>Townsend</td>
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<tr>
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<tr>
<td>Hubbardston</td>
<td>Princeton</td>
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<td>Lancaster</td>
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<td>Ayer</td>
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<td>Mendon</td>
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<tr>
<td>Blackistone</td>
<td>Boylston</td>
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<tr>
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<td>Pepperell</td>
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<td>Gorton</td>
<td>Franklin</td>
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<td>Littleton</td>
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<th>Towns</th>
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<td>Rowley</td>
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<td>Chelmsford</td>
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<th>Norwood</th>
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<td>Orleans</td>
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<td>Westport</td>
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<td>Nantucket</td>
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**MICHIGAN**

Ten Professional Standards Review Organization areas are designated in Michigan, composed of the following counties:

<table>
<thead>
<tr>
<th>AREA I</th>
<th>Keweenaw</th>
<th>Gogebic</th>
<th>Ontonagon</th>
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<tbody>
<tr>
<td>Houghton</td>
<td>Baraga</td>
<td>Marquette</td>
<td></td>
</tr>
</tbody>
</table>
### AREA II
- **Emmet**
- **Charlevoix**
- **Montmorency**
- **Benzie**
- **Gladwin**
- **Alcona**
- **Roscommon**

### Area III
- **Mason**
- **Oceana**
- **M Becker**
- **Kent**

### Area IV
- **Clare**
- **Midland**
- **Saginaw**
- **Sanilac**

### Area V
- **Shiawassee**

### Area VI
- **Clinton**
- **Livingston**

### Area VII
- **Washtenaw**
- **Jackson**

### Area VIII
- **Wayne**

### Area IX
- **Oakland**

### Area X
- **Allegan**
- **Calhoun**
- **St. Joseph**

### MINNESOTA
- Three Professional Standards Review Organization areas are designated in Minnesota, composed of the following counties:

### AREA I
- **Kittson**
- **Koochiching**
- **Cook**
- **Itasca**
- **Red Lake**

### AREA II
- **Schoolcraft**
- **Iron**
- **Delta**

### AREA III
- **Cheboygan**
- **Antrim**
- **Alpena**
- **Grand Traverse**
- **Crawford**
- **Wexford**
- **Ogemaw**

### AREA IV
- **Lake**
- **Newaygo**
- **Montcalm**
- **Ionia**

### AREA V
- **Osceola**
- **Mecosta**
- **Ottawa**
- **Barry**

### AREA VI
- **Isabella**
- **Iosco**
- **Tuscola**

### AREA VII
- **Lenawee**
- **Hillsdale**

### AREA VIII
- **Monroe**

### AREA IX
- **Macomb**

### AREA X
- **Van Buren**
- **Berrien**
- **Branch**

### MINNESOTA
- **Lake**
- **Beltrami**
- **Pennington**
- **Mahnomen**

---

**DEPARTMENT OF HEALTH, EDUCATION AND WELFARE**
Clearwater Hubbard Cass
Wadena Crow Wing Aitkin
Calton Todd Morrison
Mille Lacs Kanabec Pine
Pope Stearns Benton
Cherbourne Isanti Chisago
Wright Clay Becker
Wilkin Otter Tail Traverse
Grant Douglas Big Stone
Stevens

AREA II : Anoka Hennepin Ramsey
Washington Carver Scott
Dakota

AREA III : Swift Lac Qui Parle Chippewa
Kandiyohi Meeker Yellow Medicine
Renville McLeod Lincoln
Lyon Redwood Brown
Sibley Nicollet LeSeur
Rice Goodhue Wabasha
Pipestone Murray Cottonwood
Watowan Blue Earth Waseca
Steele Dodge Olmstead
Winona Rock Nobles
Jackson Martin Faribault
Freeborn Mower Fillmore
Houston

MISSISSIPPI : The State of Mississippi is designated as a single Professional Standards Review Organization area.

MISSOURI : Five Professional Standards Review Organization areas are designated in Missouri, composed of the following counties:

AREA I : Atchison Grundy Lafayette
Nodaway Buchanan Saline
Worth Clinton Cass
Harrison Caldwell Johnson
Mercer Livingston Pettis
Holt Platte Bates
Andrew Clay Henry
Gentry Ray Benton
De Kalb Carroll Vernon
Daviess Jackson St. Clair


AREA II: Putnam, Schuler, Scotland, Clark, Sullivan, Adair, Knox, Lewis, Linn, Macon, Shelby, Marion;

Chariton, Randolph, Monroe, Ralls, Pike, Howard, Boone, Audrain, Callaway, Montgomery, Cooper, Morgan;

Moniteau, Cole, Osage, Gasconade, Miller, Maries, Camden, Pulaski, Phelps, Crawford, Dent.

AREA III: Lincoln, Warren;

St. Charles, Franklin;

St. Louis, St. Louis City.

AREA IV: Barton, Cedar, Hickory, Dallas, Laclede, Dade, Polk, Jasper;

Lawrence, Greene, Webster, Wright, Texas, Shannon, Newton, Christian;

Douglas, Howell, Oregon, McDonald, Barry, Stone, Taney, Ozark.

AREA V: Jefferson, Carter, Ste. Genevieve, Madison, Perry, New Madrid, Bollinger;

Cape Girardeau, St. Francois, Butler, Scott, Mississippi, Wayne, Pemiscot;


MONTANA: The State of Montana is designated as a single Professional Standards Review Organization area.

NEBRASKA: The State of Nebraska is designated as one Professional Standards Review Organization area.

NEVADA: The State of Nevada is designated as a single Professional Standards Review Organization area.

NEW HAMPSHIRE: The State of New Hampshire is designated as a single Professional Standards Review Organization area.

NEW JERSEY: Eight Professional Standards Review Organization areas are designated in New Jersey, composed of the following counties:
AREA I : Sussex, Warren, Morris
Except Chilton Hospital

AREA II : Passaic, Chilton Hospital

AREA III : Bergen

AREA IV : Essex

AREA V : Hudson

AREA VI : Union

AREA VII : Hunterdon, Mercer, Middlesex, Monmouth
Somerset, Atlantic, Ocean

AREA VIII : Burlington, Camden, Salem, Cumberland
Gloucester, Cape May

NEW MEXICO : The State of New Mexico is designated as one Professional
Standards Review Organization area.

NEW YORK : Seventeen Professional Standards Review Organization areas are
designated in New York, composed of the following counties:

AREA I : Niagara, Orleans, Erie
Genesee, Wyoming, Chautauqua
Cattaraugus, Allegany

AREA II : Monroe, Wayne, Livingston
Ontario, Seneca, Yates
Steuben

AREA III : St. Lawrence, Jefferson, Oswego
Cayuga, Onondaga, Tompkins
Cortland, Tioga, Broome
Chemung, Schuyler

AREA IV : Oneida, Herkimer, Madison
Chenango, Lewis

AREA V : Franklin, Clinton, Hamilton
Essex, Fulton, Warren
Saratoga, Washington

AREA VI : Schenectady, Montgomery, Schoharie

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
NORTH CAROLINA: Eight Professional Standards Review Organization areas are designated in North Carolina, composed of the following counties:

AREA I: Watauga, McDowell, Transylvania
Avery, Rutherford, Swain
Caldwell, Madison, Jackson
Burke, Buncombe, Macon
Mitchell, Henderson, Graham
Yancey, Polk, Cherokee
Haywood, Clay

AREA II: Ashe, Surry, Rowan
Alleghany, Yadkin, Stokes
Wilkes, Iredell, Forsyth
Alexander, Davie, Davidson

AREA III: Rockingham, Guilford, Randolph
Caswell, Alamance

AREA IV: Person, Durham
Orange, Chatham

AREA V: Granville, Franklin
Harnett
NORTH DAKOTA: The State of North Dakota is designated as a single Professional Standards Review Organization area.

OHIO: Twelve Professional Standards Review Organization areas are designated in Ohio, composed of the following counties:

AREA I: Butler Hamilton Highland
Warren Clermont Adams
Clinton Brown

AREA II: Darke Miami Montgomery
Shelby Clark Greene
Champaign Preble

AREA III: Van Wert Seneca Hardin Crawford
Allen Mercer Logan Marion
Hancock Auglaize Wyandot

AREA IV: Williams Ottawa Wood Putnam
Fulton Defiance Sandusky Lucas
Henry Paulding
### AREA V: Lake Geauga Ashtabula

### AREA VI: Summit Stark Portage Mahoning Trumbull Columbiana

### AREA VII: Coshocton Tuscarawas Carroll Belmont

### AREA VIII: Licking Noble Muskingum Perry Athens Guernsey Morgan Washington

### AREA IX: Hocking Pike Vinton Jackson Meigs Gallia

### AREA X: Morrow Pickaway Knox Union Franklin

### AREA XI: Erie Medina Lorain Huron Ashland

### AREA XII: Cuyahoga

- Lake Geauga Ashtabula
- Summit Stark Portage Mahoning Trumbull Columbiana
- Coshocton Tuscarawas Carroll Belmont
- Licking Noble Muskingum Perry Athens Guernsey Morgan Washington
- Hocking Pike Vinton Jackson Meigs Gallia
- Morrow Pickaway Knox Union Franklin
- Erie Medina Lorain Huron Ashland
- Cuyahoga

**OKLAHOMA**: The State of Oklahoma is designated as one Professional Standards Review Organization area.

**OREGON**: Two Professional Standards Review Organization areas are designated in Oregon, composed of the following counties:

### AREA I: Multnomah

- Clatsop Union Deschutes
- Columbia Wallowa Crook
- Tillamook Lincoln Coos
- Washington Polk Douglas
- Yamhill Benton Curry
- Clackamas Marion Josephine
- Hood River Linn Jackson
- Wasco Jefferson Klamath
- Sherman Wheeler Lake
- Gilliam Grant Harney
- Morrow Baker Malheur
- Umatilla Lane

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**DEPARTMENT OF HEALTH, EDUCATION AND WELFARE**
PENNSYLVANIA: Twelve Professional Standards Review Organization areas are designated in Pennsylvania, composed of the following counties:

AREA I: Erie, Potter, Elk
   Warren, Crawford, Cameron
   McKean, Forest

AREA II: Tioga, Centre, Columbia
   Bradford, Union, Snyder
   Clinton, Northumberland, Mifflin
   Lycoming, Montour, Juniata
   Sullivan

AREA III: Susquehanna, Lackawanna, Luzerne
   Wyoming

AREA IV: Wayne, Monroe, Northampton
   Pike, Carbon, Lehigh

AREA V: Mercer, Jefferson, Butler
   Venango, Clearfield, Armstrong
   Clarion, Lawrence, Indiana

AREA VI: Allegheny

AREA VII: Beaver, Washington, Westmoreland
   Greene, Fayette

AREA VIII: Cambria, Huntingdon, Bedford
   Blair, Somerset

AREA IX: Schuylkill, Berks, Franklin
   Perry, Cumberland, Adams
   Dauphin, Lancaster, York
   Lebanon, Fulton

AREA X: Chester, Delaware

AREA XI: Bucks, Montgomery

AREA XII: Philadelphia

PUERTO RICO: Puerto Rico is designated as a single Professional Standards Review Organization area.

RHODE ISLAND: The State of Rhode Island is designated a single Professional Standards Review Organization area.
SOUTH CAROLINA: The State of South Carolina is designated as a single Professional Standards Review Organization area.

SOUTH DAKOTA: The State of South Dakota is designated as a single Professional Standards Review Organization area.

TENNESSEE: Two Professional Standards Review Organization areas are designated in Tennessee, composed of the following counties:

AREA I: Lauderdale Madison Shelby Chester
AREA II: Lake Henry Carroll Stewart Sumner Clay Dickson Wilson Overton Hickman Cannon Claiborne Sullivan Anderson Sevier Cocke De Kalb Cumberland Maury Coffee Wayne Lincoln Unicoi Loudon Bledsoe McMinn Sequatchie Bradley

TEXAS: Nine Professional Standards Review Organization areas are designated in Texas, composed of the following counties:

AREA I: Dallam Sherman

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
AREA I  :  Moore  Hutchinson  Potter  Carson  Gray  Wheeler  Deaf Smith  Randall  Armstrong  Donley  Collingsworth  Parmer  Castro  Swisher  Briscoe  Hall  Childress  Hardeman  Bailey
(Continued)  Lamb  Hale  Floyd  Motley  Oldham  Cottle  Potter  Wilbarger  Wilchita  Cochrane  Hockley  Lubbock  Crosby  Dickens  King  Knox  Baylor  Archer  Clay  Montaque  Yoakum  Terry  Lyon  Lamb  Hale  Floyd  Motley  Oldham  Cottle  Potter  Wilbarger  Wilchita  Cochrane  Hockley  Lubbock  Crosby  Dickens  King  Knox  Baylor  Archer  Clay  Montaque  Yoakum  Terry  Lyon
Garza  Kent  Stonewall  Haskell  Throckmorton  Young  Jack  Surry  Fisher  Jones  Shackelford  Stephens  Mitchell  Nolan  Taylor  Callahan  Eastland  Coleman  Brown  Comanche  Runnels

AREA II  :  Wise  Palo Pinto  Johnson
Parker  Tarrant  Erath
Hood  Somervell

AREA III  :  Grayson  Fannin  Collin  Hunt
Dallas  Rockwall  Ellis  Kaufman
Navarro  Cooke  Denton

AREA IV  :  Lamar  Red River  Bowie  Delta  Hopkins  Franklin  Titus  Camp  Morris  Cass  Rains  Wood  Upshur
Marion  Van Zandt  Smith  Gregg  Harrison  Henderson  Anderson  Cherokee  Rusk  Panola  Houston  Angelina  Nacogdoches
Shelby  Sabine  Trinity  San Jacinto  Polk  Tyler  Jasper  Newton  San Augustine  Hardin  Orange  Jefferson

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
AREA V : Andrews Coke Crockett
         Martin Ward Schleicher
         Howard Crane Menard
         El Paso Upton Mason
         Hudspeth Reagan Sutton
         Culberson Sterling Kimble
         Reeves Irion Presido
         Loving Tom Green Brewer
         Winkler Concho Terrell
         Ector McCulloch Gaines
         Midland Jeff Davis Dawson
         Glasscock Pecos Borden

AREA VI : Mills Robertson Grimes
          Hamilton Leon Blanco
          Bosque Madison Travis
          Hill Llano Bastrop
          Limestone Burnet Lee
          Freestone Bell Burleson
          Lampasas Williamson Washington
          Coryell Milam Hays
          McLennan Brazos Caldwell
          Falls San Saba Fayette

AREA VII : Walker Harris Chambers
          Montgomery Liberty

AREA VIII : Austin Brazoria Waller
            Wharton Galveston Colorado
            Fort Bend Matagorda

AREA IX : Val Verde Maverick Calhoun
          Edwards Zavala San Patricio
          Real Frio Aransas
          Kerr Atascosa Webb
          Bandera Karnes Duval
          Gillespie De Witt Jim Wells
          Kendall Victoria Nueces
          Comal Jackson Kleberg
          Kinney Dimmit Zapata
          Medina La Salle Jim Hogg
          Bexar McMullen Brooks
          Guadalupe Live Oak Kenedy
          Gonzales Bee Starr
          Lavaca Goliad Hidalgo
          Wilson Refugio Willacy
          Uvalde Cameron
UTAH: The State of Utah is designated as a single Professional Standards Review Organization area.

VERMONT: The State of Vermont is designated as a single Professional Standards Review Organization area.

VIRGIN ISLANDS: The Virgin Islands are designated as one Professional Standards Review Organization area.

VIRGINIA: Five Professional Standards Review Organization areas are designated in Virginia, composed of the following counties and independent cities:

<table>
<thead>
<tr>
<th>AREA I</th>
<th>Counties</th>
<th>Independent Cities</th>
</tr>
</thead>
<tbody>
<tr>
<td>AREA I</td>
<td>Frederick Clarke Warren Shenandoah Page Rappahannock Fauquier Rockingham Greene Madison Culpeper Stafford</td>
<td>King George Highland Augusta Albemarle Orange Louisa Spotsylvania Caroline Bath Rockbridge Nelson Fluvanna</td>
</tr>
<tr>
<td>AREA II</td>
<td>Loudoun Prince William</td>
<td>Fairfax Arlington</td>
</tr>
</tbody>
</table>
## AREA IV
- Buckingham
- Cumberland
- Goochland
- Powhatan
- Hanover
- Henrico
- New Kent
- Charles City
- Prince Edward
- Amelia
- Chesterfield

- Prince George
- Surry
- Nottoway
- Dinwiddie
- Sussex
- Charlotte
- Lunenburg
- Brunswick
- Greensville
- Halifax
- Mecklenburg

- Richmond
- Colonial Heights
- Hopewell
- Petersburg
- South Boston

## AREA V
- Westmoreland
- Northumberland
- Accomack
- Richmond
- Lancaster
- Northampton
- Essex
- Middlesex
- Mathews

- King and Queen
- Gloucester
- King William
- James City
- York
- Southampton
- Isle of Wight

- Williamsburg
- Newport News
- Hampton
- Franklin
- Suffolk
- Nansemond
- Portsmouth
- Norfolk
- Chesapeake
- Virginia Beach

## WASHINGTON
- The State of Washington is designated as a single Professional Standards Review Organization area.

## WEST VIRGINIA
- The State of West Virginia is designated as a single Professional Standards Review Organization area.

## WISCONSIN
- Two Professional Standards Review Organization areas are designated in Wisconsin, composed of the following counties:

### AREA I
- Douglas
- Chippewa
- Iron
- Pierce
- Washburn
- Buffalo
- Oneida
- Wood
- Polk
- Monroe
- Taylor
- Vernon
- St. Croix
- Oconto
- Calumet
- Menominee

- Green Lake
- Brown
- Richland
- Jefferson
- Dodge
- Rock
- Dunn
- Ashland
- Marathon
- Burnett
- Eau Clair
- Price
- Jackson
- Florence
- La Crosse
- Rusk

- Adams
- Langlade
- Marinette
- Winnebago
- Shawano
- Marquette
- Outagamie
- Sheboygan
- Dane
- Columbia
- Bayfield
- Clark
- Vilas
- Pepin
**AREA I** (Continued)

<table>
<thead>
<tr>
<th>Sawyer</th>
<th>Lincoln</th>
<th>Fond Du Lac</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trempealeau</td>
<td>Crawford</td>
<td>Kewaunee</td>
</tr>
<tr>
<td>Forest</td>
<td>Waushara</td>
<td>Sauk</td>
</tr>
<tr>
<td>Portage</td>
<td>Door</td>
<td>Lafayette</td>
</tr>
<tr>
<td>Barron</td>
<td>Manitowoc</td>
<td>Grant</td>
</tr>
<tr>
<td>Juneau</td>
<td>Waupaca</td>
<td></td>
</tr>
</tbody>
</table>

**AREA II**

<table>
<thead>
<tr>
<th>Washington</th>
<th>Walworth</th>
<th>Ozaukee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racine</td>
<td>Waukesha</td>
<td>Kenosha</td>
</tr>
<tr>
<td>Milwaukee</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**WYOMING**

The State of Wyoming is designated as a single Professional Standards Review Organization area.

204.3 Number of Proposed and Final Areas for Each State

<table>
<thead>
<tr>
<th>State</th>
<th>Proposed Areas</th>
<th>Final Areas</th>
<th>Proposed Areas</th>
<th>Final Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA</td>
<td>1</td>
<td>1</td>
<td>ILLINOIS</td>
<td>7</td>
</tr>
<tr>
<td>ALASKA</td>
<td>1</td>
<td>1</td>
<td>INDIANA</td>
<td>5</td>
</tr>
<tr>
<td>ARIZONA</td>
<td>2</td>
<td>2</td>
<td>IOWA</td>
<td>1</td>
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<td>ARKANSAS</td>
<td>1</td>
<td>1</td>
<td>KANSAS</td>
<td>1</td>
</tr>
<tr>
<td>CALIFORNIA</td>
<td>21</td>
<td>28</td>
<td>KENTUCKY</td>
<td>1</td>
</tr>
<tr>
<td>COLORADO</td>
<td>1</td>
<td>1</td>
<td>LOUISIANA</td>
<td>4</td>
</tr>
<tr>
<td>CONNECTICUT</td>
<td>4</td>
<td>4</td>
<td>MAINE</td>
<td>1</td>
</tr>
<tr>
<td>DELAWARE</td>
<td>1</td>
<td>1</td>
<td>MARYLAND</td>
<td>5</td>
</tr>
<tr>
<td>DISTRICT OF COLUMBIA</td>
<td>1</td>
<td>1</td>
<td>MASSACHUSETTS</td>
<td>5</td>
</tr>
<tr>
<td>FLORIDA</td>
<td>8</td>
<td>12</td>
<td>MICHIGAN</td>
<td>8</td>
</tr>
<tr>
<td>GEORGIA</td>
<td>3</td>
<td>1</td>
<td>MINNESOTA</td>
<td>3</td>
</tr>
<tr>
<td>HAWAII, AMERICAN SAMOA, GUAM, TRUST TERRITORIES OF THE PACIFIC ISLANDS</td>
<td>2</td>
<td>1</td>
<td>MISSISSIPPI</td>
<td>1</td>
</tr>
<tr>
<td>IDAHO</td>
<td>1</td>
<td>1</td>
<td>MISSOURI</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MONTANA</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NEBRASKA</td>
<td>1</td>
</tr>
</tbody>
</table>
### National Summary of PSRO Areas

Total Number of Proposed PSRO Areas - 203

States Designated as Single PSRO Areas - (31):

<table>
<thead>
<tr>
<th>State</th>
<th>Proposed Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>1</td>
</tr>
<tr>
<td>Alaska</td>
<td>1</td>
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<tr>
<td>Arkansas</td>
<td>1</td>
</tr>
<tr>
<td>Colorado</td>
<td>2</td>
</tr>
<tr>
<td>Delaware</td>
<td>2</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>1</td>
</tr>
<tr>
<td>Georgia</td>
<td>1</td>
</tr>
<tr>
<td>Hawaii, American Samoa, Guam</td>
<td>1</td>
</tr>
<tr>
<td>North Dakota</td>
<td>1</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>1</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>1</td>
</tr>
<tr>
<td>South Carolina</td>
<td>1</td>
</tr>
<tr>
<td>South Dakota</td>
<td>1</td>
</tr>
<tr>
<td>Tennessee</td>
<td>2</td>
</tr>
<tr>
<td>Texas</td>
<td>9</td>
</tr>
<tr>
<td>Utah</td>
<td>1</td>
</tr>
<tr>
<td>Vermont</td>
<td>1</td>
</tr>
<tr>
<td>Virgin Islands</td>
<td>1</td>
</tr>
<tr>
<td>Virginia</td>
<td>5</td>
</tr>
<tr>
<td>Washington</td>
<td>3</td>
</tr>
<tr>
<td>West Virginia</td>
<td>1</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>2</td>
</tr>
<tr>
<td>Wyoming</td>
<td>1</td>
</tr>
</tbody>
</table>

**Total**........................... 182 203
States Designated as Multiple PSRO Areas - (22):

<table>
<thead>
<tr>
<th>Arizona</th>
<th>Massachusetts</th>
<th>Ohio</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Michigan</td>
<td>Oregon</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Minnesota</td>
<td>Pennsylvania</td>
</tr>
<tr>
<td>Florida</td>
<td>Missouri</td>
<td>Tennessee</td>
</tr>
<tr>
<td>Illinois</td>
<td>New Jersey</td>
<td>Texas</td>
</tr>
<tr>
<td>Indiana</td>
<td>New York</td>
<td>Virginia</td>
</tr>
<tr>
<td>Louisiana</td>
<td>North Carolina</td>
<td>Wisconsin</td>
</tr>
<tr>
<td>Maryland</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX A

REGIONAL HEALTH ADMINISTRATORS

Region I Maine, Vermont, New Hampshire, Massachusetts, Connecticut, and Rhode Island

Gertrude Hunter, M.D.
John F. Kennedy Federal Building
Government Center - Room 1400
Boston, Massachusetts 02203

Region II New York, New Jersey, Puerto Rico, and Virgin Islands

Jaime-Rivera-Dueno, M.D.
Federal Building
26 Federal Plaza
New York, New York 10007

Region III Pennsylvania, Maryland, Delaware, Virginia, West Virginia, and District of Columbia

George C. Gardiner, M.D.
Post Office Box 13716
Philadelphia, Pennsylvania 19101

Region IV Alabama, Georgia, Mississippi, South Carolina, North Carolina, Tennessee, Kentucky, and Florida

George Reich, M.D.
Peachtree-Seventh Building
50 Seventh Street, N.E.
Atlanta, Georgia 30323

Region V Illinois, Indiana, Ohio, Michigan, Wisconsin, and Minnesota

Frank Ellis, M.D.
300 South Wacker Drive
Chicago, Illinois 60607
REGIONAL HEALTH ADMINISTRATORS

Region VI Louisiana, Arkansas, Oklahoma, Texas, and New Mexico
Floyd A. Norman, M.D.
1114 Commerce Street
Dallas, Texas 75202

Region VII Missouri, Iowa, Kansas, and Nebraska
Holman Wherritt, M.D.
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Region VIII Colorado, Utah, Wyoming, South Dakota, North Dakota, and Montana
Hilary H. Connor, M.D.
Federal Office Building
19th and Stout Streets
Denver, Colorado 80202

Region IX California, Nevada, Arizona, Guam, Hawaii, and Samoa
Donald P. McDonald, M.D.
Federal Office Building
50 Fulton Street
San Francisco, California 94102

Region X Washington, Oregon, Idaho, and Alaska
David W. Johnson, M.D.
Arcade Building
1321 Second Avenue
Seattle, Washington 98101
APPENDIX F

PRINCIPAL GENERAL AND SPECIFIC PROVISIONS OF SOCIAL SECURITY ACT (OTHER THAN PSRO PROVISIONS OF LAW) AUTHORIZING AND REQUIRING REVIEW
PRINCIPAL GENERAL AND SPECIFIC PROVISIONS OF SOCIAL SECURITY ACT (OTHER THAN PSRO PROVISIONS OF LAW) AUTHORIZING AND REQUIRING REVIEW ACTIVITIES

I. ACCESS TO RECORDS AND OTHER DATA

Medicare

Intermediaries—Section 1816(a) (2) (B) ... "to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part . . . ."

Carriers—Section 1842(a) (1) (C) ... "to make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part . . . ."

Medicaid

Section 1902(a) (27) ... "provide for agreements with very person or institution providing services under the State plan under which such institution or persons agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency may from time to time request . . . ."

II. GENERAL REVIEW REQUIREMENTS

Medicare

Section 1862(a) (1) ... "Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—(1) which are not reasonable or necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member . . . ."

Medicaid

Section 1902(a) (30) ... "provide such methods and procedures relating to the utilization of, and the payment for, care and service available under the plan (including but not limited to utilization review plans provided for in Section 1963(i) (4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payment (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy and quality of care . . . ."

III. STATEWIDE PROGRAM REVIEW TEAMS

Medicare

Section 1862(d) (4) ... "(4) For the purposes of paragraph (1) (B) and (C) of this subsection, and clause (F) of section 1860(b) (2), the Secretary shall, after consultation with appropriate State and local professional societies, the appropriate carriers and intermediaries utilized in the administration of this title, and consumer representatives familiar with the health needs of residents of the State, appoint one or more program review teams (composed of physicians, other professional personnel in the health care field, and the consumer representatives) in each State which shall, among other things—(A) undertake to review such statistical data on program utilization as may be submitted by the Secretary.(B) submit to the Secretary periodically, as may be prescribed in regulations, a report on the results of such review, together with recommendations with respect thereto.(C) undertake to review particular cases where there is a likelihood that the person or persons furnishing services and supplies to individuals may come within the provisions of paragraph (1) (B) and (C) of this subsection or clause (F) of section 1860(b) (2), and(D) submit to the Secretary periodically, as may be prescribed in regulations, a report of cases reviewed pursuant to subparagraph (C) along with an analysis of, and recommendations with respect to, such cases."
IV. AUTHORITY TO SUSPEND PRACTITIONERS AND PROVIDERS

**Medicare**

Section 1862(d)(1) . . . "No payment may be made under this title with respect to any item or services furnished to an individual by a person where the Secretary determines under this subsection that such person— . . . (C) has furnished services or supplies which are determined by the Secretary, with the concurrence of the members of the appropriate program review team . . . who are physicians or other professional personnel in the health care field, to be substantially in excess of the needs of individuals or to be harmful to individuals or to be a grossly inferior quality.

(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, posthospital extended care services, and home health services such determination shall be effective in the manner provided in section 1866(b) (3) and (4) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis of such determination has been removed and that there is reasonable assurance that it will not recur."

**Medicaid**

Section 1903(i) . . . "Payment under the preceding provisions of this section shall not be made . . . (2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or another person during any period of time, if payment may be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d) (1) or under clause (D), (E), or (F) of section 1866(b) (2) . . . ."

**GENERAL AUTHORITY OF SECRETARY TO ISSUE REGULATIONS AND ASSURE COMPLIANCE**

**Social security act programs**

Section 1102 . . . "The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, respectively, shall make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which each is charged under this Act."

**Medicare**

Section 1871 . . . "The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title . . . ."
APPENDIX G

Public Law 92-603

Title XI

GENERAL PROVISIONS AND PROFESSIONAL STANDARDS

REVIEW

(Establishing the PSRO Program)
GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

"(1) only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and

"(2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion.

"DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

"Sec. 1132. (a) The Secretary shall (1) not later than January 1, 1974, establish throughout the United States appropriate areas with respect to which Professional Standards Review Organizations may be designated, and (2) at the earliest practicable date after designation of an area enter into an agreement with a qualified organization whereby such an organization shall be conditionally designated as the Professional Standards Review Organization for such area. If, on the basis of its performance during such period of conditional designation, the Secretary determines that such organization is capable of fulfilling, in a satisfactory manner, the obligations and requirements for a Professional Standards Review Organization under this part, he shall enter into an agreement with such organization designating it as the Professional Standards Review Organization for such area.

"(b) For purposes of subsection (a), the term "qualified organization" means

"(1) when used in connection with any area—

"(A) an organization (i) which is a nonprofit professional association (or a component organization thereof), (ii) which is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area, (iii) the membership of which includes a substantial proportion of all such physicians in such area, (iv) which is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which Professional Standards Review Organizations have review responsibilities under this part, (v) the membership of which is voluntary and open to all doctors of medicine or osteopathy licensed to engage in the practice of medicine or surgery in such area without requirement of membership in or payment of dues to any organized medical society or association, and (vi) which does not restrict the eligibility of any member for service as an officer of the Professional Standards Review Organization or eligibility for and assignment to duties of such Professional Standards Review Organization, or, subject to subsection (c) (1),

"(B) such other public, nonprofit private, or other agency or organization, which the Secretary determines, in accordance with criteria prescribed by him in regulations, to be of professional competence and otherwise suitable; and

"(2) an organization which the Secretary, on the basis of his examination and evaluation of a formal plan submitted to him by the association, agency, or organization (as well as on the basis of other relevant data and information), finds to be willing to perform and capable of performing, in an effective, timely, and objective manner and at reasonable cost, the duties, functions, and
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activities of a Professional Standards Review Organization required by or pursuant to this part.

"(c) (1) The Secretary shall not enter into any agreement under this part under which there is designated as the Professional Standards Review Organization for any area any organization other than an organization referred to in subsection (b) (1) (A) prior to January 1, 1976, nor after such date, unless, in such area, there is no organization referred to in subsection (b) (1) (A) which meets the conditions specified in subsection (b) (2).

"(2) Whenever the Secretary shall have entered into an agreement under this part under which there is designated as the Professional Standards Review Organization for any area any organization other than an organization referred to in subsection (b) (1) (A), he shall not renew such agreements with such organization if he determines that-

"(A) there is in such area an organization referred to in subsection (b) (1) (A) which has not been previously designated as a Professional Standards Review Organization, and (ii) is willing to enter into an agreement under this part under which such organization would be designated as the Professional Standards Review Organization for such area;

"(I) such organization meets the conditions specified in subsection (b) (2); and

"(C) the designation of such organization as the Professional Standards Review Organization for such area is anticipated to result in substantial improvement in the performance in such area of the duties and functions required of such organizations under this part.

"(d) Any such agreement under this part with an organization (other than an agreement established pursuant to section 1154) shall be for a term of 12 months; except that, prior to the expiration of such term such agreement may be terminated—

"(1) by the organization at such time and upon such notice to the Secretary as may be prescribed in regulations (except that notice of more than 3 months may not be required); or

"(2) by the Secretary at such time and upon such reasonable notice to the organization as may be prescribed in regulations, but only after the Secretary has determined (after providing such organization with an opportunity for a formal hearing on the matter) that such organization is not substantially complying with or effectively carrying out the provisions of such agreement.

"(e) In order to avoid duplication of functions and unnecessary review and control activities, the Secretary is authorized to waive any or all of the review, certification, or similar activities otherwise required under or pursuant to any provision of this Act (other than this part) where he finds, on the basis of substantial evidence of the effective performance of review and control activities by Professional Standards Review Organizations, that the review, certification, and similar activities otherwise required are not needed for the provision of adequate review and control.

"(f) (1) In the case of agreements entered into prior to January 1, 1976, under this part under which any organization is designated as the Professional Standards Review Organization for any area, the Secretary shall, prior to entering into any such agreement with any organization for any area, inform (under regulations of the Secretary) the doctors of medicine or osteopathy who are in active practice in such area of the Secretary's intention to enter into such an agreement with such organization.
(2) If, within a reasonable period of time following the serving of such notice, more than 10 per centum of such doctors object to the Secretary's entering into such an agreement with such organization on the ground that such organization is not representative of doctors in such area, the Secretary shall conduct a poll of such doctors to determine whether or not such organization is representative of such doctors in such area. If more than 50 per centum of the doctors responding to such poll indicate that such organization is not representative of such doctors in such area the Secretary shall not enter into such an agreement with such organization.

"REVIEW PENDING DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATION"

"SEC. 1153. Pending the assumption by a Professional Standards Review Organization for any area, of full review responsibility, and pending a demonstration of capacity for improved review effort with respect to matters involving the provision of health care services in such area for which payment (in whole or in part) may be made under this Act, any review with respect to such services which has not been designated by the Secretary as the full responsibility of such organization, shall be reviewed in the manner otherwise provided for under law.

"TRIAL PERIOD FOR PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS"

"SEC. 1154. (a) The Secretary shall initially designate an organization as a Professional Standards Review Organization for any area on a conditional basis with a view to determining the capacity of such organization to perform the duties and functions imposed under this part on Professional Standards Review Organizations. Such designation may not be made prior to receipt from such organization and approval by the Secretary of a formal plan for the orderly assumption and implementation of the responsibilities of the Professional Standards Review Organization under this part.

"(b) During any such trial period (which may not exceed 24 months), the Secretary may require a Professional Standards Review Organization to perform only such of the duties and functions required under this part of Professional Standards Review Organization as he determines such organization to be capable of performing. The number and type of such duties shall, during the trial period, be progressively increased as the organization becomes capable of added responsibility so that, by the end of such period, such organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of Professional Standards Review Organizations under this part with respect to the review of health care services provided or ordered by physicians and other practitioners and institutional and other health care facilities, agencies, and organizations. Any of such duties and functions not performed by such organization during such period shall be performed in the manner and to the extent otherwise provided for under law.

"(c) Any agreement under which any organization in conditionally designated as the Professional Standards Review Organization for any area may be terminated by such organization upon 90 days notice to the Secretary or by the Secretary upon 90 days notice to such organization."
DUTIES AND FUNCTIONS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Sec. 1155. (a) (1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall (subject to the provision of subsection (e)) be the duty and function of each Professional Standards Review Organization for any area to determine, at the earliest date practicable, responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

(A) such services and items are or were medically necessary;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

(A) any elective admission to a hospital, or other health care facility, or

(B) any other health care service which will consist of extended or costly courses of treatment, whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in clauses (A) and (C) of paragraph (1).

(3) Each Professional Standards Review Organization shall, in accordance with regulations of the Secretary, determine and publish, from time to time, the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order most effectively to carry out the purposes of this part, exercise the authority conferred upon it under paragraph (2).

(4) Each Professional Standards Review Organization shall be responsible for the maintenance of and the regular review of profiles of care and services received and provided with respect to patients, utilizing to the greatest extent practicable in such patient profiles, methods of coding which will provide maximum confidentiality as to patient identity and assure objective evaluation consistent with the purposes of this part. Profiles shall also be regularly reviewed on an ongoing basis with respect to each health care practitioner and provider to determine whether the care and services ordered or rendered are consistent with the criteria specified in clauses (A), (B), and (C) of paragraph (1).

(5) Physicians assigned responsibility for the review of hospital care may be only those having active hospital staff privileges in at least one of the participating hospitals in the area served by the Professional Standards Review Organization and (except as may be otherwise provided under subsection (e) (1) of this section) such physicians ordinarily should not be responsible for, but may participate in, the review of care and services provided in any hospital in which such physicians have active staff privileges.
(6) No physician shall be permitted to review—

(A) health care services provided to a patient if he was directly or indirectly involved in providing such services, or

(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, any financial interest in such institution, organization, or agency.

For purposes of this paragraph, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.

(b) To the extent necessary or appropriate for the proper performance of its duties and functions, the Professional Standards Review Organization serving any area is authorized in accordance with regulations prescribed by the Secretary to—

(1) make arrangements to utilize the services of persons who are practitioners of or specialists in the various areas of medicine (including dentistry), or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization;

(2) undertake such professional inquiry either before or after, or both before and after, the provision of services with respect to which such organization has a responsibility for review under subsection (a)(1);

(3) examine the pertinent records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under subsection (a)(1); and

(4) inspect the facilities in which care is rendered or services provided (which are located in such area) of any practitioner or provider.

(c) No Professional Standards Review Organization shall utilize the services of any individual who is not a duly licensed doctor of medicine or osteopathy to make final determinations in accordance with its duties and functions under this part with respect to the professional conduct of any other duly licensed doctor of medicine or osteopathy, or any act performed by any duly licensed doctor of medicine or osteopathy in the exercise of his profession.

(d) In order to familiarize physicians with the review functions and activities of Professional Standards Review Organizations and to promote acceptance of such functions and activities by physicians, patients, and other persons, each Professional Standards Review Organization, in carrying out its review responsibilities, shall (to the maximum extent consistent with the effective and timely performance of its duties and functions)—

(1) encourage all physicians practicing their profession in the area served by such Organization to participate as reviewers in the review activities of such Organizations;

(2) provide rotating physician membership of review committees on an extensive and continuing basis;

(3) assure that membership on review committees have the broadest representation feasible in terms of the various types of practice in which physicians engage in the area served by such Organization; and

(4) utilize, whenever appropriate, medical periodicals and similar publications to publicize the functions and activities of Professional Standards Review Organizations.
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"(e)(1) Each Professional Standards Review Organization shall utilize the services of, and accept the findings of, the review committee of a hospital or other operating health care facility or organization located in the area served by such organization, but only when and only to the extent and only for such time that such committees in such hospital or other operating health care facility or organization have demonstrated to the satisfaction of such organization their capacity effectively and in timely fashion to review activities in such hospital or other operating health care facility or organization (including the medical necessity of admissions, types and extent of services ordered, and lengths of stay) so as to aid in accomplishing the purposes and responsibilities described in subsection (a)(1), except where the Secretary determines, for good cause, such acceptance.

"(2) The Secretary may prescribe regulations to carry out the provisions of this subsection.

"(f)(1) An agreement entered into under this part between the Secretary and any organization under which such organization is designated as the Professional Standards Review Organization for any area shall provide that such organization will—

"(A) perform such duties and functions and assume such responsibilities as may be required by regulations prescribed by the Secretary pursuant to subsection (c); and

"(B) collect such data relevant to its functions and such information and maintain such records in such form and manner as the Secretary may require to carry out the purposes of this part.

"(2) Any such agreement with an organization under this part shall provide that the Secretary shall make payments to such organization equal to the amount of expenses reasonably and necessarily incurred, as determined by the Secretary, by such organization in carrying out or preparing to carry out the duties and functions required by such agreement.

"(g) Notwithstanding any other provision of this part, the responsibility for review of health care services of any Professional Standards Review Organization shall be the responsibility of the Secretary to determine the services and functions required by such agreement.

"Norms of Health Care Services for Various Illnesses or Health Conditions

"Sec. 1156. (a) Each Professional Standards Review Organization shall apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice in its regions (including typical lengths-of-stay for institutional care by age and diagnosis) as principal points of evaluation and review. The National Professional Standards Review Council and the Secretary shall provide such technical assistance to the organization as will be helpful in utilizing and applying such norms of care, diagnosis, and treatment. Where the actual norms of care, diagnosis, and treatment in a Professional Standards Review Organization area are significantly different from professionally developed regional norms of care, diagnosis, and
treatment approved for comparable conditions, the Professional Standards Review Organization concerned shall be so informed, and in the event that appropriate consultation and discussion indicate reasonable basis for usage of other norms in the area concerned, the Professional Standards Review Organization may apply such norms in such area as are approved by the National Professional Standards Review Council.

“(b) Such norms with respect to treatment for particular illnesses or health conditions shall include (in accordance with regulations of the Secretary)—

“(1) the types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care;

“(2) the type of health care facility which is considered, consistent with such standards, to be the type in which health care services which are medically appropriate for such illness or condition can most economically be provided.

“(c) (1) The National Professional Standards Review Council shall provide for the preparation and distribution, to each Professional Standards Review Organization and to each other agency or person performing review functions with respect to the provision of health care services under this Act, of appropriate materials indicating the regional norms to be utilized pursuant to this part. Such data concerning norms shall be reviewed and revised from time to time. The approval of the National Professional Standards Review Council of norms of care, diagnosis, and treatment shall be based on its analysis of appropriate and adequate data.

“(2) Each review organization, agency, or person referred to in paragraph (1) shall utilize the norms developed under this section as a principal point of evaluation and review for determining, with respect to any health care services which have been or are proposed to be provided, whether such care and services are consistent with the criteria specified in section 1155(a)(1).

“(d) (1) Each Professional Standards Review Organization shall—

“(A) in accordance with regulations of the Secretary, specify the appropriate points in time after the admission of a patient for inpatient care in a health care institution, at which the physician attending such patient shall execute a certification stating that further inpatient care in such institution will be medically necessary effectively to meet the health care needs of such patient; and

“(B) require that there be included in any such certification with respect to any patient such information as may be necessary to enable such organization properly to evaluate the medical necessity of the further institutional health care recommended by the physician executing such certification.

“(2) The points in time at which any such certification will be required (usually, not later than the 50th percentile of lengths-of-stay for patients in similar age groups with similar diagnoses) shall be consistent with and based on professionally developed norms of care and treatment and data developed with respect to length of stay in health care institutions of patients having various illnesses, injuries, or health conditions, and requiring various types of health care services or procedures.
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SECTION 1157. If, in discharging its duties and functions under this part, any Professional Standards Review Organization determines that any health care practitioner or any hospital, or other health care facility, agency, or organization has violated any of the obligations imposed by section 1167, such organization shall report the matter to the Statewide Professional Standards Review Council for the State in which such organization is located together with the recommendations of such organization as to the action which should be taken with respect to the matter. Any Statewide Professional Standards Review Council receiving any such report and recommendation shall review the same and promptly transmit such report and recommendation to the Secretary together with any additional responsibilities recommendations therein as it deems appropriate. The Secretary may utilize a Professional Standards Review Organization, in lieu of a program review team as specified in sections 1862 and 1866, for purposes of subparagraph (C) of section 1862(d)(1) and subparagraph (F) of section 1866(b)(2).

SECTION 1158. (a) Except as provided for in section 1159, no Federal funds appropriated under any title of this Act (other than title V) for the provision of health care services or items shall be used (directly or indirectly) for the payment, under such title or any program established pursuant thereunder, of any claim for the provision of such services or items, unless the Secretary, pursuant to regulation determines that the claimant is without fault if—

1. the provision of such services or items is subject to review under this part by any Professional Standards Review Organization, or other agency; and

2. such organization or other agency has, in the proper exercise of its duties and functions under or consistent with the purposes of this part, disapproved of the services or items giving rise to such claim, and has notified the practitioner or provider who provided or proposed to provide such services or items and the individual who would receive or was proposed to receive such services or items of its disapproval of the provision of such services or items.

(b) Whenever any Professional Standards Review Organization, in the discharge of its duties and functions as specified by or pursuant to this part, disapproves of any health care services or items furnished or to be furnished by any practitioner or provider, such organization shall, after notifying the practitioner, provider, or other organization or agency of its disapproval in accordance with subsection (a), promptly notify the agency or organization having responsibility for acting upon claims for payment for or on account of such services or items.

Hearings and Review by Secretary

SECTION 1159. (a) Any beneficiary or recipient who is entitled to benefits under this Act (other than title V) or a provider or practitioner who is dissatisfied with a determination with respect to a claim made by a Professional Standards Review Organization in carrying out its responsibilities for the review of professional activities in accordance with paragraphs (1) and (2) of section 1155(a) shall, after being

Post, p. 1418.

Stat, p. 1408.

Ante, p. 1408.

Ante, p. 1431.
nullified of such determination, he entitled to a reconsideration thereof by the Professional Standards Review Organization, and, where the Professional Standards Review Organization reaffirms such determination in a State which has established a Statewide Professional Standards Review Council, and where the matter in controversy is $100 or more, such determination shall be reviewed by professional members of such Council and, if the Council so determines, revised.

(b) Where the determination of the Statewide Professional Standards Review Council is adverse to the beneficiary or recipient (or, in the absence of such Council in a State and where the matter in controversy is $100 or more), such beneficiary or recipient shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 295(b), and, where the amount in controversy is $1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 295(g). The Secretary will render a decision only after appropriate professional consultation on the matter.

(c) Any review or appeals provided under this section shall be in lieu of any review, hearing, or appeal under this Act with respect to the same issue.

"OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW"

Sec. 110. (a) (1) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure that services or items rendered by such practitioner or person to beneficiaries and recipients under this Act—

(A) will be provided only when, and to the extent, medically necessary; and

(B) will be of a quality which meets professionally recognized standards of health care; and

(C) will be supported by evidence of such medical necessity and quality in such form and fashion and at such time as may reasonably be required by the Professional Standards Review Organization in the exercise of its duties and responsibilities; and

it shall be the obligation of any health care practitioner in ordering, authorizing, directing, or arranging for the provision by any other person (including a hospital or other health care facility, organization, or agency), of health care services for any patient of such practitioner, to exercise his professional responsibility with a view to assuring (to the extent of his influence or control over such patient, such person, or the provision of such services) that such services or items will be provided—

(D) only when, and to the extent, medically necessary; and

(E) will be of a quality which meets professionally recognized standards of health care.

(2) Each health care practitioner, and each hospital or other provider of health care services, shall have an obligation, within reasonable limits of professional discretion, not to take any action, in the exercise of his profession (in the case of any health care practitioner), or in the conduct of his business (in the case of any hospital or other such provider), which would authorize any individual to be admitted as an inpatient in or to continue as an inpatient in any hospital or other health care facility unless—

"(A) Inpatient care is determined by such practitioner and by such hospital or other provider, consistent with professionally recognized health care standards, to be medically necessary for the proper care of such individual; and

"(B) (i) the inpatient care required by such individual cannot, consistent with such standards, be provided more economically in a health care facility of a different type; or

"(ii) in the case of a patient who requires care which can, consistent with such standards, be provided more economically in a health care facility of a different type, there is, in the area in which such individual is located, no such facility or no such facility which is available to provide care to such individual at the time when care is needed by him.

"(b)(1) If, after reasonable notice and opportunity for discussion with the practitioner or provider concerned, any Professional Standards Review Organization submits a report and recommendations to the Secretary pursuant to section 1157 (which report and recommendations shall be submitted through the Statewide Professional Standards Review Council, if such Council has been established, which shall promptly transmit such report and recommendations together with any additional comments and recommendations thereto as it deems appropriate) and if the Secretary determines that such practitioner or provider, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this Act has-

"(A) by failing, in a substantial number of cases, substantially to comply with any obligation imposed on him under subsection (a), or

"(B) by grossly and flagrantly violating any such obligation more or more instances, demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, he (in addition to any other sanction provided under law) may exclude (permanently for such period as the Secretary may prescribe) such practitioner or provider from eligibility to provide such services on a reimbursable basis.

"(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of institutional health care services such determination shall be effective in the manner provided in title XVIII with respect to terminations of provider agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

"(3) In lieu of the sanctions authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or provider to provide such health care services on a reimbursable basis) such practitioner or provider pay to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or provider of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided, or (if less) $5,000. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the person from whom such amount is claimed.
“(a) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary’s final decision after such hearing as is provided in section 207(c).

“(c) It shall be the duty of each Professional Standards Review Organization and each Statewide Professional Standards Review Council to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or provider (referred to in subsection (a)) providing health care services in such area shall comply with all obligations imposed on him under subsection (a).

“NOTICE TO PRACTITIONER OR PROVIDER

“Sec. 1162. Whenever any Professional Standards Review Organization takes any action or makes any determination—

“(a) which denies any request, by a health care practitioner or other provider of health care services, for approval of a health care service or item proposed to be ordered or provided by such practitioner or provider; or

“(b) that any such practitioner or provider has violated any obligation imposed on such practitioner or provider under section 1160,

such organization shall, immediately after taking such action or making such determination, give notice to such practitioner or provider of such determination and the basis therefor, and shall provide him with appropriate opportunity for discussion and review of the matter.

“STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCILS; ADVISORY GROUPS TO SUCH COUNCILS

“Sec. 1162. (a) In any State in which there are located three or more Professional Standards Review Organizations, the Secretary shall establish a Statewide Professional Standards Review Council.

“(b) The membership of any such Council for any State shall be appointed by the Secretary and shall consist of—

“(1) one representative from and designated by each Professional Standards Review Organization in the State;

“(2) four physicians, two of whom may be designated by the State medical society and two of whom may be designated by the State hospital association of such State to serve as members on such Council; and

“(3) four persons knowledgeable in health care from such State whom the Secretary shall have selected as representatives of the public in such State (at least two of whom shall have been recommended for membership on the Council by the Governor of such State).

“(c) It shall be the duty and function of the Statewide Professional Standards Review Council for any State, in accordance with regulations of the Secretary, (1) to coordinate the activities of, and disseminate information and data among the various Professional Standards Review Organizations within such State including assisting the Secre-
tary in development of uniform data gathering procedures and operating procedures applicable to the several areas in a State (including, where appropriate, common data processing operations serving several or all areas) to assure efficient operation and objective evaluation of comparative performance of the several areas and, (2) to assist the Secretary in evaluating the performance of each Professional Standards Review Organization, and (3) where the Secretary finds it necessary to replace a Professional Standards Review Organization, to assist him in developing and arranging for a qualified replacement Professional Standards Review Organization.

"(d) The Secretary is authorized to enter into an agreement with any such Council under which the Secretary shall make payments to such Council equal to the amount of expenses reasonably and necessarily incurred, as determined by the Secretary, by such Council in carrying out the duties and functions provided in this section.

"(e) (1) The Statewide Professional Standards Review Council for any State or in a State which does not have such Council, the Professional Standards Review Organizations in such State which have agreements with the Secretary) shall be advised and assisted in carrying out its functions by an advisory group (of not less than seven nor more than eleven members) which shall be made up of representatives of health care practitioners (other than physicians) and hospitals and other health care facilities which provide within the State health care services for which payment (in whole or in part) may be made under any program established by or pursuant to this Act.

"(2) The Secretary shall by regulations provide the manner in which members of such advisory group shall be selected by the Statewide Professional Standards Review Council (or Professional Standards Review Organizations in States without such Councils).

"(3) The expenses reasonably and necessarily incurred, as determined by the Secretary, by such group in carrying out its duties and functions under this subsection shall be considered to be expenses necessarily incurred by the Statewide Professional Standards Review Council served by such group.

"NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

"SEC. 1163. (a) (1) There shall be established a National Professional Standards Review Council (hereinafter in this section referred to as the 'Council') which shall consist of eleven physicians, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

"(2) Members of the Council shall be appointed for a term of three years and shall be eligible for reappointment.

"(3) The Secretary shall from time to time designate one of the members of the Council to serve as Chairman thereof.

"(b) Members of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medical practice. A majority of such members shall be physicians who have been recommended by the Secretary to serve on the Council by national organizations recognized by the Secretary as representing practicing physicians. The membership of the Council shall include physicians who have been recommended for membership on the Council by consumer groups and other health care interests.

"(c) The Council is authorized to utilize, and the Secretary shall make available, or arrange for, such technical and professional consultative assistance as may be required to carry out its functions, and the

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Secretary shall, in addition, make available to the Council such secretarial, clerical and other assistance and such pertinent data prepared by, for, or otherwise available to, the Department of Health, Education, and Welfare as the Council may require to carry out its functions.

Compensation.

"(d) Members of the Council, while serving on business of the Council, shall be entitled to receive compensation at a rate fixed by the Secretary (but not in excess of the daily rate paid under 5 U.S.C. 5532 of the General Schedule under section 5532 of title 5, United States Code), including travel time; and while serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5701 of title 5, United States Code, for persons in Government service employed intermittently.

Duties.

"(e) It shall be the duty of the Council to—

"(1) advise the Secretary in the administration of this part;

"(2) provide for the development and distribution, among Statewide Professional Standards Review Councils and Professional Standards Review Organizations of information and data which will assist such review councils and organizations in carrying out their duties and functions;

"(3) review the operations of Statewide Professional Standards Review Councils and Professional Standards Review Organizations with a view to determining the effectiveness and comparative performance of such review councils and organizations in carrying out the purposes of this part; and

"(4) make or arrange for the making of studies and investigations with a view to developing and recommending to the Secretary and to the Congress measures designed more effectively to accomplish the purposes and objectives of this part.

(f) The National Professional Standards Review Council shall from time to time, but not less often than annually, submit to the Secretary and to the Congress a report on its activities and shall include in such report the findings of its studies and investigations together with any recommendations it may have with respect to the more effective accomplishment of the purposes and objectives of this part. Such report shall also contain comparative data indicating the results of review activities, conducted pursuant to this part, in each State and in each of the various areas thereof.

APPLICATION OF THIS PART TO CERTAIN STATE PROGRAMS RECEIVING FEDERAL FINANCIAL ASSISTANCE

"Sec. 1161. (a) In addition to the requirements imposed by law as a condition of approval of a State plan approved under any title of this Act under which health care services are paid for in whole or part, with Federal funds, there is hereby imposed the requirement that provisions of this part shall apply to the operation of such plan or program.

"(b) The requirement imposed by subsection (a) with respect to such State plans approved under this Act shall apply—

"(1) in the case of any such plan where legislative action by the State legislature is not necessary to meet such requirement, on and after January 1, 1974; and

"(2) in the case of any such plan where legislative action by the State legislature is necessary to meet such requirement, whichever of the following is earlier—

"(A) on and after July 1, 1974; or

"(B) on and after the first day of the calendar month which first commences more than ninety days after the close of the first regular session of the legislature of such State, which begins after December 31, 1973.

"CORRELATION OF FUNCTIONS BETWEEN PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS AND ADMINISTRATIVE INSTRUMENTALITIES

"Sec. 1165. The Secretary shall by regulations provide for such correlation of activities, such interchange of data and information, and such other cooperation consistent with economical, efficient, coordinated, and comprehensive implementation of this part (including, but not limited to, usage of existing mechanical and other data-gathering capacity) between and among—

"(a) (1) agencies and organizations which are parties to agreements entered into pursuant to section 1816, (2) carriers which are parties to contracts entered into pursuant to section 1842, and (3) any other public or private agency (other than a Professional Standards Review Organization) having review or control functions, or proved relevant data-gathering procedures and expertise, and

"(b) Professional Standards Review Organizations, as may be necessary or appropriate for the effective administration of title XVIII, or State plans approved under this Act.

"PROHIBITION AGAINST DISCLOSURE OF INFORMATION

"Sec. 1166. (a) Any data or information acquired by any Professional Standards Review Organization, in the exercise of its duties and functions, shall be held in confidence and shall not be disclosed to any person except (1) to the extent that may be necessary to carry out the purposes of this part or (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care.

"(b) It shall be unlawful for any person to disclose any such information other than for such purposes, and any person violating the provisions of this section shall, upon conviction, be fined not more than $5,000, and imprisoned for not more than six months, or both, together with the costs of prosecution.

"LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION, AND FOR MEMBERS AND EMPLOYEES OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS, AND FOR HEALTH CARE PRACTITIONERS AND PROVIDERS

"Sec. 1167. (a) Notwithstanding any other provision of law, no person providing information to any Professional Standards Review Organization shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) unless—

"(1) such information is unrelated to the performance of the duties and functions of such Organization, or

"(2) such information is false and the person providing such information knew, or had reason to believe, that such information was false.

"(b) (1) No individual who, as a member or employee of any Professional Standards Review Organization or who furnishes profes-
sional counsel or services to such organization, shall be held by reason
of the performance by him of any duty, function, or activity authorized
or required of Professional Standards Review Organizations under
this part, to have violated any criminal law, or to be civilly liable
under any law, of the United States or of any State (or political sub-
division thereof) provided he has exercised due care.

(2) The provisions of paragraph (1) shall not apply with respect
to any action taken by any individual if such individual, in taking
such action, was motivated by malice toward any person affected by
such action.

(c) No doctor of medicine or osteopathy and no provider (including
directors, trustees, employees, or officials thereof) of health care
services shall be civilly liable to any person under any law of the
United States or of any State (or political subdivision thereof) on
account of any action taken by him in compliance with or reliance
upon professionally developed norms of care and treatment applied
by a Professional Standards Review Organization (which has been
designated in accordance with section 1122(b)(1)(A)) operating in
the area where such doctor of medicine or osteopathy or provider took
such action but only if—

(1) he takes such action (in the case of a health care practi-
tioner) in the exercise of his profession as a doctor of medicine
or osteopathy (or in the case of a provider of health care services)
in the exercise of his functions as a provider of health care serv-
ices, and

(2) he exercised due care in all professional conduct taken or
directed by him and reasonably related to, and resulting from,
the actions taken in compliance with or reliance upon such pro-
essionally accepted norms of care and treatment.

"AUTHORIZATION FOR USE OF CERTAIN FUNDS TO ADMINISTER THE
PROVISIONS OF THIS PART"

"Sec. 1168. Expenses incurred in the administration of this part
shall be payable from—

(a) funds in the Federal Hospital Insurance Trust Fund;

(b) funds in the Federal Supplementary Medical Insurance
Trust Fund; and

(c) funds appropriated to carry out the health care provisions
of the several titles of this Act;

in such amounts from each of the sources of funds (referred to in sub-
sections (a), (b), and (c)) as the Secretary shall deem to be fair and
equitable after taking into consideration the costs attributable to the
administration of this part with respect to each of such plans and
programs.

"TECHNICAL ASSISTANCE TO ORGANIZATIONS DESIRING TO BE DESIGNATED
AS PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS"

"Sec. 1169. The Secretary is authorized to provide all necessary
technical and other assistance (including the preparation of prototype
plans of organization and operation) to organizations described in sec-
section 1152(b)(1) which—

(a) express a desire to be designated as a Professional Stan-
dards Review Organization; and

(b) the Secretary determines have a potential for meeting the
requirements of a Professional Standards Review Organization;
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to assist such organizations in developing a proper plan to be submitted to the Secretary and otherwise in preparing to meet the requirements of this part for designation as a Professional Standards Review Organization.

"EXEMPTIONS OF CHRISTIAN SCIENCE SANATORIUMS"

"Sec. 1170. The provisions of this part shall not apply with respect to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts."
(b) Title XI of such Act is further amended by adding the following:

"PART B—PROFESSIONAL STANDARDS REVIEW

"DECLARATION OF PURPOSE

"Sec. 1151. In order to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made (in whole or in part) under this Act and in recognition of the interests of patients, the public, practitioners, and providers in improved health care services, it is the purpose of this part to assure, through the application of suitable procedures of professional standards review, that the services for which payment may be made under the Social Security Act will conform to appropriate professional standards for the provision of health care and that payment for such services will be made—
APPENDIX H

EXCERPTS FROM THE AMERICAN MEDICAL
ASSOCIATION'S PROJECT ON MODEL SCREENING CRITERIA
TO ASSIST PSRO
MODEL SCREENING CRITERIA TO ASSIST PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

developed under the 
AMA CRITERIA DEVELOPMENT PROJECT

as a joint effort between the  
AMERICAN MEDICAL ASSOCIATION 
and 
THIRTY-FIVE NATIONAL MEDICAL SPECIALTY AND PROFESSIONAL SOCIETIES

This project is funded by  
CONTRACT NO. HSA 105-74-206  
with the 
HEALTH SERVICES ADMINISTRATION 
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

AMERICAN MEDICAL ASSOCIATION 
535 NORTH DEARBORN STREET 
CHICAGO, ILLINOIS 60610
The American Medical Association's concern for the proper development of screening criteria led to a contract with the Department of Health, Education and Welfare on June 29, 1974, which called for the establishment of model sets of criteria for screening the appropriateness, necessity and quality of medical services in acute-care short stay general hospitals. The contract called for the AMA to coordinate a project under which national medical specialty societies would develop screening criteria for those diagnoses which account for 75% of hospitalization within each specialty. The Association believes that criteria development must be a function of the individual specialty societies and must be coordinated nationally, with the completed criteria made available to all physician groups for adaptation or revision to reflect local conditions.

The model screening criteria sets in this document are in draft form and will require revision through actual use in a review system. They are intended as "models" to be reviewed and tested locally. A revision is planned in late 1975 or possibly early 1976. This document has been distributed to all state and county medical societies, all conditional and planning PSROs, all United States acute-care short stay hospitals, medical specialty societies, and to individual physicians upon request. In order to aid in this revision and provide the most useful document possible for local review systems, it would be appreciated if each recipient (especially PSROs and hospital medical staffs that have tested these criteria sets) would submit comments and suggestions to the AMA. An evaluation form designed for that purpose is enclosed.

Prior to the application of these model sets in a local review system it is important that the scope and limitations of screening criteria in general and these model sets in particular be clearly understood.

SCREENING CRITERIA CAN:

1. **Provide an effective review mechanism.** Screening criteria are useful because they allow for selecting out from a large number of cases being reviewed, a small number for which peer review is appropriate.

2. **Reduce physician review time.** Screening criteria allow physician reviewers to use their limited time to review those cases where there is a higher potential that a problem exists in terms of sub-standard quality or misutilization of services. The criteria should be short and based on easily obtainable objective data where possible.

SCREENING CRITERIA DO NOT:

1. **Define rigid standards of quality** (neither maximum or minimum nor any level of quality). In other words, if a case fails to meet the
screening criteria, it does not necessarily mean that poor quality care was delivered to that patient. It is intended only that under those circumstances, physician review should be required.

2. **Define which services will be paid for as part of claims review.** Screening criteria should not be used by fiscal intermediaries to make a "pay or no pay" decision.

3. **Preclude innovation by a physician.** The particular needs of each individual patient must be the physician's primary concern. Medical decisions on appropriate diagnostic and therapeutic procedures for any given patient should not be made solely on what is contained in a screening criteria set. Frequent deviation from a criterion may be only an indication that the criterion needs to be changed.

4. **Provide a complete review system to fully analyze and evaluate the quality of care.** More in-depth, comprehensive criteria will be needed for physicians performing peer review and for retrospective in-depth studies of specific problems affecting quality and proper utilization of facilities and services. In addition, screening criteria do not contain standards (acceptable variation from norms) that are necessary to the evaluation of quality.

The model screening criteria sets contained in this document focus on intermediate outcomes and process elements. They necessarily address only those elements related to outcomes which are in turn related to the care provided. Also, the criteria sets relate only to care provided in the hospital, not to all elements important to patient health. Ambulatory preventive measures and post-hospital care are not included.

It must be emphasized that in assisting in the measurement of quality medical care, this format deals only with clinical aspects of health care delivery. A substantial portion of quality health care delivery involves the human aspects of medicine. In order to validly measure the entire spectrum of health care, the importance of the patient-physician relationship cannot be overlooked. It is recognized that effective communication skills and sensitivity to patient need by a physician can significantly influence patient outcome.
ACKNOWLEDGEMENTS

The American Medical Association gratefully expresses its appreciation for the cooperative efforts of thirty-five national medical specialty and professional societies for their contributions in the creation of this publication. In particular, recognition must be given to the individual members of the criteria committees and the executive staffs of each society whose efforts made this publication possible.

The following medical specialty and professional societies were responsible for the development of the model screening criteria sets (note the Appendix for a listing of the specific criteria sets each society was responsible for developing). Those societies involved in the same specialty area which jointly developed criteria are listed together.

- American Academy of Allergy
- American College of Allergists
- American Association for Clinical Immunology and Allergy

- American Academy of Child Psychiatry

- American Academy of Dermatology

- American Academy of Neurology

- American Academy of Ophthalmology and Otolaryngology
- American Association of Ophthalmology
- American Council of Otolaryngology

- American Academy of Orthopaedic Surgeons

- American Academy of Pediatrics

- American Academy of Physical Medicine & Rehabilitation

- American Association for Thoracic Surgery
- The Society of Thoracic Surgeons

- American College of Cardiology

- American College of Chest Physicians
- American Thoracic Society
American College of Gastroenterology
American Gastroenterological Association
American Society for Gastrointestinal Endoscopy

American College of Obstetricians & Gynecologists

American College of Physicians
American Society of Internal Medicine

American College of Surgeons

American Dental Association

American Pediatric Surgical Association

American Psychiatric Association

American Society of Colon & Rectal Surgeons

American Society of Oral Surgeons

American Society of Plastic and Reconstructive Surgeons

American Urological Association

The Society for Vascular Surgery

The following specialty societies reviewed and provided comments on the screening criteria sets developed by other specialties:

American Academy of Family Physicians

American College of Radiology

College of American Pathologists
A special note of appreciation and recognition is extended to those national medical specialty societies that served as coordinators and reviewers between specialties to minimize overlap and provide more consistent terminology within the criteria sets. Those societies are:

American College of Physicians
American Society of Internal Medicine

The joint American College of Physicians-American Society of Internal Medicine Committee had several functions. It developed criteria sets for certain broad diagnoses or problems in the field of internal medicine. Under its supervision, criteria sets were developed for the fields of endocrinology, hematology, infectious diseases, nephrology and rheumatology, through the use of consulting internists expert in those subspecialty fields. In the fields of allergy, cardiology, gastroenterology and pulmonary diseases, the Joint Committee's role was to edit for consistency and to reconcile overlaps in the criteria sets developed by the participating organizations.

American College of Surgeons

The American College of Surgeons had several functions in the project. It developed criteria sets for certain diagnoses in the field of general surgery independent of the AMA contract with DHEW which are included in this document. In addition, the College coordinated a criteria set review with the surgical specialty criteria committee chairmen and the members and consultants of the ACS Peer Review Committee and ACS Advisory Councils for the Surgical Specialties to achieve consistency among overlapping surgical specialty criteria sets.

The American Medical Association wishes to recognize and express its appreciation to the following project committee members for their leadership, dedication, and contributions toward this initial publication:

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In an effort to assist the participating medical specialty and professional societies in identifying those diagnoses or problems which account for the most frequent hospital admissions in their area, the American Medical Association would like to recognize the technical assistance and data provided by the:

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Ann Arbor, Michigan
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DIABETES MELLITUS

I. JUSTIFICATION FOR ADMISSION

A. Uncontrolled diabetes
   - institution of insulin therapy
   - pregnancy
   - reregulation of brittle diabetes
B. Uncontrolled vomiting
C. Uncontrolled infection
D. Insulin resistance

II. LENGTH OF STAY

A. INITIAL LENGTH OF STAY ASSIGNMENT FOR PRIMARY DIAGNOSIS OR PROBLEM (numerical determinations to be established locally based on statistical norms)

B. EXTENDED LENGTH OF STAY ASSIGNMENT (numerical determinations to be established based on the individual patient's condition at the end of the initial length of stay period)

1. REASONS FOR EXTENDING THE INITIAL LENGTH OF STAY
   a. Progression into ketoacidosis
   b. Complicating chronic infection
   c. Labile or brittle diabetes

III. VALIDATION OF:

A. DIAGNOSIS

   1. Fasting and post-prandial hyperglycemia
   2. Abnormal glucose tolerance test
   3. History of the disease
B. REASONS FOR ADMISSION

1. Pregnancy (IA)
2. Insulin therapy or change in insulin therapy (IA)
3. Requirement for IV fluids or antibiotics (IC)
4. Insulin requirement greater than 200 units/day (IE)

IV. CRITICAL DIAGNOSTIC AND THERAPEUTIC SERVICES

<table>
<thead>
<tr>
<th>Screening Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Repetitive analysis blood and urine sugars</td>
</tr>
<tr>
<td>B. Diet order</td>
</tr>
<tr>
<td>C. Instruction in diet, urine testing, footcare, insulin administration when indicated</td>
</tr>
<tr>
<td>D. Obstetrical care when appropriate</td>
</tr>
<tr>
<td>E. Disease counseling</td>
</tr>
</tbody>
</table>

V. DISCHARGE STATUS

A. Improved control of diabetes

VI. COMPLICATIONS

A. PRIMARY DISEASE AND TREATMENT-SPECIFIC COMPLICATIONS

1. Development of hypoglycemia with therapy
2. Further deterioration in diabetic control
   - hyperglycemia
   - ketosis
   - acidosis

B. NON-SPECIFIC INDICATORS

None
GASTROENTERITIS - Includes Bacterial, Viral, Toxic, Drug-related and Parasitic (Giardia)

H-ICDA 007.1, 008.4, 008.9, 136, 561

I. JUSTIFICATION FOR ADMISSION

A. Dehydration
B. Shock

II. LENGTH OF STAY

A. INITIAL LENGTH OF STAY ASSIGNMENT FOR PRIMARY DIAGNOSIS OR PROBLEM (numerical determinations to be established locally based on statistical norms)

B. EXTENDED LENGTH OF STAY ASSIGNMENT (numerical determinations to be established based on the individual patient's condition at the end of the initial length of stay period)

1. REASONS FOR EXTENDING THE INITIAL LENGTH OF STAY

a. Failure to resolve
b. Renal failure

III. VALIDATION OF:

A. DIAGNOSIS

1. Stool examination and culture positive for pathogen or
2. Relevant epidemiologic investigation or
3. Systolic blood pressure less than 90mm Hg or
4. Positive blood culture for pathogen or
5. Sunken eyes, dry skin and mouth, loss of skin turgor and
6. Drop in hematocrit or increase in urine output in response to treatment
B. **REASONS FOR ADMISSION**

No entry necessary

IV. **CRITICAL DIAGNOSTIC AND THERAPEUTIC SERVICES**

<table>
<thead>
<tr>
<th>Service</th>
<th>Screening Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Stool examination and culture</td>
<td>100%</td>
</tr>
<tr>
<td>B. Fluid replacement</td>
<td>100%</td>
</tr>
<tr>
<td>C. Serum electrolytes and BUN or creatinine</td>
<td>100%</td>
</tr>
</tbody>
</table>

V. **DISCHARGE STATUS**

A. Resolution of admitting problems  
B. Documentation of follow-up plan

VI. **COMPLICATIONS**

A. **PRIMARY DISEASE AND TREATMENT-SPECIFIC COMPLICATIONS**

1. Prolapsed hemorrhoids  
2. Aspiration pneumonia  
3. Renal failure  
4. Inducement of Salmonella carrier state due to insufficient antibiotic therapy

B. **NON-SPECIFIC INDICATORS**

None

Developed by AMERICAN COLLEGE OF GASTROENTEROLOGY/AMERICAN GASTROENTEROLOGICAL ASSOCIATION/AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY and the AMERICAN COLLEGE OF PHYSICIANS/AMERICAN SOCIETY OF INTERNAL MEDICINE
HEART DISEASE, ARTERIOSCLEROTIC - Include Angina Pectoris and "Chest Pain"

I. JUSTIFICATION FOR ADMISSION

A. Suspicion of unstable angina pectoris, including new angina pectoris
B. Scheduled for coronary cineangiography

II. LENGTH OF STAY

A. INITIAL LENGTH OF STAY ASSIGNMENT FOR PRIMARY DIAGNOSIS OR PROBLEM (numerical determinations to be established locally based on statistical norms)

B. EXTENDED LENGTH OF STAY ASSIGNMENT (numerical determinations to be established based on the individual patient's condition at the end of the initial length of stay period)

1. REASONS FOR EXTENDING THE INITIAL LENGTH OF STAY

a. Persistent, recurrent angina pectoris
b. Additional diagnostic evaluation (coronary cineangiography)
c. Complications of diagnostic procedures (e.g., arterial occlusion, bleeding)
d. Myocardial infarction

III. VALIDATION OF:

A. DIAGNOSIS

1. History is sufficient
2. Electrocardiographic confirmation of myocardial infarction
3. Stress electrocardiographic test positive or resting electrocardiogram during spontaneous angina positive
4. Coronary cineangiographic confirmation
B. REASONS FOR ADMISSION

1. Suspicion of angina or positive electrocardiographic findings of ischemia (rest or exercise) (IB)

IV. CRITICAL DIAGNOSTIC AND THERAPEUTIC SERVICES

A. Electrocardiogram
B. Chest x-ray

V. DISCHARGE STATUS

A. Patient clinically stable or improving
B. Documented plan of follow-up

VI. COMPLICATIONS

A. PRIMARY DISEASE AND TREATMENT-SPECIFIC COMPLICATIONS

1. Complications of coronary cineangiography and catheterization (e.g., arterial occlusion, bleeding)

B. NON-SPECIFIC INDICATORS

1. Surgery

Developed by AMERICAN COLLEGE OF CARDIOLOGY
HYPOGLYCEMIA

I. JUSTIFICATION FOR ADMISSION

A. Severe symptoms of altered mentation consistent with hypoglycemia
   - coma
   - syncope

II. LENGTH OF STAY

A. INITIAL LENGTH OF STAY ASSIGNMENT FOR PRIMARY DIAGNOSIS OR
   PROBLEM (numerical determinations to be established locally based on statistical norms)

B. EXTENDED LENGTH OF STAY ASSIGNMENT (numerical determinations to be established based on the individual patient's condition at the end of the initial length of stay period)

1. REASONS FOR EXTENDING THE INITIAL LENGTH OF STAY

   a. Pancreatic adenoma
   b. Intractable symptomatic fasting hypoglycemia

III. VALIDATION OF:

A. DIAGNOSIS

1. Fasting blood glucose less than 40mg percent and
2. Hypoglycemic symptoms coincident with blood glucose less than 40mg percent; or
3. Elevated insulin level in presence of lowered glucose
B. **REASONS FOR ADMISSION**

No entry necessary

---

**IV. CRITICAL DIAGNOSTIC AND THERAPEUTIC SERVICES**

<table>
<thead>
<tr>
<th>Screening Benchmark</th>
<th>A. Order for monitoring level of consciousness and blood glucose</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B. History of insulin or drug intake</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>C. Tolbutamide tolerance test in documented fasting hypoglycemia</td>
<td>0%</td>
</tr>
</tbody>
</table>

---

V. **DISCHARGE STATUS**

A. Ambulatory
B. Initiation of disease specific therapy

---

VI. **COMPLICATIONS**

A. **PRIMARY DISEASE AND TREATMENT-SPECIFIC COMPLICATIONS**

1. Development of coma
2. Seizure
3. Prolonged symptomatic hypoglycemia for longer than 30 minutes

B. **NON-SPECIFIC INDICATORS**

None

---

Developed by AMERICAN COLLEGE OF PHYSICIANS/AMERICAN SOCIETY OF INTERNAL MEDICINE
PROJECT DIRECTORY, EFFECTIVE JULY 1, 1975, OF LOCAL PSROs AND DHEW REGIONAL OFFICE FOCAL POINTS FOR PSRO ASSISTANCE

(Organized by State; by Organizational Status - i.e., Planning, Conditional or Operational Phase; and by Health Service Administration Contract Number.)
PSRO FOCAL POINTS IN OFFICES OF THE RHA's

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   Boston, Massachusetts 02203
   Phone: (617) 223-5807

II  NEW YORK REGION: New York, New Jersey, Puerto Rico, Virgin Islands
    F. Lawrence Clare, M.D., MPH
    Alternate: Jean-Marie Moore
    Federal Building, Room 3300
    26 Federal Plaza
    New York, New York 10007
    Phone: (212) 264-4680

III  PHILADELPHIA REGION:
    Pennsylvania, Maryland, District of Columbia, Delaware, Virginia, West Virginia
    Clyde Couchman
    Alternate: Diane Krisinger
    P.O. Box 13716
    Room 4139
    Philadelphia, Pennsylvania 19101
    Phone: (215) 596-6601

IV  ATLANTA REGION: Alabama, Georgia, Mississippi, Florida, South Carolina, Tennessee, North Carolina, Kentucky
    C. Dexter Kimsey
    Alternate: Mary Gregory
    Peachtree-Seventh Building RM860
    50 Seventh Street, N.E.
    Atlanta, Georgia 30323
    Phone: (404) 526-2410

V  CHICAGO REGION: Illinois, Indiana, Ohio, Michigan, Wisconsin, Minnesota
    Robert Goodnow
    Alternate: Anne Martin
    300 South Wacker Drive, RM3300
    Chicago, Illinois 60607
    Phone: (312) 353-1720

VI  DALLAS REGION: Louisiana, Arkansas, Oklahoma, Texas, New Mexico
    Kenneth Schneider, M.D.
    Alternate: Kay Kimbrough
    1114 Commerce Street, RM8C-53
    Dallas, Texas 75202
    Phone: (214) 749-7477

VII  KANSAS CITY REGION: Missouri, Iowa, Kansas, Nebraska
    Sam D. Wheeler
    Alternate: J. Ted Herbelin, MD, MPH
    Federal Office Building
    601 East 12th Street
    RM 5th Floor West
    Kansas City, Missouri 64106
    Phone: (816) 374-5746
VIII DENVER REGION: Colorado, Utah, Wyoming, South Dakota, North Dakota, Montana

Fred Tosh, M.D.  
Alternate: Robert Chandler  
Federal Office Building RM11037  
19th and Stout Streets  
Denver, Colorado 80202  
Phone: (303) 837-4734

IX SAN FRANCISCO REGION:  
California, Nevada, Arizona, Guam, Hawaii, Samoa

Al Miller, M.D.  
Alternate: Fred Zentgraf  
Federal Office Building  
50 Fulton Street, RM 237  
San Francisco, California 94102  
Phone: (415) 556-3100

X SEATTLE REGION: Washington, Oregon, Idaho, Alaska

Richard Marquardt  
Alternate: Penni St.Hilaire  
Arcade Building  
1321 Second Avenue  
Mail Stop 506  
Seattle, Washington 98101  
Phone: (206) 442-0511
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</table>
Single PSRO Area

**PLANNING**

**ALABAMA**

Alabama Medical Review, Inc.
400 Office Park Drive
Suite 105
Birmingham, Alabama 35223
Phone: (205) 871-3525
Executive Director: Robert King

**ALASKA**

Alaska Professional Review Organization
1135 West 8th Avenue, Suite 6
Anchorage, Alaska 99501
Phone: (907) 279-4536
Administrator: Marvin Janzen

**ARKANSAS**

Arkansas Foundation for Medical Care
216 North 12th Street
P.O. Box 1208
Fort Smith, Arkansas 72901
Phone: (501) 785-2471
Project Director: Paul C. Schaefer

**ARIZONA**

Pima Foundation For Medical Care,
2343 East Broadway, Suite 204
Tucson, Arizona 85719
Phone: (602) 327-6047
Project Director: Lloyd Epstein
## Twenty-eight PSRO Areas

### PLANNING

<table>
<thead>
<tr>
<th>Area</th>
<th>Location</th>
<th>Phone</th>
<th>Administrative Director</th>
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<tr>
<td>Area V</td>
<td>San Francisco Peer Review Organization, Inc.</td>
<td>(415) 563-7491</td>
<td>Tod A. Anderson</td>
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<tr>
<td>Area IX</td>
<td>Santa Clara Valley PSRO</td>
<td>(408) 998-8850</td>
<td>Harry R. Gladstein, M.D.</td>
</tr>
<tr>
<td>Area XIV</td>
<td>Kern County PSRO, Inc.</td>
<td>(805) 325-9027</td>
<td>Martin G. Dale</td>
</tr>
<tr>
<td>Area XV</td>
<td>San Bernardino Foundation PSRO</td>
<td>(714) 825-6053</td>
<td>Gene Scott</td>
</tr>
<tr>
<td>Area XVI</td>
<td>Organization for PSR of Santa Barbara/San Luis Obispo Counties</td>
<td>(805) 687-2691</td>
<td>Robert J. Marvin</td>
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<tr>
<td>Area XVII</td>
<td>Ventura Area PSRO, Inc.</td>
<td>(805) 647-0750</td>
<td>Walter Anderson</td>
</tr>
</tbody>
</table>

### Areas

- Area V: San Francisco Peer Review Organization, Inc.
  - 250 Masonic Avenue
  - San Francisco, California 94118
  - Phone: (415) 563-7491
  - Administrative Director: Tod A. Anderson

- Area IX: Santa Clara Valley PSRO
  - 700 Empey Way
  - San Jose, California 95128
  - Phone: (408) 998-8850
  - President: Harry R. Gladstein, M.D.

- Area X: Stanislaus-Merced-Mariposa PSRO, Inc.
  - 2030 Coffee Road, Suite A-6
  - P.O. Box 1755
  - Modesto, California 95354
  - Phone: (209) 526-8450
  - Chief Executive Officer: Paul O. Humbert, Jr.

- Area XIV: Kern County PSRO, Inc.
  - 2012 18th Street
  - Bakersfield, California 93301
  - Phone: (805) 325-9027
  - Project Director: Martin G. Dale

- Area XV: San Bernardino Foundation PSRO
  - 666 Fairway Drive
  - San Bernardino, California 92408
  - Phone: (714) 825-6053
  - Executive Director: Gene Scott

- Area XVI: Organization for PSR of Santa Barbara/San Luis Obispo Counties
  - 41 Hitchcock Way
  - Santa Barbara, California 93105
  - Phone: (805) 687-2691
  - Project Director: Robert J. Marvin

- Area XVII: Ventura Area PSRO, Inc.
  - 3212 Loma Vista Road
  - Ventura, California 93003
  - Phone: (805) 647-0750
  - Executive Director: Walter Anderson
CALIFORNIA (CONT'D)

Area XX
California Area XX PSRO
15250 Ventura Blvd. Suite 804
Sherman Oaks, California 91403
Phone: (213) 995-0805
Project Director: Lila L. Marcus

Area XXI
California Area XXI PSRO, Inc.
1401 West Huntington Drive
Arcadia, California 91006
Phone: (213) 447-2186
Project Director: John W.H. Sleeter, M.D.

Area XXII
California Area XXII PSRO
3828 Hughes Avenue
Culver City, California 90230
Phone: (213) 826-8311
Project Director: Edwin W. Butler, M.D.

Area XXIII
California PSRO Area XXIII
c/o Mrs. Jess Mullen
3655 Lomita Blvd., Suite 319
Torrance, California 90505
Phone: (213) 378-5275
Project Director: John M. Wasserman, M.D.

CONDITIONAL

Area I
Redwood Coast Region PSRO
2200 County Center Drive, Suite F
Santa Rosa, California 95401
Phone: (707) 528-8585
Executive Director: M.R. Corbett

Area III
North Bay PSRO
4460 Redwood Highway
P.O. Box #4344
San Rafael, California 94903
Phone: (415) 472-7771
Executive Director:

Area IV
Greater Sacramento PSRO
650 University Avenue
Sacramento, California 95825
Phone: (916) 929-1480
Project Director: Reginald Claytor

Area VIII
San Joaquin Area PSRO
540 E. Market Street
Stockton, California 95201
Phone: (209) 948-8059
Executive Director: Dan Sheehy
### Area XII
- Monterey Bay Area PSRO
- 19045 Portola Drive
- P.O. Box 308
- Salinas, California 93901
- Phone: (408) 455-1833
- Executive Director: Edgar H. Colvin

### Area XXIV
- Area XXIV PSRO
- 3200 Wilshire Boulevard, Suite 906
- Los Angeles, California 90010
- Phone: (213) 389-1267
- Medical Director: Rex Greene, M.D.

### Area XXVII
- Riverside County PSRO
- 6833 Indiana Avenue
- Riverside, California 92506
- Phone: (714) 686-0200
- Executive Director: Paul S. Parry

### SUPPORT CENTER
- United Foundations for Medical Care, Inc.
- 215 Market Street, Suite 1301
- San Francisco, California 94105
- Phone: (415) 495-0940
- Project Director: Edward G. Zivot

### COLORADO
- Colorado Foundation for Medical Care
- 1601 East 19th Avenue
- Denver, Colorado 80218
- Phone: (303) 534-8580
- Executive Vice President: Donald Derry

### CONNECTICUT
- PSRO of Fairfield County, Inc.
- 60 Katona Drive
- Fairfield, Connecticut 06430
- Phone: (203) 576-1214
- Executive Director: Greg Martel

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**CALIFORNIA (CONT'D)**

<table>
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<th>Area</th>
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<tr>
<td>XII</td>
<td>Monterey Bay Area PSRO</td>
<td>19045 Portola Drive, Salinas, CA 93901</td>
<td>(408) 455-1833</td>
<td>Edgar H. Colvin</td>
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<tr>
<td>XXIV</td>
<td>Area XXIV PSRO</td>
<td>3200 Wilshire Boulevard, Los Angeles, CA 90010</td>
<td>(213) 389-1267</td>
<td>Rex Greene, M.D.</td>
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<td>XXVII</td>
<td>Riverside County PSRO</td>
<td>6833 Indiana Avenue, Riverside, CA 92506</td>
<td>(714) 686-0200</td>
<td>Paul S. Parry</td>
</tr>
</tbody>
</table>

**SUPPORT CENTER**
- United Foundations for Medical Care, Inc.
  - 215 Market Street, San Francisco, CA 94105
  - Phone: (415) 495-0940
  - Project Director: Edward G. Zivot

**COLORADO**
- Colorado Foundation for Medical Care
  - 1601 East 19th Avenue, Denver, CO 80218
  - Phone: (303) 534-8580
  - Executive Vice President: Donald Derry

**CONNECTICUT**
- PSRO of Fairfield County, Inc.
  - 60 Katona Drive, Fairfield, CT 06430
  - Phone: (203) 576-1214
  - Executive Director: Greg Martel
CONNECTICUT (CONT'D)

Area II
Connecticut Area II PSRO, Inc.
8 Lunar Drive
P.O. Box 3907
Woodbridge, Connecticut 06525
Phone: (203) 389-5781
Executive Director: John H. Herder

Area III
Hartford County PSRO Inc.
40 Woodland Street
Hartford, Connecticut 06105
Phone: (203) 525-5383
Executive Director: Norman Reich

Area IV
Eastern Connecticut PSRO, Inc.
15 Mansfield Avenue
Willimantic, Connecticut 06226
Phone: (203) 456-2228
Administrative Director: Donald E. Woodbury

SUPPORT CENTER
Connecticut Medical Institute
90 Sargent Drive
New Haven, Connecticut 06509
Phone: (203) 777-4494
Executive Director: Joseph W. Marin

DELAWARE

Single PSRO Area

PLANNING
Delaware Review Organization
1925 Lovering Avenue
Wilmington, Delaware 19806
Phone: (302) 654-9524
Executive Director: Paul L. Gandillot

DISTRICT OF COLUMBIA

Single PSRO Area

CONDITIONAL
National Capital Medical Foundation, Inc.
1828 L Street, N.W., Suite 220
Washington, D.C. 20036
Phone: (202) 223-4422
Executive Director: Norman A. Fuller, Ph.D.
Twelve PSRO Areas

PLANNING

Area III
Jacksonville Area PSRO
515 Lomax Street
Jacksonville, Florida 32204
Phone: (904) 355-6561
Project Director: Ernest R. Currie

CONDITIONAL

Area XII
Dade Monroe PSRO, Inc.
444 Brickell Avenue, Suite M-100
Miami, Florida 33131
Phone: (305) 358-4224
Executive Director: Gerard E. Mayer

Single PSRO Area

GEORGIA

[No Contract Awarded]

HAWAII
(Also American Samoa, Guam, Trust Territories of the Pacific Islands)

Single PSRO Area

PLANNING

Pacific PSRO, Inc.
510 South Beretania Street
Honolulu, Hawaii 96813
Phone: (808) 536-6980
Project Director: Jon R. Won

IDAHO

Single PSRO Area

CONDITIONAL

The Idaho Health Care Review Organization, Inc.
407 West Bannock Street
Boise, Idaho 83702
Phone: (208) 377-1910
Executive Director: Ben Kermmoade
Eight PSRO Areas

ILLINOIS

PLANNING

Area III
Chicago Foundation for Medical Care
332 South Michigan Avenue, Room 503
Chicago, Illinois 60604
Phone: (312) 939-2480
Operations Officer: William D. Gannon

CONDITIONAL

Area IV
Quad River Foundation for Medical Care
58 North Chicago Street
Joliet, Illinois 60431
Phone: (815) 726-2441
Executive Director: Myron W. Osborn

Seven PSRO Areas

INDIANA

PLANNING

Area I
Calumet Area Professional Review Organization
2825 Jewett Street
Highland, Indiana 46322
Phone: (219) 923-8614
Executive Director: Charles C. Shoemaker

Area V
Indiana Area V PSRO
2501 Executive Drive, Suite 108
Indianapolis, Indiana 46241
Phone: (317) 243-3746
Executive Director: Arthur G. Loftin

SUPPORT CENTER
Indiana Physicians Support Agency
2501 Directors Row, Suite 106
Indianapolis, Indiana 46241
Phone: (317) 243-3229
Project Director: Wilbert McIntosh, M.D.
IOWA

Single PSRO Area

CONDITIONAL

The Iowa Foundation for Medical Care, Inc.
1005 Grand Avenue
West Des Moines, Iowa 50265
Phone: (515) 274-4931
Executive Director: Fred Ferree

KANSAS

Single PSRO Area

PLANNING

Kansas Foundation for Medical Care, Inc.
1300 Topeka Avenue
Topeka, Kansas 66612
Phone: (913) 235-2383
Executive Director: James E. Agin

KENTUCKY

Single PSRO Area

PLANNING

Kentucky Peer Review Organization, Inc.
Professional Towers Building
4010 Dupont Circle, Suite 410
Louisville, Kentucky 40207
Phone: (502) 897-5188
Executive Director: Paul Osborne

LOUISIANA

Four PSRO Areas

[No Contracts Awarded]

MAINE

Single PSRO Area

CONDITIONAL

Pine Tree Organization for Professional Standards Review, Inc.
99 Western Avenue
P.O. Box 706
Augusta, Maine 04330
Phone: (207) 622-9368
Executive Director: Ronald G. Thurston
Single PSRO Areas

**MARYLAND**

**PLANNING**

**Area I**
Western Maryland Review Organization, Inc.
329 N. Potomac Street
Hagerstown, Maryland 21740
Phone: (301) 733-4440
Project Director: Charles C. Spencer

**CONDITIONAL**

**Area II**
Baltimore City Professional Standards Review Organization, Inc.
2 Hamill Road, Suite 262
Baltimore, Maryland 21210
Phone: (301) 433-8300
Executive Director: Alvin D. Ankrum

**Area III**
Montgomery County, Maryland Medical Care Foundation, Inc.
2446 Reedie Drive
Wheaton, Maryland 20902
Phone: (301) 933-8330
Executive Director: Betsy Carrier

**Area IV**
Prince George's Foundation for Medical Care, Inc.
5801 Annapolis Road, Suite 400
Hyattsville, Maryland 20784
Phone: (301) 927-3385
Executive Director: Robert J. Helfrich

**Area V**
Central Maryland PSRO, Inc.
8635 Lock Raven Blvd., Suite 5
Baltimore, Maryland 21204
Phone: (301) 668-5150
Executive Director: Frederick Menosky

**Area VI**
Southern Maryland PSRO, Inc.
P.O. Box #445
Edgewater, Maryland 21037
Phone: 224-4144
Executive Director: Curtis J. Spicer

**Area VII**
Delmarva Foundation for Medical Care, Inc.
108 N. Harrison Street
Easton, Maryland 21601
Phone: (301) 822-7223
Executive Director: Peter J. Borchardt
MARYLAND (CONT'D)

SUPPORT CENTER
Maryland Foundation for Health Care
1501 W. Mount Royal Avenue
Baltimore, Maryland 21217
Phone: (301) 225-0300
Executive Director: Alvin D. Ankrum

MASSACHUSETTS

PLANNING

Area II
Central Massachusetts Health Care Foundation, Inc.
105 Merrick Street
Worcester, Massachusetts 01609
Phone: (617) 798-8667
Executive Director: Richard Kaplan

CONDITIONAL

Area I
Western Massachusetts PSRO, Inc.
103 Van Deene Avenue
West Springfield, Massachusetts 01089
Phone: (413) 781-8640
Executive Director: Charles Everett

Area III
Charles River Health Care Foundation
25 Walnut Street
Wellesley Hills, Massachusetts 02181
Phone: (617) 235-5399
Executive Director: Dr. Lewis S. Pilcher, M.D.

Area IV
Bay State PSRO, Inc.
100 Charles River Plaza
Boston, Massachusetts 02114
Phone: (617) 723-2250
Executive Director: Gary M. Janko

Area V
Southeastern Massachusetts PSRO, Inc.
P.O. Box 676
Middleboro, Massachusetts 02346
Phone: (617) 947-4358
Executive Director: Paul Egan

SUPPORT CENTER
Massachusetts Support Center
Commonwealth Institute of Medicine
100 Charles River Plaza
Boston, Massachusetts 02114
Phone: (617) 723-6580
Executive Director: Richard Beckman
Ten PSRO Areas

PLANNING

Area VII
Federation of Physicians in Southeastern Michigan
1010 Antietam
P.O. Box 125
Detroit, Michigan 48207
Phone: (313) 885-1466
Project Director: Ralph R. Cooper, M.D.

CONDITIONAL

Area I
Upper Peninsula Quality Assurance Association
420 West Magnetic Street
Marquette, Michigan 49855
Phone: (906) 228-7685
Executive Director: Bradley Cory

Area V
Professional Review Organization - GLSC
700 Metropolitan Building
432 N. Saginaw Street
Flint, Michigan 48502
Phone: (313) 233-6071
Executive Director: Donald Blass

SUPPORT CENTER
Michigan PSRO Support Center
120 West Saginaw Street
P.O. Box 950
East Lansing, Michigan 48823
Phone: (517) 332-0875
Project Director: Herbert Mehler

Three PSRO Areas

PLANNING

Area III
Professional Services Quality Council of Minnesota
200 First Street, S.W.
Rochester, Minnesota 55901
Phone: (507) 282-2511
Priority Pager 409
Project Director: Richard W. Hill, M.D.

MINNESOTA

I-15
MINNESOTA (CONT'D)

**CONDITIONAL**

**Area II**
Foundation for Health Care Evaluation
1535 Medical Arts Building
Minneapolis, Minnesota 55402
Phone: (612) 339-6871
Executive Director: Carl G. Gustafson

**Single PSRO Area**

**MISSISSIPPI**

**CONDITIONAL**
Mississippi Foundation for Medical Care, Inc.
P.O. Box 4665
Jackson, Mississippi 39216
Phone: (601) 948-8894
Executive Director: Tom H. Mitchell, M.D.

**MISSOURI**

**Five PSRO Areas**

**PLANNING**

**Area I**
Northwest Missouri PSRO
3036 Gillham Road
Kansas City, Missouri 64108
Phone: (816) 531-8432
Project Director: Robert E. Watkins

**Area II**
Mid-Missouri PSRO Foundation
1907 William Street
P.O. Box 253
Jefferson City, Missouri 65101
Phone: (314) 634-3321
Executive Director: Jacquelyn Admire

**Area IV**
MOAF, Inc.
223A Professional Building
Springfield, Missouri 65806
Phone: (417) 866-1994
Project Director: N.L. McCartney
MISSOURI (CONT'D)

Area V
Southeast Missouri Foundation for Medical Care
P.O. Box 816
Cape Girardeau, Missouri 63701
Phone: (314) 334-3016
Executive Director: Thomas E. Mangus

CONDITIONAL

Area III
Central Eastern Missouri Professional Review Organization Committee
4625 Lindell Blvd., Suite 212
St. Louis, Missouri 63108
Phone: (314) 367-5900
Executive Director: William C. Lindsley

SUPPORT CENTER
Missouri PSRO Support Center
P.O. Box 862, 1907 William Jefferson City, Missouri 65101
Phone: (314) 634-3155
Executive Vice President: E. Mark Halvorson

MONTANA

Single PSRO Area

CONDITIONAL
Montana Foundation for Medical Care
2717 Airport Way
P.O. Box 191
Helena, Montana 59601
Phone: (406) 443-4020
Executive Director: David Coyner

NEBRASKA

Single PSRO Area

[No Contract Awarded]

NEVADA

Single PSRO Area

PLANNING
Nevada PSRO
129 West 6th Street
Reno, Nevada 89503
Phone: (702) 786-1842
Executive Director: James W. Hand
Single PSRO Area

CONDITIONAL

New Hampshire Foundation
for Medical Care
The Durham Road
P.O. Box 658
Durham, New Hampshire 03824
Phone: (603) 869-7410
Director: Constance Azzi

Eight PSRO Areas

PLANNING

Area I
Professional Standards Review
Organization
Area I, Region II
2 Shunpike Road
Madison, New Jersey 07940
Phone: (201) 377-8100
Executive Director: Frank Mahoney

Area IV
Essex Physicians' Review
Organization, Inc.
144 South Harrison Street
East Orange, New Jersey 07018
Phone: (201) 672-0558
Executive Director: Anthony Petruzzi

Area VII
Central New Jersey PSRO
223 Highway 18
E. Brunswick Prof. Park
East Brunswick, New Jersey 08817
Phone: (201) 246-8200
Executive Director: Dennis Duffy

Area VIII
Southern New Jersey PSRO
1486 Haddon Avenue
Camden, New Jersey 08060
Phone: (609) 428-6709
Executive Director: Michael Trend

CONDITIONAL

Area II
Passaic Valley PSRO.
573 Valley Road
Wayne, New Jersey 07470
Phone: (201) 696-3730
Project Director: William A. Dwyer, Jr., M.D.
### NEW JERSEY (CONT'D)

**SUPPORT CENTER**
New Jersey Foundation for Health Care Evaluation  
315 West State Street  
Trenton, New Jersey 08618  
Phone: (609) 393-6371  
Administrative Director: Thomas J. Crane

**NEW MEXICO**

**Single PSRO Area**
**CONDITIONAL**
New Mexico PSRO  
2650 Yale, S.E.  
Albuquerque, New Mexico 87106  
Phone: (505) 842-6236  
Administrative Director: Jim Buffington

**NEW YORK**

**Seventeen PSRO Areas**

**PLANNING**

**Area III**
PSRO of Central New York, Inc.  
224 Harrison Street, RM 806  
Syracuse, New York 13202  
Phone: (315) 474-3995  
Executive Director: Peter B. Whitten

**Area IV**
Five-County Organization for Medical Care & PSR  
210 Clinton Road  
New Hartford, New York 13413  
Phone: (315) 735-2204  
Project Director: Clarke T. Case, M.D.

**Area XII**
Richmond County, New York PSRO  
100 Central Avenue  
Staten Island, New York 10301  
Phone: (212) 720-8383  
Executive Director: Dominic A. Florio

**Area XIV**
PSRO of Queens County  
112-25 Queens Blvd.  
Forest Hills, New York 11375  
Phone: (212) 268-7300  
Project Director: Lester J. Candela, M.D.
CONDITIONAL

Area I
Erie Region PSRO, Inc.
560 Delaware Avenue, Suite 300
Buffalo, New York 14202
Phone: (716) 881-6150
Project Director: Warren A. Mutz

Area II
Genesee Region PSRO, Inc.
109 South Union Street
P.O. Box 1939
Rochester, New York 14603
Phone: (716) 232-5521
Executive Director: John Coleman

Area V
Adirondack PSRO
24 Elm Street
Glens Falls, New York 12801
Phone: (518) 793-4667
Executive Director: Conrad S. Kaczmarek

Area IX
Area 9 PSRO of New York, Inc.
Purchase Street
Purchase, New York 10577
Phone: (914) 948-4100
Executive Director: Michael J. Maffucci

Area X
PSRO of Rockland
120 North Main Street
New City, New York 10956
Phone: (914) 634-0505
Executive Director: Jack Cohen

Area XI
New York County Health Services Review Organization
40 West 57th Street
New York, New York 10019
Phone: (212) 582-5858
Executive Director: Dr. Eleanor Rothenberg, Ph.D.

Area XIII
Kings County Health Care Review Organization
1313 Bedford Avenue
Brooklyn, New York 11216
Phone: (212) 467-9000
Project Director: Ralph M. Schwartz, M.D.

Area XV
Nassau Physicians Review Organization
1200 Stewart Avenue
Garden City, New York 11530
Phone: (516) 333-4300
Project Director: Eugene O'Reilly
Area XVI
The Bronx Medical Services Foundation, Inc.
1941 Williams Bridge Road
Bronx, New York 10461
Phone: (212) 863-6000
Executive Director: Harry M. Feder

SUPPORT CENTER
Medical Society of the State of New York
420 Lakeville Road
Lake Success, New York 11040
Phone: (516) 488-6100
Executive Director: Morton Chalef

Eight PSRO Areas

NORTH CAROLINA

Area II
Piedmont Medical Foundation, Inc.
2240 Cloverdale
Winston-Salem, North Carolina 27103
Phone: (919) 723-6916
Executive Director: William C. Park, Jr.

SUPPORT CENTER
North Carolina Medical Peer Review Foundation, Inc.
P.O. Box 19047
Raleigh, North Carolina 27609
Phone: (919) 872-1708
Director, PSRO Operations: Otto Mueller

Single PSRO Area

NORTH DAKOTA

PLANNING
North Dakota Health Care Review
810 E. Rosser
Medical Arts Building
Bismarck, North Dakota 58501
Phone: (701) 258-1133
Executive Director: Almon B. Strong
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<tr>
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<th>Peer Review Organization</th>
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<tr>
<td>II</td>
<td>Area II Peer Review Organization</td>
<td>1030 Fidelity Medical Building, Dayton, Ohio 45402</td>
<td>(513) 223-3180</td>
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<tr>
<td>VI</td>
<td>Region Six Peer Review Organization</td>
<td>430 Grant Street, Akron, Ohio 44311</td>
<td>(216) 535-2387</td>
<td>Mary Barley</td>
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<td>X</td>
<td>Region X Professional Review Organization</td>
<td>3720 Jolentangy River Road, Columbus, Ohio 43215</td>
<td>(614) 481-8874</td>
<td>Robert P. Stone</td>
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<tr>
<td>XII</td>
<td>Physicians Peer Review Organization</td>
<td>10525 Carnegie Avenue, Cleveland, Ohio 44106</td>
<td>(216) 421-5900</td>
<td>Donald Mortimer</td>
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<td>I</td>
<td>Medco Peer Review, Inc.</td>
<td>208 Lytle Towers, Cincinnati, Ohio 45202</td>
<td>(513) 721-2345</td>
<td>Edward Willenborg</td>
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<td>IV</td>
<td>Fourth Ohio Area PSR Council</td>
<td>3550 Secor Road, Suite 202, Toledo, Ohio 43606</td>
<td>(419) 535-0537</td>
<td>Robert L. Hauman, M.D.</td>
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<tr>
<td></td>
<td>Medical Advances Institute</td>
<td>1225 Dublin Road, Columbus, Ohio 43215</td>
<td>(614) 481-8871</td>
<td>Edward A. Lentz</td>
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</table>
Single PSRO Area

OKLAHOMA

Oklahoma Foundation for Peer Review
601 N.W. Expressway
Oklahoma City, Oklahoma 73118
Phone: (405) 842-3361
Project Director: Edward Kelsey

OREGON

Multnomah Foundation for Medical Care
5201 S.W. Westgate Drive
Portland, Oregon 97221
Phone: (503) 297-1704
Executive Director: Philip C. Walker, II

Two PSRO Areas

CONDITIONAL

Area I
Multnomah Foundation for Medical Care
5201 S.W. Westgate Drive
Portland, Oregon 97221
Phone: (503) 297-1704
Executive Director: Philip C. Walker, II

Area II
Greater Oregon PSRO
2164 S.W. Park Place
Portland, Oregon 97205
Phone: (503) 226-1555
Executive Director: Robert Dernedde

Twelve PSRO Areas

PLANNING

Area II
Central Pennsylvania Area II PSRO
699 Rural Avenue
Box 26
Williamsport, Pennsylvania 17701
Phone: (717) 323-3786
Executive Director: Paul John

Area IV
Eastern Pennsylvania Health Care Foundation, Inc.
65 East Elizabeth, Room 203
Bethlehem, Pennsylvania 18018
Phone: (215) 865-1481
Executive Director: William O. Prettyman, Jr.

PENNSYLVANIA
### PENNSYLVANIA (CONT'D)

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<th>Area</th>
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<td>Area VIII</td>
<td>Highlands PSRO Corporation</td>
<td>325 Swank Building, Johnstown, Pennsylvania 15901</td>
<td>(814) 539-7077</td>
<td>Bernard G. Koval</td>
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<td>Area VI</td>
<td>Allegheny PSRO</td>
<td>One Allegheny Square, Suite 1730, Pittsburgh, Pennsylvania 15212</td>
<td>(412) 231-1706</td>
<td>John F. Kuhn</td>
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<td>Area VII</td>
<td>Southwestern Pennsylvania PSRO</td>
<td>825 North Main Street, Greensburg, Pennsylvania 15601</td>
<td>(412) 836-5858</td>
<td>Sandra Levine</td>
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<td>Area IX</td>
<td>Southcentral Pennsylvania PSRO</td>
<td>2401 North Fourth Street, Harrisburg, Pennsylvania 17110</td>
<td>(717) 233-0273</td>
<td>Harold Diehl, Jr., FACHA</td>
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<td>Area XI</td>
<td>Montgomery/Bucks PSRO, Inc.</td>
<td>650 Blue Bell West, Suite 209, Blue Bell, Pennsylvania 19422</td>
<td>(215) 628-2121</td>
<td>Ralph Rolan, II</td>
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<td>Area XII</td>
<td>Philadelphia PSRO</td>
<td>2100 Spring Garden Street, Philadelphia, Pennsylvania 19130</td>
<td>(215) 567-2792</td>
<td>Tom DiVincenzo</td>
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<td>SUPPORT CENTER</td>
<td>Pennsylvania Medical Care Foundation</td>
<td>20 Erford Road, Lemoyne, Pennsylvania 17043</td>
<td>(717) 238-1635</td>
<td>Larry R. Fosselman</td>
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| PUERTO RICO | Single       | PLANNING      | Foundation for Medical Care of Puerto Rico  
1305 Fernandez Juncos Avenue  
Santurce, Puerto Rico 00908  
Phone: (809) 725-6969, X240  
Executive Director: Osvaldo Lastra, M.D. |
| RHODE ISLAND| Single       | CONDITIONAL   | Rhode Island PSRO, Inc. (Ripsro, Inc.)  
40 Westminster Street, Suite 1730  
Providence, Rhode Island 02903  
Phone: (401) 331-6661  
Executive Director: Edward J. Lynch |
| SOUTH CAROLINA| Single | CONDITIONAL | South Carolina Medical Care Foundation  
3325 Medical Park Road  
P.O. Box 11188, Capital Station  
Columbia, South Carolina 29211  
Phone: (803) 779-4780  
Project Director: William F. Mahon |
| SOUTH DAKOTA | Single       | PLANNING      | South Dakota Foundation for Medical Care  
608 West Avenue, North  
Sioux Falls, South Dakota 57104  
Phone: (605) 336-1965  
Executive Director: Robert Johnson |
Two PSRO Areas

PLANNING

Area I
Shelby County Foundation for Medical Care, Inc.
969 Madison Avenue, Suite 1300
Memphis, Tennessee 38104
Phone: (901) 726-1332
Executive Director: Leon J. Swatzell

CONDITIONAL

Area II
Tennessee Foundation for Medical Care, Inc.
Continental Plaza, Suite 300
4301 Hillsboro Road
Nashville, Tennessee 37215
Phone: (615) 385-2444
Executive Director: William D. Tribble, Ph.D.

Nine PSRO Areas

[No Contracts Awarded]

UTAH

Single PSRO Area

CONDITIONAL

Utah PSRO
555 East 2nd South, Suite 208
Salt Lake City, Utah 84102
Phone: (801) 364-8483
Executive Director: David Buchanan

VERMONT

Single PSRO Area

PLANNING
Vermont PSRO, Inc.
P.O. Box 415
Shelburne, Vermont 05482
Phone: (802) 985-9716
Executive Director: Dr. Robert Aiken
VIRGIN ISLANDS

Single PSRO Area

(No Contract Awarded)

VIRGINIA

Five PSRO Areas

PLANNING

Area II
Northern Virginia Foundation for Medical Care
4660 Kenmore Avenue, Suite 320
Alexandria, Virginia 22304
Phone: (703) 370-8707
Executive Director: Gerard G. Coleman

Area V
Colonial Virginia FMC
976 Norfolk Square
Norfolk, Virginia 23502
Phone: (804) 623-5314
Executive Director: William S. Grant

SUPPORT CENTER
Virginia Professional Standards Review Foundation
Towers Office Building, Room 711
1224 West Main Street
Charlottesville, Virginia 22903
Phone: (804) 977-7211
Executive Director: Leon Geoffrey

WASHINGTON

Single PSRO Area

CONDITIONAL
Washington State PSRO
2150 North 107th Street, Suite 504
Seattle, Washington 98125
Phone: (206) 364-9700
Executive Director: Terry G. Kelley
WEST VIRGINIA

Single PSRO Area

CONDITIONAL

West Virginia Medical Institute, Inc.
4701 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304
Phone: (304) 925-7011
Acting Executive Director: Betty Kirkwood

WISCONSIN

Two PSRO Areas

CONDITIONAL

Area I
Wisconsin Professional Review Organization
330 East Lakeside Street
P.O. Box 1109
Madison, Wisconsin 53701
Phone: (608) 257-6781
Executive Director: Donald McIntyre

Area II
The Foundation for Medical Care Evaluation of Southeastern Wisconsin, Inc.
756 North Milwaukee Street
Milwaukee, Wisconsin 53202
Phone: (414) 224-6127
Executive Director: Robert R. Cadmus, M.D.

WYOMING

Single PSRO Area

CONDITIONAL

Wyoming Health Services Company, Inc.
2727 O'Neil Avenue
P.O. Box 4009
Cheyenne, Wyoming 82001
Phone: (307) 635-2424
Executive Director: Robert G. Smith
APPENDIX J

STATISTICAL REPORTS ILLUSTRATING

COST SAVINGS RESULT OF

MCF REVIEW ACTIVITY
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<thead>
<tr>
<th>Month</th>
<th>Cases</th>
<th>Fee</th>
<th>Utilization</th>
<th>Reduced</th>
<th>Approved</th>
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<td>179</td>
<td>24</td>
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*Approximate

Source: Anonymous Medical Care Foundation and Operational PSRO
# Foundation for Health Care Evaluation

## Yearly Report-1974

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<th>Month</th>
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<th>Reduction</th>
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<td>Average T.O. 33</td>
<td>$71,757.94</td>
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Source: Anonymous Medical Care Foundation and Operational PSRO