

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 Z", 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 Academy of Family Physicians, which makes no reference to educational matters in regard to peer review (Statement on Peer Review, adopted 1972, reaffirmed 1973, and on PSROs, adopted 1971, reaffirmed 1972).

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 out-patient 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 state-wide 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.

O. 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.

- (5) 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;

- (2) 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;
- (3) The operating costs of PSRO in relation to the type of organization performing the review;
- (4) The impact of Private Initiative's quality assurance program on the content, utilization and cost of medical care;
- (5) 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;
- (6) Pine Tree Organization for PSR, Inc., Augusta, Maine.

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

- . LOGICAL DISTRIBUTION AND FUNDING OF CAPITAL INTENSIVE HEALTH PROGRAMS, i.e. BUILDINGS, EQUIPMENT, MAJOR NEW PROGRAMS (NATIONAL HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT OF 1974)

- . LOGICAL PRODUCTION AND ASSIGNMENT OF HEALTH MANPOWER (BILL PENDING IN BOTH HOUSES)

- . ASSURANCE OF THE MEDICAL NECESSITY, OPTIMUM QUALITY, AND APPROPRIATENESS OF SETTING IN WHICH HEALTH CARE IS DELIVERED (PSRO - PEER REVIEW PROGRAMS)

- . MAXIMUM ALLOWABLE COSTS TO BE REIMBURSED FOR SPECIFIC PRODUCTS AND SERVICES (ALREADY HAVE STARTED THROUGH MAC - DRUGS AND PHARMACEUTICAL REGULATIONS)

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

drug area.

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 cook book 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 venders 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 be 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 it 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 syatem 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:

1. Data Processing
2. Systems Consulting
3. Educational Consulting
4. Data Analytical services
5. Training Services
6. Newsletters and Ways of Disseminating Information about PSRO

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 under populated with physicians, and the urban areas being over populated 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 27.

BASELINE DATA OPTIONS

	ACCESSIBILITY	ACCURACY	ADEQUACY	TIMELINESS	COST	COMMENTS
1) Sample patient records from national sample of hospitals	Likely to pose significant problems	Good	Good for utilization; Good (with reservations) for quality of care; Good for cost	Good	Very high	Substantial accessibility problem
2) Individual PSROs sample records from national sample of hospitals	Likely to pose some problems	Good	Good for utilization; Good (with reservations) for quality care; Good for cost	Good	Very high	Accuracy may be variable across PSRO areas
3) Use abstract service data (PAS and other abstract services)	Likely to pose some problems	Questionable	Good for utilization; Fair for quality; No cost data	Very good	Moderate	If used would want to investigate data quality
4) Use MADOC data	Good	Questionable	Fair for utilization; (no Medicaid data); Poor for quality of care Good for cost	Fair, available for both new and existing PSROs but with delay of 1 to 2 years	Very low	Unacceptable, unless substantially modified
5) Use UHDA data	Good	Questionable but somewhat better than PAS	Good for utilization; Poor for quality of care Good for cost	Fair, may not be implemented nationally until 1976	Low	Risk of data not being available for early PSROs. May be considered for use with PAS or MADOC as a backup
6) Collect retrospective data on quality of care as part of National Medical Care Evaluation Studies	Good	Good	Good for quality of care	Good	Unknown	For use to provide data on quality of care - must be used with some other option
7) Individual PSROs sample patient records prior to quality assurance effort*	Good	Good	Good for quality care	Good	Unknown	For use to provide data on quality of care - must be used with some other option

*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

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

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 implemen-

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 detailmen, 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 governments 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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APPENDIX A

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. Conversely, 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

B I B L I O G R A P H Y

APPENDIX B

BIBLIOGRAPHY

1. General Information

Arthur D. Little, Inc., PSRO: An Evaluation of Functional Specifications and the Availability of Necessary Criteria and Methodologies, for Community Health Services, Dept. of HEW, November 1972.

Arthur D. Little, Inc., A Workshop for PSRO Policy Education, for Bureau of Quality Assurance, Dept. of HEW, January 1974.

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.

Brown, C.R., Jr., M.D. and Daniel S. Fleisher, M.D., "Bi-Cycle Concept Relating Continuing Education Directly to Patient Care," New England Journal of Medicine, 284: Supplement, May 20, 1971.

Commission on Professional and Hospital Activities: Lenth of Stay in PAS Hospitals, U.S. Regional, 1969, Ann Arbor, Michigan, 1970.

"Continuing Education Courses for Physicians," Supplement to JAMA, Vol. 229, No. 7, August 12, 1974.

Donabedian, A., M.D., "Evaluating the Quality of Medical Care," Milbank Mem. Fd. Quarterly, Vol. 44 (July, 1966), pp. 166-206 (Part 2).

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

Felch, W.C. M.D., "Data Processing and Peer Review," NY Medicine, Vol. 27 (1971), pp. 295-297.

Goldberg, George et al. Inventory of Current Peer Review Activities. Rockville, Maryland: Community Health Service, 1972.

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., "Influences on Continuing Medical Education," Rocky Mountain Medical Journal, Vol. 70 No. 7: 28-30, July 1973.

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

Lusted, L.B. and Coffin, R.W. PRIME: An Operational Model for a Hospital Automated Information System. Proc. IEEE 57: 1961-1973.

Payne, B.C. M.D., "Continued Evolution of a System of Medical Care Appraisal," JAMA, Vol. 201 (1967), p. 536-540.

Payne, B.C. M.D., (ed.), Hospital Utilization Review Manual (Ann Arbor: The University of Michigan, 1972).

"Report of the Fourth Biennial Conference on Continuing Medical Education for State Medical Associations and Specialty Societies," Department of Continuing Medical Education, American Medical Association, October 1974.

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.

Slee, V.N. M.D., "Professional Activity Study," Medical Care, Vol. VIII, No. 4, Supplement; July - August 1970.

Slee, V.N. M.D., "PSRO and the Hospital's Quality Control," Annals of Internal Medicine, Vol. 81, No. 1, July 1974.

U.S. Dept. of Health, Education and Welfare, Office of Professional Standards Review, "PSRO Program Manual," March 1974.

U.S. Dept. of Health, Education and Welfare, Bureau of Quality Assurance, "PSRO: An Educational Force on Improving Quality of Care".

U.S. Dept. of Health, Education and Welfare, Regional Medical Programs Service, "Quality Assurance of Medical Care-Monograph," February 1973.

Waldman, Martin L. M.D., "The Medical Audit Study--A Tool for Quality Control," Hospital Progress, February 1973.

Williamson, J.W. and Berdit, M., "The Next Step: Quality Assurance Programs Integrating Health Services Research with Continuing Medical Education," in Sterns, N., Getchell, M., and Gold, R., Continuing Medical Education in Community Hospitals, Boston, Postgraduate Medical Institute, The Massachusetts Medical Society, 1971.

2. Information About PSRO

(a) Development of a PSRO

Decker, Barry M.D. and Paul Bonner, (eds.), PSRO: Organization for Regional Peer Review, Ballinger Publishing Company, Cambridge, Massachusetts, 1973.

Henry, James L. M.D., "The Ohio Program for Peer Review - MAI-PSRO," Ohio State Medical Journal, March 1973.

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.

Tribble, William Ph.D. and Ho, Yan Chin Ph.D., A PSRO Health Care Review System, Tennessee Foundation for Medical Care, Nashville, Tennessee, 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

PSRO Program Manual, U.S. Department of Health, Education and Welfare, Official of Professional Standards Review, 5600 Fishers Lane, Room 16A-17, Rockville, Maryland 20852.

P.L. 92-603, Section 249F (PSRO Law), Implementation of PSRO Legislation, "Hearings before the Subcommittee on Health of the Committee on Finance, U.S. Senate, 93rd Congress, Second Session, May 8 and 9, 1974.

3. Information About Utilization Review

Anderson, O.W. "What Utilization Review Will and Won't Do," Modern Hospital, 116:97-100, Jan. 1, 1971.

Buttaro, P.J. "Utilization Review Committee--Some Legal Implications," Hospital Progress 50:79-81, June, 1969.

Cashman, J.W., Maki, N.C., Logsdon, R. "Utilization Review: Whose Responsibility? What are Its Potentials?" Hospital Progress 50:79-81, June, 1969.

Fuller, H.F. "Simplified Approaches to Utilization Review: Background and Introduction," North Carolina Medical Journal 30:349-357, September, 1969.

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.

Henry, J.L. "Role of the County Medical Society in Hospital Utilization Review," Ohio State Medical Journal, 66:170-172, Feb. 1970.

Kolb, J., Sidel, V.W. "Influence of Utilization Review on Hospital Length of Stay." Journal of the American Medical Association, 203:95-97, Jan. 8, 1968.

Lewis, P.M. The Hospital Utilization Project of Pennsylvania. Public Health Reports 83:743-750, Sept. 1968.

McStein, M. "Problems of Utilization Review," Rocky Mountain Medical Journal 65:45-49, June, 1968.

Maki, N.C., Walden, D., Cohen, L. "Issues and Outlook," Public Health Reports 83:708-713, Sept. 1968.

Marshall, M. "Utilization Review Committees: Their Role and Function," Journal of the Mississippi State Medical Association, 8:1-4, Jan. 1967.

Proceedings of 1965 Conference on Utilization Review, AMA, 1966.

Sarley, V.C. "Utilization Review: a Commentary," Chicago Medicine, 72:217-219, March 15, 1969.

Shindell, S. "The Use of Automated Techniques in Aiding Utilization Committees," Wisconsin Medical Journal, 69:98-104, March 1970.

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.

Taaffe, G., Josephson, C. "The Role of the Non-Physician in Utilization Review," Michigan Medicine, 67:1511-1512, December, 1968.

Utilization Review: A Handbook for the Medical Staff, Chicago, AMA, 1965.

Wahl, R.A. "The Role of the Physician in Utilization Review," Michigan Medicine, 58:370, April, 1969.

Wallace, J.D. "Developing an Effective Utilization Review Program," Hospitals, 41:70-73, November 16, 1967.

Wolfe, H. "A Computerized Screening Device for Selecting Cases for Utilization Review," Medical Care, 5:44-51, 1967.

4. Information About Medical Audit

Beaumont, G., Feigal, D., Magraw, R.M. "Medical Auditing in a Comprehensive Clinic Program," Journal of Medical Education, 42:359-367, April 1967.

Bianco, E.A. "The Medical Audit: Powerful Tool for Upgrading Care," Hospital Progress, 51:72-74, July, 1970.

Brooke, R. "An Audit of the Quality of Care in Social Medicine," Milbank Memorial Fund Quarterly, Part 1, 46:351-376, July, 1968.

Donabedian, A. "Promoting Quality Through Evaluating the Process of Patient Care," Medical Care, 6:181-202, May, June, 1968.

Eisele, C.W. "The Medical Audit in Continuing Education," Journal of Medical Education, 44:263-265, April, 1969.

Jonas, S. "Why Audit Quality of Medical Care?" Journal of the National Medical Association, 60:228-233, May, 1968.

Lembcke, P.A. "Evolution of the Medical Audit," Journal of the American Medical Association, 199:543-550, February 20, 1967.

Morehead, M.A. "The Medical Audit as an Operational Tool," American Journal of Public Health, 57:1643-1656, September, 1967.

Riesser, L.T. "Evaluating the Medical Audit in a Community Hospital," Hospital Topics, 48:27-31, September, 1970.

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., Falk, I.S., Laviertes, P.H. "The Development of Standards for the Audit and Planning of Medical Care," Medical Care, 6:101-114, 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.

HMO and Health Services Report, published monthly by Girard Associates, Inc., Mt. Arlington, New Jersey 07856. \$40.00 per year.

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

Legislative Roundup, published weekly by the Council on Legislation, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. Free.

Medical News Report, published weekly by Blasingame Associates, Suite 200, 535 North Michigan Avenue, Chicago, Illinois 60611. \$50.00 per year.

OPSR Memo, published irregularly by the Office of Professional Standards Review, Department of Health, Education, and Welfare, Room 16A17, 5600 Fishers Lane, Rockville, Maryland 20852. Free.

PSRO Letter, published semi-monthly by McGraw-Hill, Inc., 437 National Press Building, Washington, D.C. 20004. \$150.00 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.

Ambulatory Medical Care Records: Uniform Minimum Basic Data Set, (A Report of the United States National Committee on Vital and Health Statistics); U.S. Department of Health, Education, and Welfare, Public Health Service, Health Resources Administration; National Center for Health Statistics, Rockville, Maryland; August, 1974. (DHEW Publication Number (HRA) 75-1453).

Patient Classification for Long-Term Care: User's Manual, (Based on Work of Four Research Groups); Department of Health, Education and Welfare; Health Resources Administration, Bureau of Health Services Research and Evaluation; December, 1973. (DHEW Publication Number HRA 74-3107).

APPENDIX C

DRAFT POLICY STATEMENT OF DHEW ON THE
USE OF NORMS, CRITERIA
AND STANDARDS OF MEDICAL CARE

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

FEDERAL REVIEW
 NON-FEDERAL REVIEW

QUARTERLY PSRO FUNCTION COST SUMMARY

PCRD Superior

REPORTING PERIOD

DATES FROM: 0,4,0,1,7,5 TO 0,6,3,0,7,5

FUNCTION COST CENTER

COST COMPONENTS	FUNCTION COST CENTER									
	CONCURRENT REVIEW (1)	MEDICAL CARE EVALUATION STUDIES (2)	CRITERIA AND STANDARDS (3)	PROFILE (4)	ADMINISTRATION OR INDIRECT (5)	LONG TERM CARE REVIEW (6)	AMCULATORY CARE REVIEW (7)	QUARTERLY TOTAL FOR QTR. (8)	CUMULATIVE TOTAL (9)	ANNUAL BUDGET (10)
A. DIRECT PERSONNEL COSTS										
1. PHYSICIANS	150	1,100	500	200	200			2,150	5,250	17,000
2. REVIEW COORDINATORS	22,000				250			22,250	42,500	72,000
3. TECHNICAL SUPPORT	125	2,135	870	1,165	250	430	275	5,250	12,750	38,000
4. ADMINISTRATIVE	1,120	525	4,225	635	18,150	950	695	26,300	47,900	83,000
5. ADMINISTRATIVE SUPPORT					4,136			4,136	7,290	16,000
6. EMPLOYEE BENEFITS (10%)	2,340	386	560	200	2,299	138	87	6,010	11,569	22,600
7. SUBTOTAL PERSONNEL	25,735	4,246	6,155	2,200	25,285	1,518	957	66,096	127,529	248,500
B. SUPPORT COSTS										
B. OFFICE SPACE										
8a. RENT					1,250			1,250	2,500	5,000
8b. REPAIRS & MAINTENANCE					102			102	154	1,000
8c. UTILITIES					189			189	309	700
8d. INSURANCE									290	300
9. OFFICE FURNITURE & EQUIPMENT					522			522	6,211	7,500
10. OFFICE SUPPLIES					239			239	827	1,000
11. REPRODUCTION & PRINTING					295			295	522	1,200
12. POSTAGE					430			430	967	1,400
13. SUBSCRIPTIONS					21			21	40	200
14. EDUCATIONAL MATERIAL					629			629	629	1,000
15. TELEPHONE										
15a. LOCAL					140			140	280	600
15b. LONG-DISTANCE			75	39	121			235	428	1,200

FUND Superior

REPORTING PERIOD

DATE FROM 0,410,117,5 TO 0,613,017,5

QUARTERLY PSRO FUNCTION COST SUMMARY (continued)

COST COMPONENTS	FUNCTION COST CENTER							QUARTERLY TOTAL FOR QTR. (8)	CUMULATIVE TOTAL (9)	ANNUAL BUDGET (10)
	CONCURRENT REVIEW (1)	MEDICAL CARE EVALUATION STUDIES (2)	CRITERIA AND STANDARDS (3)	PROFILE (4)	ADMINISTRATION OR INDIRECT (5)	LONG TERM CARE REVIEW (6)	AMBULATORY CARE REVIEW (7)			
16. LOCAL TRAVEL										
16a. TRANSPORTATION	175				134			310	590	1,200
16b. PER DIEM	25							25	75	600
17. LONG DISTANCE TRAVEL										
17a. TRANSPORTATION					325			325	325	500
17b. PER DIEM					50			50	50	100
18. SUBCONTRACTS										
18a. Electronic Data Processing	1,750	1,050		1,200	200			4,200	8,250	15,000
18b.										
18c.										
19. CONSULTANTS										
19a. PHYSICIAN ADVISORS	12,000							12,000	24,000	48,600
19b. PHYSICIANS		2,150	3,200	600		250	200	6,400	7,400	16,000
19c. REVIEW COORDINATORS	1,400				250			1,650	3,000	5,000
19d. LEGAL					150			150	250	500
19e. DATA		275	200					475	1,010	2,500
19f. ACCOUNTING									400	1,000
19g. OTHER										
20. ALL OTHER COSTS										
21. SUBTOTAL SUPPORT	15,351	3,475	3,475	1,839	5,077	250	200	29,667	58,527	112,100
22. TOTAL (LINE 7 + LINE 21)	41,036	7,721	9,630	4,039	30,362	1,768	1,157	95,763	185,786	360,700

Bureau of Quality Assurance
Health Services Administration

Office of Management and Budget
Approval Number

QUARTERLY DELEGATED HOSPITALS

FUNCTION COST SUMMARY

PSRO

REPORTING PERIOD

DATES FROM

TO

COST COMPONENT	FUNCTION COST CENTER							TOTAL (8)
	CONCURRENT REVIEW (1)	MEDICAL CARE EVALUATION STUDIES (2)	CRITERIA AND STANDARDS (3)	PROFILES (4)	ADMINISTRATION (5)	LONG TERM CASE REVIEW (6)	AMBULATORY CARE REVIEW (7)	
A PERSONNEL								
(1) PHYSICIANS								
(2) REVIEW COORDINATORS								
(3) OTHER								
B SUPPORT								
(1) PHYSICIAN ADVISORS								
(2) OTHER PERSONNEL								
(3) OTHER								
C TOTAL								

Office of Management and Budget
Approval Number

Bureau of Quality Assurance
Health Services Administration

RE-STUDY REPORT

PSRO _____

DATE RE-STUDY BEGAN 6/1/75 PAGE _____ OF _____

DATE RE-STUDY COMPLETED 6/20/75

CONDUCTED BY: PSRO
 DELEGATED HOSPITAL

1. IDENTIFICATION OF ORIGINAL STUDY

a. TOPIC OF MCE STUDY: Management of Pts. with Acute Myocardial Infarction in CCU

b. DATE MCE 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) ELEMENT(S) USED Days in CCU
(4) ELEMENT(S) TO BE INCORPORATED IN ROUTINE DATA SET None

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. MCE STUDY
 g. CHANGE IN CONCURRENT REVIEW
 h. OTHER REVIEW MODIFICATION
 i. NO ACTION NECESSARY
 j. OTHER (Specify) _____

5. PERSONPOWER 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.

RESERVED FOR PROCESSING CONTROL

PSRO _____

DATES FROM 1 0 0 1 7 4 TO 1 2 3 1 7 4 PAGE 1 OF 1

MCE STUDY STATUS REPORT

MCE STUDY TOPIC (1)	PSRO (2)	DELEGATED HOSPITAL (3)	DATE STARTED (4)	ESTIMATED COMPLETION DATE (5)	ACTUAL COMPLETION DATE (6)	SUCCESS RATING		
						POOR (7)	AVERAGE (8)	EXCELLENT (9)
Pneumococcal Pneumonia	✓		8/10/74	9/30/74	11/01/74		✓	
Transfused Patients		✓	9/01/74	10/01/74	10/01/74			✓
T & A in Pediatric Pts.	✓		10/01/74	11/30/74	12/15/74			✓
AMI Pts. in CCU		✓	10/15/74	11/20/74	11/15/74	✓		
AMI Pts. in CCU		✓	10/15/74	11/30/74	12/10/74			✓
Hip Fractures		✓	12/01/74	1/01/75				
CVA Outcomes	✓	✓	12/01/74	3/01/75				

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PSRO MEDICAL CARE EVALUATION STUDY ABSTRACT

PSRO _____

MCE STUDY BEGUN: 2/14/75 PAGE _____ OF _____

MCE STUDY COMPLETED: 3/1/75

CONDUCTED BY: DELEGATED HOSPITAL
 PSRO

1. STUDY TOPIC
(Write In)

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
 - (1) MEDICAL AUDIT COMMITTEE
 - (2) UR COMMITTEE
 - (3) OTHER (Specify) _____

4. DERIVATION OF CRITERIA (Check one)

- a. SELF GENERATED
- b. NATIONAL ORGANIZATION
- c. OTHER PSRO(S)
- d. OTHER HOSPITAL(S)
- e. OTHER (Specify) _____

5. SETTING OF CRITERIA AND STANDARDS (Check One)

- a. PSRO (COMMITTEE)
- b. HOSPITAL
 - (1) MEDICAL AUDIT COMMITTEE
 - (2) UR COMMITTEE
 - (3) 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. RETROSPECTIVE
- b. PROSPECTIVE
- c. MIXED

8. SAMPLE SIZE

- a. # OF SUBJECTS 118
- b. OTHER MI Pts. Discharged
in 4th quarter of 1974.

9. DATA SOURCE AND COLLECTION (Check One)

- a. SPECIAL ABSTRACT
- b. ROUTINE ABSTRACT
- c. OTHER (Specify) _____

10. DATA QUALITY CONTROLS (Check One)

- a. VERIFIED
- b. VERIFIED - SOURCE INADEQUATE
- c. VERIFIED - DATA INACCURATE
- d. NONE
- e. OTHER (Specify) _____

11. DATA PROCESSING (Check One)

- a. MANUAL
 - b. EDP
- COST: \$ _____

12. FINDINGS (Check One)

- a. COMPLIANCE WITH STANDARDS
- b. VARIATION FROM STANDARDS
 - (1) VARIATION JUSTIFIED
 - (2) DEFICIENCY

13. DEFICIENCY ANALYSIS (Check One)

- a. KNOWLEDGE
- b. PERFORMANCE
- c. OTHER _____

14. ATTRIBUTION (Check all that apply)

- a. MORE THAN ONE DEFICIENCY
- b. INDIVIDUAL PHYSICIAN(S)
- c. GROUP(S) OF PHYSICIANS
- d. HOSPITALS
- e. FURTHER STUDY NEEDED
- f. OTHER _____

15. TYPE OF ACTION RECOMMENDED (Check all that apply)

- a. MORE THAN ONE DEFICIENCY
- b. PHYSICIAN COUNSELING
- c. EDUCATIONAL PROGRAM
 - (1) SINGLE HOSPITAL
 - (2) PSRO SUB-AREA
 - (3) PSRO-WIDE
- d. ADMINISTRATIVE CHANGE
- e. CHANGE IN CONCURRENT REVIEW
- f. OTHER REVIEW MODIFICATION
- g. OTHER (Specify) _____

16. IF EDUCATION IS RECOMMENDED, IS THERE LINKAGE WITH EXISTING CONTINUING MEDICAL EDUCATION PROGRAMS?

YES NO
IF YES, PLEASE DESCRIBE: Regular Monthly
Program for Medicine Dept.

17. ACTION RECOMMENDED TO: Medical Staff

- a. MEDICAL STAFF (COMMITTEE)
- b. HOSPITAL BOARD OF TRUSTEES
- c. HOSPITAL ADMINISTRATION
- d. OTHER (Specify) Nursing Staff

18. PERSONNEL UTILIZED (Enter in whole hours the time spent for this study)

MCE STUDY TASK	PHYSICIAN	OTHER
a. SELECTION AND DESIGN	1	1
b. SETTING CRITERIA AND STANDARDS	3	
c. DATA COLLECTION AND DISPLAY		4
d. INTERPRETATION AND ANALYSIS OF FINDINGS	3	
e. TOTAL	7	5

ADDITIONAL EXPLANATORY REMARKS (USE ADDITIONAL PAPER IF NECESSARY)

RESERVED FOR PROCESSING CONTROL

DELEGATION STATUS

- PRO REVIEW
NON DELEGATED
- HOSPITAL REVIEW
DELEGATED
- PARTIALLY
DELEGATED

Bureau of Quality Assurance
Health Services Administration

CONCURRENT REVIEW ACTIVITY SUMMARY
QUARTERLY REPORT

Office of Management and Budget
Approval Number:

PSRO DPADP

DATES FROM: TO: PAGE OF

DATE SUBMITTED:

PAYMENT SOURCE (1)	ADMISSION CERTIFICATION				CONTINUED STAY REVIEW			CERTIFIED DAYS OF STAY		TOTAL DAYS OF STAY (11)
	CASES REVIEWED CONCUR. (2)	PRE-ADM. (3)	REFERRED TO PHYSICIAN ADVISOR (4)	DAYS CERTIFIED INITIALLY (5)	CASES REVIEWED (6)	EXTENSIONS REVIEWED (7)	EXTENSIONS REF'D TO PHYS ADVISOR (8)	MEDICALLY NECESSARY (9)	OTHER (10)	
FEDERAL PATIENTS										
TITLE V	223	20	33	900	45	55	12	1108	89	11253
TITLE XVIII	3320	345	498	13861	435	468	92	14981	575	16801
TITLE XIX	2297	225	344	8965	365	381	82	9605	450	11443
TOTAL FEDERAL	5840	770	875	23726	845	904	186	25684	1114	29497
OTHER PATIENTS										
OTHER FED	0	0	0	0	0	0	0	0	0	0
Blue Cross	241	24	36	843	36	41	12	932	65	1156
UMW	93	10	14	375	8	11	4	405	15	505
TOTAL OTHER	334	34	50	1218	44	55	16	1337	80	1651
TOTAL	6174	804	925	24944	889	959	202	27031	1194	31148

(12) NUMBER OF
CASES DENIED
ADMISSION
BY PRE-ADM.
REVIEW

105

(13) NUMBER OF CASES
DENIED CONCURRENT
ADMISSION CERTIFICATION

125

(14) NUMBER OF
CASES DENIED
EXTENSION

105

(15) NUMBER OF
CASES RECONSIDERED
AFTER DENIAL

245

(16) NUMBER OF
CASES DENIED
AFTER RECONSIDERATION

125

BQA 123 2/75

FIGURE 1

SUMMARY OF GENERAL INSTRUCTIONS FOR REPORT PREPARATION AND SUBMISSION

Title of Section of Manual	Report Title	Form Number	Reporting Period	When Due	Where Reports are to be Sent
1. Concurrent Review Reporting	Concurrent Review Activity Summary	BQA 121	January 1 to March 31 February 1 to June 30 July 1 to Sept. 30 Oct. 1 to Dec. 31	May 1 Aug. 1 Nov. 1 Feb. 1	Bureau of Quality Assurance
2. PSRO Uniform Hospital Discharge Data Set (PUHDDS)	PHUDDS	BQA 131	Quarterly as above	Ninety (90) days following end of quarter	Bureau of Quality Assurance
3. Medical Care Evaluation Study Reporting	Medical Care Evaluation Study Abstract	BQA 141	Quarterly as above (for all MCE's completed during the quarter)	30 days following end of quarter	Bureau of Quality Assurance
	Restudy Report	BQA 143	Quarterly as above for all Restudies completed during the quarter	30 days following end of quarter	
	Medical Care Evaluation Study Status Report	BQA 145	Quarterly as above	30 days following end of quarter	

APPENDIX E

PSRO AREA DESIGNATIONS - STATE BY STATE LISTING

AND

STATISTICAL SUMMARIES

(From PSRO Program Manual)

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- 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 designations 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

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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 | Yavapai |
| | | Coconino | Maricopa |
| | | Navajo | Gila |
| | | Apache | |
| AREA II | : | Yuma | Pima |
| | | Pinal | Santa Cruz |
| | | Graham | Cochise |
| | | Greenlee | |
- 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 | Lake | Humboldt |
| | | Mendocino | Sonoma | |
| AREA II | : | Siskiyou | Tehama | Colusa |
| | | Modoc | Plumas | Sutter |
| | | Trinity | Glenn | Yuba |
| | | Shasta | Butte | Sierra |
| | | Lassen | | |

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AREA III	: Napa	Solano	Marin
AREA IV	: Nevada Placer	Yolo Sacramento	El Dorado
AREA V	: San Francisco		
AREA VI	: San Mateo		
AREA VII	: Contra Costa	Alameda	
AREA VIII	: San Joaquin Amador	Alpine Calaveras	Tuolumne
AREA IX	: Santa Clara		
AREA X	: Stanislaus	Merced	Mariposa
AREA XI	: Fresno	Madera	
AREA XII	: Santa Cruz	San Benito	Monterey
AREA XIII	: Kings	Tulare	
AREA XIV	: Kern		
AREA XV	: Mono	San Bernardino	Inyo
AREA XVI	: San Luis Obispo	Santa Barbara	
AREA XVII	: Ventura		
AREA XVIII	: Altadena Alhambra San Marino Tujunga Glendale San Gabriel Temple City Sunland	Verdugo City Pasadena Garvey Eagle Rock Rosemead La Crescenta Montrose	La Vina El Monte South Pasadena Monterey Park La Canada South San Gabriel Wilmar
AREA XIX	: Avalon Wilmington Palos Verdes Estates Long Beach	Terminal Island Hawaiian Gardens Lakewood San Pedro	Dominguez Harbor City Palos Verdes Peninsula Los Alamitos

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AREA XX	: Agoura Palmdale Chatsworth Burbank Hidden Hills Olive View Raseda San Fernando Tarzana Sun Valley Lancaster	Little rock Canoga Park Quartz Hill Granada Hills North Hollywood Northridge Panorama City Sherman Oaks Studio City Woodland Hills Toluca Lake	Calabasas Pearblossom Encino Mission Hills Newhall Pacoima Saugus Sepulveda Van Nuys Sylmar
AREA XXI	: Commerce Glendora East Los Angeles Rowland Heights Norwalk Valinda Whittier La Verne Baldwin Park Walnut	Durate La Mirada Monrovia Montebello Temple City Santa Fe Springs Claremont Azusa San Dimas	Hacienda Heights La Puente Los Nietos Sierra Madre Pico Rivera West Covina Arcadia Pomona Covina
AREA XXII	: Culver City Sawtelle Mar Vista Pacific Palsades Los Angeles Postal Zones: 90034 90066	Santa Monica Marina del Rey Westwood Palms 90049 90073	Malibu Venice Ocean Park Playa del Rey 90064
AREA XXIII	: Gardena Torrance Manhattan Beach Bellflower Compton El Segundo Huntington Park Lawndale Paramount Los Angeles Postal Zones: 90009	Rolling Hills Lomita Bell Redondo Beach Willowbrook Home Gardens Inglewood Maywood South Gate 90045	Hermosa Beach Artesia Palos Verdes Bell Gardens Downey Hawthorne Lynwood Lennox
AREA XXIV	: Los Angeles Postal Zones: 90006 90008 90012 90043	90013 90056 90023 90062	90033 90007 90053 90018

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- | | | | |
|------------------------|--|-----------|------------|
| AREA XXIV : | 90058 | 90005 | 90014 |
| (Continued) | 90035 | 90042 | 90059 |
| | 90002 | 90016 | 90031 |
| | 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 | 90068 | 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: | | |

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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 Sotro	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.		

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- ILLINOIS : Eight Professional Standards Review Organization areas are designated in Illinois, composed of the following counties:
- | | | | |
|-----------|--|---|--|
| AREA I | : Jo Davless
De Kalb
Boone | Ogle
Winnebago
Carroll | Stephenson
Whiteside
Lee |
| AREA II | : McHenry
DuPage | Kane | Lake |
| AREA III | : Cook | | |
| AREA IV | : Kendall
Kankakee | 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 |

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- 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 |
| | | Miami | Newton | Wabash |
| | | Jasper | Carroll | Starke |
| | | Warren | Marshall | Tippecanoe |
| | | Kosciusko | Clinton | Pulaski |
| | | Howard | Fulton | Tipton |
| | | Benton | Fountain | White |
| | | Montgomery | | |
| 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.

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- 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 | Quachita | Grant |
| | | Bossier | Richland | La Salle |
| | | Webster | Madison | Catahoula |
| | | Claiborne | De Soto | Concordia |
| | | Lincoln | Red River | Vernon |
| | | Union | Natchitoches | Rapides |
| | | Morehouse | Winn | Avoyelles |
| | | West Carroll | Caldwell | Sabine |
| | | East Carroll | Franklin | Tensas |
| | | Bienville | Jackson | |
| AREA II | : | Beauregard | Allen | Evangeline |
| | | St. Landry | Calcasieu | Jefferson Davis |
| | | Acadia | Lafayette | St. Martin |
| | | Cameron | Vermilion | Iberia |
| | | St. Mary | | |
| AREA III | : | Point Coupe | West Feliciana | East Feliciana |
| | | St. Helena | Tangipahoa | Washington |
| | | Iberville | West Baton Rouge | East Baton Rouge |
| | | Livingston | Ascension | |
| AREA IV | : | Assumption | St. James | St. John the Baptist |
| | | St. Tammany | St. Charles | Jefferson |
| | | Orleans | St. Bernard | Terrebonne |
| | | Lafourche | Plaquemines | |
- 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 | Allegany | Washington |
| | | Frederick | | |
| AREA II | : | Baltimore City | | |
| AREA III | : | Montgomery | | |
| AREA IV | : | Prince Georges | | |

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AREA V :	Baltimore Howard	Carroll	Harford
AREA VI :	Anne Arundel St. Marys	Calvert	Charles
AREA VII :	Cecil Caroline Wicomico	Kent Talbot Somerset	Queen Annes Dorchester Worcester

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

AREA I :	Williamstown Monroe Rowe Westhampton Leyden Amherst Warwick Lee Charlemont Petersham Tryingham Greenfield Blandford Hancock Westfield Windsor Holyoke Conway Chicopee Windell Ware Dalton Mount Washington Worthington Sandisfield Chesterfield Williamsburg West Springfield Sunderland Pittsfield Wilbraham Shutesburg Brimfield	Adams North Adams Huntington Colrain Hadley Northfield Stockbridge Savoy Alford Great Barrington Shelburne Otis Erving Montgomery Cheshire Easthampton Ashfield Granby Montague Belchertown Lanesborough Egremont Peru New Marlborough Goshen Granville Whately Hatfield Pelham East Longmeadow Leverett Monson Washington	Clarksburg Florida Heath Northampton Bernardston West Stockbridge Orange Becket Hawley Buckland Monterey Gill Russell New Asford Southampton Plainfield South Hadley Deerfield Ludlow New Salem Palmer Warren Hinsdale Sheffield Cummington Tolland Southwick Agawam Longmeadow Richmond Hampden Lenox Wales
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	Middlefield Royalston	Holland Athol	Chester Phillipston
AREA II :	Winchedon Oakham Townsend Westminster Hubbardston Lancaster Ayer Holden Clinton Northborough Shrewsbury North Brookfield Brookfield Millbury Sturbridge Oxford Douglas Uxbridge Blackistone Medway Gorton Littleton	Ashby Ashburnham Templeton Fitchburg Princeton Shirley Barre Sterling Bolton Hardwick Westborough Leicester Spencer Grafton Southbridge Dudley Sutton Mendon Boylston Pepperell Franklin	New Braintree Paxton Gardiner Lunenburg Leominster Harvard Rutland West Boylston Berlin Worcester West Brookfield Auburn East Brookfield Upton Charleton Webster Northbridge Millville Dunstable Bellingham Westford
AREA III :	Hudson Wayland Needham Sherborn Framingham Holliston	Sudbury Weston Wellesley Marlborough Ashland Milford	Newton Waltham Natick Southborough Hopkinton Hopedale
AREA IV :	Amesburg Haverhill Newbury Methuen Tyngsborough Tewksbury Lawrence Middleton Essex Wenham Danvers Marblehead Nahant North Reading Billerica	Salisbury West Newbury Groveland Rowley Chelmsford Andover Boxford Topsfield Gloucester Beverly Peabody Swampscott Saugus Reading Carlisle	Merrimac Newburyport Georgetown Dracut Lowell North Andover Ipswich Hamilton Rockport Manchester Salem Lynn Lynnfield Wilmington Bedford

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Burlington	Lexington	Woburn
Winchester	Wakefield	Melrose
Malden	Medford	Everett
Chelsea	Revere	Winthrop
Somerville	Cambridge	Arlington
Belmont	Watertown	Brookline
Lincoln	Concord	Acton
Roxborough	Stow	Maynard
Boston	Dedham	Milton
Quincy	Randolph	Braintree
Holbrook	Weymouth	Hingham
Cohasset	Hull	Westwood
Dover	Medfield	Millis
Wrentham	Norfolk	Foxborough
Plainville	North Attleborough	Norton
Taunton	Raynham	Mansfield
Attleboro	Berkley	Dighton
Rehoboth	Seekonk	Freetown
Norwell	Scituate	Stoneham

AREA V :	Norwood	Walpole	Canton
	Sharon	Stoughton	Avon
	Easton	Brockton	Abington
	Rockland	Hanover	Whitman
	Hanson	Pembroke	Marshfield
	Duxbury	Kingston	Halifax
	East Bridgewater	West Bridgewater	Bridgewater
	Lakeville	Middleborough	Plympton
	Carver	Wareham	Rochester
	Marion	Plymouth	Bourne
	Sandwich	Falmouth	Mashpee
	Barnstable	Yarmouth	Dennis
	Brewster	Chatham	Orleans
	Wellfleet	Truro	Provincetown
	Gosnold	Gay Head	Chilmark
	West Tisbury	Edgartown	Oak Bluffs
	Tisbury	Mattapoisett	Acushnet
	Fairhaven	New Bedford	Dartmouth
	Westport	Fall River	Somerset
	Swansea	Eastham	Nantucket
	Harwick		

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

AREA I :	Keweenaw	Gogebic	Ontonagon
	Houghton	Baraga	Marquette

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	Alger	Schoolcraft	Luce
	Chippewa	Iron	Dickinson
	Menominee	Delta	Mackinac
AREA II :	Emmet	Cheboygan	Presque Isle
	Charlevoix	Antrim	Otsego
	Montmorency	Alpena	Leelanau
	Benzie	Grand Traverse	Kalkaska
	Gladwin	Crawford	Oscoda
	Alcona	Wexford	Missaukee
	Roscommon	Ogemaw	Manistee
AREA III :	Mason	Lake	Osceola
	Oceana	Newaygo	Mecosta
	Muckegon	Montcalm	Ottawa
	Kent	Ionia	Barry
AREA IV :	Clare	Arenac	Isabella
	Midland	Bay	Iosco
	Saginaw	Huron	Tuscola
	Sanilac	St. Clair	
AREA V :	Shiawassee	Genesee	Lapeer
AREA VI :	Clinton	Eaton	Ingham
	Livingston	Gratiot	
AREA VII :	Washtenaw	Lenawee	Monroe
	Jackson	Hillsdale	
AREA VII :	Wayne		
AREA IX :	Oakland	Macomb	
AREA X :	Allegan	Van Buren	Kalamazoo
	Calhoun	Berrien	Cass
	St. Joseph	Branch	
MINNESOTA :	Three Professional Standards Review Organization areas are designated in Minnesota, composed of the following counties:		
AREA I :	Kittson	Roseau	Lake of the Woods
	Koochiching	St. Louis	Lake
	Cook	Marshall	Beltrami
	Itasca	Polk	Pennington
	Red Lake	Norman	Mahnomen

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Clearwater
Wadena
Calton
Mille Lacs
Pope
Cherbourne
Wright
Wilkin
Grant
Stevens

Hubbard
Crow Wing
Todd
Kanabeo
Stearns
Isanti
Clay
Otter Tail
Douglas

Cass
Aitkin
Morrison
Pine
Benton
Chisago
Becker
Traverse
Big Stone

AREA II : Anoka
Washington
Dakota

Hennepin
Carver

Ramsey
Scott

AREA III : Swift
Kandiyohi
Renville
Lyon
Sibley
Rice
Pipestone
Watowan
Steele
Winona
Jackson
Freeborn
Houston

Lac Qui Parle
Meeker
McLeod
Redwood
Nicollet
Goodhue
Murray
Blue Earth
Dodge
Rock
Martin
Mower

Chippewa
Yellow Medicine
Lincoln
Brown
LeSeur
Wabasha
Cottonwood
Waseca
Olmstead
Nobles
Faribault
Fillmore

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
Nodaway
Worth
Harrison
Mercer
Holt
Andrew
Gentry
De Kalb
Daviss

Grundy
Buchanan
Clinton
Caldwell
Livingstone
Platte
Clay
Ray
Carroll
Jackson

Lafayette
Saline
Cass
Johnson
Pettis
Bates
Henry
Benton
Vernon
St. Clair

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- | | | | |
|-----------------|--|---|---|
| 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 | Washington
Ripley
Iron
Stoddard
Reynolds
Dunklin |
| 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: | | |

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- | | | | |
|------------|--|--|------------------------------|
| AREA I | : Sussex
Except Chilton Hospital | Warren | Morris |
| AREA II | : Passaic | Chilton Hospital | |
| AREA III | : Bergen | | |
| AREA IV | : Essex | | |
| AREA V | : Hudson | | |
| AREA VI | : Union | | |
| AREA VII | : Hunterdon
Somerset | Mercer
Middlesex | Monmouth
Ocean |
| AREA VIII | : Burlington
Camden
Gloucester | Atlantic
Salem | Cumberland
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
Genesee
Cattaraugus | Orleans
Wyoming
Allegany | Erie
Chautauqua |
| AREA II | : Monroe
Ontario
Steuben | Wayne
Seneca | Livingston
Yates |
| AREA III | : St. Lawrence
Cayuga
Cortland
Chemung | Jefferson
Onondaga
Tioga
Schuyler | Oswego
Tompkins
Broome |
| AREA IV | : Oneida
Chenango | Herkimer
Lewis | Madison |
| AREA V | : Franklin
Essex
Saratoga | Clinto
Fulton
Washington | Hamilton
Warren |
| AREA VI | : Schenectady | Montgomery | Schoharie |

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AREA VII :	Otsego Delaware	Albany	Rensselaer
AREA VIII :	Greene Ulster	Columbia Dutchess	Sullivan Orange
AREA IX :	Putnam	Westchester	
AREA X :	Rockland		
AREA XI :	New York		
AREA XII :	Richmond		
AREA XIII :	Kings		
AREA XIV :	Queens		
AREA XV :	Nassau		
AREA XVI :	Suffolk		
AREA XVII :	Bronx		

NORTH CAROLINA : Eight Professional Standards Review Organization areas are designated in North Carolina, composed of the following counties:

AREA I :	Watauga Avery Caldwell Burke Mitchell Yancey Haywood	McDowell Rutherford Madison Buncombe Henderson Polk Clay	Transylvania Swain Jackson Macon Graham Cherokee
AREA II :	Ashe Alleghany Wilkes Alexander	Surry Yadkin Iredell Davie	Rowan Stokes Forsyth Davidson
AREA III :	Rockingham Caswell	Guilford Alamance	Randolph
AREA IV :	Person Orange	Durham	Chatham
AREA V :	Granville	Franklin	Harnett

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		Vance Warren	Wake Lee	Johnston
AREA VI:		Halifax Northampton Hertford Gates Chowan Perquimans Pasquotank Camden Currituck	Nash Edgecombe Bertie Martin Washington Tyrrell Dare Wilson Greene	Pitt Beaufort Hyde Lenoir Craven Pamlico Jones Carteret
AREA VII:		Catawba Lincoln Cleveland Gaston	Mecklenberg Cabarrus Stanly Union	Montgomery Anson Moore Richmond
AREA VIII:		Scotland Hoke Cumberland Robeson Columbus	Sampson Bladen Brunswick New Hanover	Wayne Duplin Onslow Pender

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

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AREA V :	Lake	Geauga	Ashtabula
AREA VI :	Summit Stark	Portage Mahoning	Trumbull Columbiana
AREA VII :	Coshocton Jefferson Monroe	Tuscarawas Harrison	Carroll Belmont
AREA VIII :	Licking Fairfield Noble	Muskingham Perry Athens	Guernsey Morgan Washington
AREA IX :	Hocking Pike Scioto	Vinton Jackson Lawrence	Meigs Gallia
AREA X :	Morrow Delaware Fayette	Knox Madison Pickaway	Union Franklin Ross
AREA XI :	Erie Medina Wayne	Lorain Richland Holmes	Huron Ashland
AREA XII :	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		
AREA II :	Clatsop Columbia Tillamook Washington Yamhill Clackamas Hood River Wasco Sherman Gilliam Morrow Umatilla	Union Wallowa Lincoln Polk Benton Marion Linn Jefferson Wheeler Grant Baker Lane	Deschutes Crook Coos Douglas Curry Josephine Jackson Klamath Lake Harney Malheur

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

AREA I	:	Erie Warren McKean	Potter Crawford Forest	Elk Cameron
AREA II	:	Tioga Bradford Clinton Lycoming Sullivan	Centre Union Northumberland Montour	Columbia Snyder Mufflin Juniata
AREA III	:	Susquehanna Wyoming	Lackawanna	Luzerne
AREA IV	:	Wayne Pike	Monroe Carbon	Northampton Lehigh
AREA V	:	Mercer Venango Clarion	Jefferson Clearfield Lawrence	Butler Armstrong Indiana
AREA VI	:	Allegheny		
AREA VII	:	Beaver Washington	Westmoreland Greene	Fayette
AREA VIII	:	Cambria Blair	Huntington Somerset	Bedford
AREA IX	:	Schuylkill Perry Dauphin Lebanon	Berks Cumberland Lancaster Fulton	Franklin Adams York
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.

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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	Tipton Henderson Fayette McNairy	Haywood Decatur Hardeman Hardin
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	Obion Dyer Benton Montgomery Trousdale Pickett Cheatham Smith Fentress Williamson Scot Hancock Johnson Union Hamblen Greene White Perry Marshall Warren Lawrence Moore Carter Knox Rhea Monroe Marion Polk	Weakley Gibson Crockett Robertson Macon Houston Davidson Jackson Humphreys Rutherford Campbell Hawkins Morgan Grainger Jefferson Washington Putnam Lewis Bedford Van Buren Giles Franklin Roane Blount Meigs Grundy Hamilton

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

AREA I	:	Dallam Sherman	Hansford Ochiltree	Lipscomb Hartley
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AREA I (Continued)	Moore Hutchinson Roberts Hemphill Oldham Potter Carson Gray Wheeler Deaf Smith Randall Armstrong Donley Collingsworth Parmer Castro Swisher Briscoe Hall Childress Hardeman Bailey	Lamb Hale Floyd Motley Cottle Foard Wilbarger Witchita Cochran Hockley Lubbock Crosby Dickens King Knox Baylor Archer Clay Montaque Yoakum Terry Lynn	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

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AREA V	:	Andrews Martin Howard El Paso Hudspeth Culberson Reeves Loving Winkler Ector Midland Glasscock	Coke Ward Crane Upton Reagan Sterling Irion Tom Green Concho McCulloch Jeff Davis Pecos	Crockett Schleicher Menard Mason Sutton Kimble Presido Brewster Terrell Gaines Dawson Borden
AREA VI	:	Mills Hamilton Bosque Hill Limestone Freestone Lampasas Coryell McLennan Falls	Robertson Leon Madison Llano Burnet Bell Williamson Milam Brazos San Saba	Grimes Blanco Travis Bastrop Lee Burlison Washington Hays Caldwell Fayette
AREA VII	:	Walker Montgomery	Harris Liberty	Chambers
AREA VIII	:	Austin Wharton Fort Bend	Brazoria Galveston Matagorda	Waller Colorado
AREA IX	:	Val Verde Edwards Real Kerr Bandera Gillespie Kendall Comal Kinney Medina Bexar Guadalupe Gonzales Lavaca Wilson	Maverick Zavala Frio Atascosa Karnes De Witt Victoria Jackson Dimmit La Salle McMullen Live Oak Bee Goliad Refugio Uvalde	Calhoun San Patricio Aransas Webb Duval Jim Wells Nueces Kleberg Zapata Jim Hogg Brooks Kenedy Starr Hidalgo Willacy Cameron

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- 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:

	<u>Counties</u>	<u>Independent Cities</u>
AREA I :	Frederick Clarke Warren Shenandoah Page Rappahannock Fauquier Rockingham Greene Madison Culpeper Stafford	King George Highland Augusta Albemarle Orange Louisa Spotsylvania Caroline Bath Rockbridge Nelson Fluvanna
AREA II :	Loudoun Prince William	Winchester Harrisonburg Fredericksburg Staunton Waynesboro Charlottesville Buena Vista
AREA III :	Alleghany Craig Botetourt Bedford Amherst Appomattox Campbell Roanoke Giles Montgomery Floyd Franklin Pittsylvania Pulaski Carroll	Fairfax Arlington Alexandria Fairfax Falls Church Clifton Forge Covington Lynchburg Roanoke Radford Norton Bristol Galax Martinsville Danville

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- | | | | | |
|----------------|---|---|---|---|
| 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
Marquette
Winnebago
Shawano
Marquette
Outagamie
Sheboygan
Dane
Columbia
Green
Iowa
Bayfield
Clark
Vilas
Pepin |

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AREA I : Sawyer Lincoln Fond Du Lac
 (Continued) Trempealeau Crawford Kewaunee
 Forest Waushara Sauk
 Portage Door Lafayette
 Barron Manitowoc Grant
 Juneau Waupaca

AREA II : Washington Walworth Ozaukee
 Racine Waukesha Kenosha
 Milwaukee

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

	<u>Proposed Areas</u>	<u>Final Areas</u>		<u>Proposed Areas</u>	<u>Final Areas</u>
ALABAMA	1	1	ILLINOIS	7	8
ALASKA	1	1	INDIANA	5	7
ARIZONA	2	2	IOWA	1	1
ARKANSAS	1	1	KANSAS	1	1
CALIFORNIA	21	28	KENTUCKY	1	1
COLORADO	1	1	LOUISIANA	4	4
CONNECTICUT	4	4	MAINE	1	1
DELAWARE	1	1	MARYLAND	5	7
DISTRICT OF COLUMBIA	1	1	MASSACHUSETTS	5	5
FLORIDA	8	12	MICHIGAN	8	10
GEORGIA	3	1	MINNESOTA	3	3
HAWAII, AMERICAN SAMOA, GUAM, TRUST TERRITORIES OF THE PACIFIC ISLANDS	2	1	MISSISSIPPI	1	1
IDAHO	1	1	MISSOURI	5	5
			MONTANA	1	1
			NEBRASKA	1	1

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NEVADA	1	1	SOUTH CAROLINA	1	1
NEW HAMPSHIRE	1	1	SOUTH DAKOTA	1	1
NEW JERSEY	8	8	TENNESSEE	3	2
NEW MEXICO	1	1	TEXAS	8	9
NEW YORK	14	17	UTAH	1	1
NORTH CAROLINA	4	8	VERMONT	1	1
NORTH DAKOTA	1	1	VIRGIN ISLANDS	1	1
OHIO	9	12	VIRGINIA	5	5
OKLAHOMA	1	1	WASHINGTON	3	1
OREGON	2	2	WEST VIRGINIA	1	1
PENNSYLVANIA	12	12	WISCONSIN	4	2
PUERTO RICO	1	1	WYOMING	1	1
RHODE ISLAND	1	1		==	==
			TOTAL.....	182	203

204.4 National Summary of PSRO Areas

Total Number of Proposed PSRO Areas - 203

States Designated as Single PSRO Areas - (31):

Alabama	Maine	Utah
Alaska	Mississippi	Vermont
Arkansas	Montana	Virgin Islands
Colorado	Nebraska	Washington
Delaware	Nevada	West Virginia
District of Columbia	New Hampshire	Wyoming
Georgia	New Mexico	
Hawaii, American Samoa, Guam	North Dakota	
Trust Territories of the	Oklahoma	
Pacific Islands	Puerto Rico	
Idaho	Rhode Island	
Iowa	South Carolina	
Kansas	South Dakota	
Kentucky		

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States Designated as Multiple PSRO Areas - (22):

Arizona
California
Connecticut
Florida
Illinois
Indiana
Louisiana
MarylandMassachusetts
Michigan
Minnesota
Missouri
New Jersey
New York
North CarolinaOhio
Oregon
Pennsylvania
Tennessee
Texas
Virginia
Wisconsin

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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

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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 1903(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 1866(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 1866(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

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"(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. 1152. (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.

"Qualified organization."

"(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) (i),

"(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 (i) 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;

"(B) 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—

Agreement expiration, prior termination, Post, p. 1432.

"(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 so required are not needed for the provision of adequate review and control.

Waiver.

"(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.

Agreement notice.

"(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

Plan, approval.

"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.

Duties.

"(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.

Termination,
notice.

"(c) Any agreement under which any organization is 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.

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"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 provisions of subsection (g)) be the duty and function of each Professional Standards Review Organization for any area to assume, 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).

Case criteria,
publication.

"(4) Each Professional Standards Review Organization shall be responsible for the arranging 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).

Patient profiles,
maintenance and
review.

"(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.

Hospital care,
physician re-
view.

"(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.

Physician's
family.

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 committees 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 disapproves, for good cause, such acceptance.

Review committees.

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

Regulations.

"(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—

Agreement requirements.

"(A) perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carry out the provisions of this part; and

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

"(2) Any such agreement with an organization under this part shall provide that the Secretary 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 review of health care services provided by or in institutions, unless such Organization shall have made a request to the Secretary that it be charged with the duty and function of reviewing other health care services and the Secretary shall have approved such request.

"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.

Preparation and
distribution of
data.

“(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).

Anta, p. 1433.

“(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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"SUBMISSION OF REPORTS BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

"SEC. 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 1160, 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 comments or recommendations thereon 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). Post, p. 1438.

"REQUIREMENT OF REVIEW APPROVAL AS CONDITION OF PAYMENT OF CLAIMS

"SEC. 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 thereto, 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

"SEC. 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 Ante, p. 1433.

notified of such determination, be 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 determined, 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 205(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 205(g). The Secretary will render a decision only after appropriate professional consultation on the matter.

53 Stat. 1368.
42 USC 405.

"(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. 1160. (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 ordered or provided 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 its 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—

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"(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 thereon 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—

Report and
recommendations.

Ante, p. 1437.

"(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 in one 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.

79 Stat. 291.
42 USC 1395.

"(3) In lieu of the sanction 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.

53 Stat. 1368.
42 USC 405.

"(4) 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 205(g).

"(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. 1161. 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

Establishment. "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.

Membership. "(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).

Duties. "(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 Secere-

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. Payments.

"(c) (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). Member selection, regulations.

"(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. Expenses.

"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. Establishment; membership.
5 USC 101 et seq.

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

"(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. Qualifications.

"(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 Consultants.

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.

5 USC 5332
note.

Duties.

Report to
Secretary and
Congress.

"(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 GS-18 of the General Schedule under section 5332 of title 5, United States Code), including traveltime; and while so 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 5703 of title 5, United States Code, for persons in Government service employed intermittently.

"(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. 1164. (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

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"(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 experience, and

79 Stat. 297.
42 USC 1395h.
42 USC 1395u.

"(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.

42 USC 1395.

"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 \$1,000, and imprisoned for not more than six months, or both, together with the costs of prosecution.

Penalty.

"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 subdivision 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 1152(b)(1)(A)) operating in the area where such doctor of medicine or osteopathy or provider took such action but only if—

Ante, p. 1430.

"(1) he takes such action (in the case of a health care practitioner) 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 services, 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 professionally 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 subsections (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 section 1152(b)(1) which—

"(a) express a desire to be designated as a Professional Standards 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."

**“TITLE XI—GENERAL PROVISIONS AND
PROFESSIONAL STANDARDS REVIEW**

“PART A—GENERAL PROVISIONS”

(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

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FOREWORD

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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

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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

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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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DIABETES MELLITUSH-ICDA
250I. 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

	<u>Screening Benchmark</u>
A. Repetitive analysis blood and urine sugars	100%
B. Diet order	100%
C. Instruction in diet, urine testing, footcare, insulin administration when indicated	100%
D. Obstetrical care when appropriate	100%
E. Disease counseling	100%

V. DISCHARGE STATUS

- A. Improved control of diabetes

VI. COMPLICATIONSA. 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

	<u>Screening Benchmark</u>
A. Stool examination and culture	100%
B. Fluid replacement	100%
C. Serum electrolytes and BUN or creatinine	100%

V. DISCHARGE STATUS

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

VI. COMPLICATIONSA. 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

<u>HEART DISEASE, ARTERIOSCLEROTIC</u> - Include	<u>H-ICDA</u>
Angina Pectoris and "Chest Pain"	412
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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

	<u>Screening Benchmark</u>
A. Electrocardiogram	100%
B. Chest x-ray	100%

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

HYPOGLYCEMIAH-ICDA
251I. 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 SERVICESScreening Benchmark

A. Order for monitoring level of consciousness and blood glucose	100%
B. History of insulin or drug intake	100%
C. Tolbutamide tolerance test in documented fasting hypoglycemia	0%

V. DISCHARGE STATUS

- A. Ambulatory
- B. Initiation of disease specific therapy

VI. COMPLICATIONSA. 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

APPENDIX I

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

- I BOSTON REGION: Maine, Vermont,
New Hampshire, Massachusetts,
Connecticut, Rhode Island
Edmund Steele
Alternate: M. Linwood Parsons
John F. Kennedy Federal Building
Room 14-01, Government Center
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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ALABAMA

Single PSRO Area

PLANNING

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

HSA-105-74-89

ALASKA

Single PSRO Area

PLANNING

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

HSA-105-74-111

ARKANSAS

Single PSRO Area

CONDITIONAL

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

HSA-105-74-53

ARIZONA

Two PSRO Areas

PLANNING

Area II

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

HSA-240-75-90

CALIFORNIA

Twenty-eight PSRO Areas

PLANNING

Area V	San Francisco Peer Review Organization, Inc. 250 Masonic Avenue San Francisco, California 94118 Phone: (415) 563-7491 Administrative Director: Tod A. Anderson	HSA-105-74-85
Area IX	Santa Clara Valley PSRO 700 Empey Way San Jose, California 95128 Phone: (408) 998-8850 President: Harry R. Gladstein, M.D.	HSA-105-74-47
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.	HSA-105-74-122
Area XIV	Kern County PSRO, Inc. 2012 18th Street Bakersfield, California 93301 Phone: (805) 325-9027 Project Director: Martin G. Dale	HSA-105-74-34
Area XV	San Bernardino Foundation PSRO 666 Fairway Drive San Bernardino, California 92408 Phone: (714) 825-6053 Executive Director: Gene Scott	HSA-240-75-94
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	HSA-105-74-87
Area XVII	Ventura Area PSRO, Inc. 3212 Loma Vista Road Ventura, California 93003 Phone: (805) 647-0750 Executive Director: Walter Anderson	HSA-105-74-32

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	HSA-240-75-93
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.	HSA-240-75-92
Area XXII	California Area XXII PSRO 3828 Hughes Avenue Culver City, California 90230 Phone: (213) 826-8311 Project Director: Edwin W. Butler, M.D.	HSA-240-75-86
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.	HSA-240-75-97
<u>CONDITIONAL</u>		
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	HSA-105-74-41
Area III	North Bay PSRO 4460 Redwood Highway P.O. Box #4344 San Rafael, California 94903 Phone: (415) 472-7771 Executive Director:	HSA-105-74-45
Area IV	Greater Sacramento PSRO 650 University Avenue Sacramento, California 95825 Phone: (916) 929-1480 Project Director: Reginald Claytor	HSA-240-75-44
Area VIII	San Joaquin Area PSRO 540 E. Market Street Stockton, California 95201 Phone: (209) 948-8059 Executive Director: Dan Sheehy	HSA-105-74-179

CALIFORNIA (CONT'D)

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	HSA-105-74-31
Area XXIV	Area XXIV PSRO 3200 Wilshire Boulevard, Suite 906 Los Angeles, California 90010 Phone: (213) 389-1267 Medical Director: Rex Greene, M.D.	HSA-105-74-210
Area XXVII	Riverside County PSRO 6833 Indiana Avenue Riverside, California 92506 Phone: (714) 686-0200 Executive Director: Paul S. Parry	HSA-105-74-36
<u>SUPPORT CENTER</u>	United Foundations for Medical Care, Inc. 215 Market Street, Suite 1301 San Francisco, California 94105 Phone: (415) 495-0940 Project Director: Edward G. Zivot	HSA-105-74-80

COLORADO

Single PSRO Area

<u>CONDITIONAL</u>	Colorado Foundation for Medical Care 1601 East 19th Avenue Denver, Colorado 80218 Phone: (303) 534-8580 Executive Vice President: Donald Derry	HSA-105-74-190
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CONNECTICUT

Four PSRO Areas

CONDITIONAL

Area I	PSRO of Fairfield County, Inc. 60 Katona Drive Fairfield, Connecticut 06430 Phone: (203) 576-1214 Executive Director: Greg Martel	HSA-105-74-182
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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	HSA-105-74-48
Area III	Hartford County PSRO Inc. 40 Woodland Street Hartford, Connecticut 06105 Phone: (203) 525-5383 Executive Director: Norman Reich	HSA-105-74-55
Area IV	Eastern Connecticut PSRO, Inc. 15 Mansfield Avenue Willimantic, Connecticut 06226 Phone: (203) 456-2228 Administrative Director: Donald E. Woodbury	HSA-105-74-33
<u>SUPPORT CENTER</u>	Connecticut Medical Institute 90 Sargent Drive New Haven, Connecticut 06509 Phone: (203) 777-4494 Executive Director: Joseph W. Marin	HSA-105-74-71

DELAWARE

Single PSRO Area

PLANNING

Delaware Review Organization 1925 Lovering Avenue Wilmington, Delaware 19806 Phone: (302) 654-9524 Executive Director: Paul L. Gandillot	HSA-105-74-166
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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.	HSA-105-74-29
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FLORIDA

Twelve PSRO Areas

PLANNING

Area III Jacksonville Area PSRO HSA-240-75-91
 515 Lomax Street
 Jacksonville, Florida 32204
 Phone: (904) 355-6561
 Project Director: Ernest R. Currie

CONDITIONAL

Area XII Dade Monroe PSRO, Inc. HSA-105-74-64
 444 Brickell Avenue, Suite M-100
 Miami, Florida 33131
 Phone: (305) 358-4224
 Executive Director: Gerard E. Mayer

GEORGIA

Single PSRO Area

[No Contract Awarded]

HAWAII

(ALSO AMERICAN SAMOA, GUAM, TRUST
 TERRITORIES OF THE PACIFIC ISLANDS)

Single PSRO Area

PLANNING Pacific PSRO, Inc. HSA-105-74-35
 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, HSA-105-74-95
 Inc.
 407 West Bannock Street
 Boise, Idaho 83702
 Phone: (208) 377-1910
 Executive Director: Ben Kermuode

ILLINOIS

Eight PSRO Areas

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	HSA-105-74-203
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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	HSA-105-74-96
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INDIANA

Seven PSRO Areas

PLANNING

Area I	Calumet Area Professional Review Organization 2825 Jewett Street Highland, Indiana 46322 Phone: (219) 923-8614 Executive Director: Charles C. Shoemaker	HSA-105-74-56
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Area V	Indiana Area V PSRO 2501 Executive Drive, Suite 108 Indianapolis, Indiana 46241 Phone: (317) 243-3746 Executive Director: Arthur G. Loftin	HSA-105-74-121
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SUPPORT CENTER

Indiana Physicians Support Agency 2501 Directors Row, Suite 106 Indianapolis, Indiana 46241 Phone: (317) 243-3229 Project Director: Wilbert McIntosh, M.D.	HSA-105-74-77
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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

HSA-105-74-88

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

HSA-105-74-92

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

HSA-105-74-40

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

HSA-105-74-84

MARYLAND

Single PSRO Areas

PLANNING

Area I	Western Maryland Review Organization, Inc. 329 N. Potomac Street Hagerstown, Maryland 21740 Phone: (301) 733-4440 Project Director: Charles C. Spencer	HSA-240-75-85
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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	HSA-105-74-62
Area III	Montgomery County, Maryland Medical Care Foundation, Inc. 2446 Reddie Drive Wheaton, Maryland 20902 Phone: (301) 933-8330 Executive Director: Betsy Carrier	HSA-105-74-49
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	HSA-105-74-194
Area V	Central Maryland PSRO, Inc. 8635 Lock Raven Blvd., Suite 5 Baltimore, Maryland 21204 Phone: (301) 668-5150 Executive Director: Frederick Menosky	HSA-105-74-61
Area VI	Southern Maryland PSRO, Inc. P.O. Box #445 Edgewater, Maryland 21037 Phone: 224-4144 Executive Director: Curtis J. Spicer	HSA-105-74-63
Area VII	Delmarva Foundation for Medical Care, Inc. 108 N. Harrison Street Easton, Maryland 21601 Phone: (301) 822-7223 Executive Director: Peter J. Borchardt	HSA-105-74-57

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

HSA-105-74-79

MASSACHUSETTS

Five PSRO Areas

PLANNING

Area II

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

HSA-105-74-184

CONDITIONAL

Area I

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

HSA-105-74-141

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.

HSA-105-74-177

Area IV

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

HSA-105-74-192

Area V

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

HSA-105-74-50

SUPPORT CENTER

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

HSA-105-74-74

MICHIGAN

Ten PSRO Areas

PLANNING

Area VII	Federation of Physicians in Southeastern Michigan 1010 Antietam P.O. Box 125 Detroit, Michigan 48207 Phone: (313) 885-1406 Project Director: Ralph R. Cooper, M.D.	HSA-240-75-119
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CONDITIONAL

Area I	Upper Peninsula Quality Assurance Association 420 West Magnetic Street Marquette, Michigan 49855 Phone: (906) 228-7685 Executive Director: Bradley Cory	HSA-105-74-159
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Area V	Professional Review Organization - GLSC 700 Metropolitan Building 432 N. Saginaw Street Flint, Michigan 48502 Phone: (313) 233-6071 Executive Director: Donald Blass	HSA-105-74-106
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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	HSA-105-74-75
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MINNESOTA

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.	HSA-105-74-163
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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	HSA-105-74-178
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MISSISSIPPI

Single PSRO Area

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.	HSA-105-74-195
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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	HSA-105-74-103
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	HSA-105-74-46
Area IV	MOAF, Inc. 223A Professional Building Springfield, Missouri 65806 Phone: (417) 866-1994 Project Director: N.L. McCartney	HSA-240-75-108

MISSOURI (CONT'D)

Area V Southeast Missouri Foundation HSA-105-74-197
 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 HSA-105-74-65
 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 HSA-105-74-82
 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 HSA-240-75-22
 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 HSA-105-74-91
 129 West 6th Street
 Reno, Nevada 89503
 Phone: (702) 786-1842
 Executive Director: James W. Hand

NEW HAMPSHIRE

Single PSRO Area

CONDITIONAL

New Hampshire Foundation
for Medical Care
The Durham Road
P.O. Box 658
Durham, New Hampshire 03824
Phone: (603) 868-7410
Director: Constance Azzi

HSA-105-74-105

NEW JERSEY

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

HSA-105-74-66

Area IV

Essex Physicians' Review
Organization, Inc.
144 South Harrison Street
East Orange, New Jersey 07018
Phone: (201) 672-0558
Executive Director: Anthony Petruzzi

HSA-105-74-30

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

HSA-240-75-100

Area VIII

Southern New Jersey PSRO
1486 Haddon Avenue
Camden, New Jersey 08060
Phone: (609) 428-6709
Executive Director: Michael Trend

HSA-240-75-99

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.

HSA-105-74-102

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

HSA-105-74-78

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

HSA-240-75-03

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

HSA-105-74-108

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.

HSA-105-74-109

Area XII
Richmond County, New York PSRO
100 Central Avenue
Staten Island, New York 10301
Phone: (212) 720-8383
Executive Director: Dominic A. Florio

HSA-105-74-107

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.

HSA-240-75-89

NEW YORK (CONT'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	HSA-105-74-86
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	HSA-105-74-37
Area V	Adirondack PSRO 24 Elm Street Glens Falls, New York 12801 Phone: (518) 793-4667 Executive Director: Conrad S. Kaczmarek	HSA-105-74-51
Area IX	Area 9 PSRO of New York, Inc. Purchase Street Purchase, New York 10577 Phone: (914) 948-4100 Executive Director: Michael J. Maffucci	HSA-105-74-38
Area X	PSRO of Rockland 120 North Main Street New City, New York 10956 Phone: (914) 634-0505 Executive Director: Jack Cohen	HSA-105-74-118
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. Eleanore Rothenberg, Ph.D.	HSA-105-74-44
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.	HSA-105-74-39
Area XV	Nassau Physicians Review Organization 1200 Stewart Avenue Garden City, New York 11530 Phone: (516) 333-4300 Project Director: Eugene O'Reilly	HSA-105-74-164

NEW YORK (CONT'D)

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	HSA-105-74-165
<u>SUPPORT CENTER</u>	Medical Society of the State of New York 420 Lakeville Road Lake Success, New York 11040 Phone: (516) 488-6100 Executive Director: Morton Chalef	HSA-105-74-72

NORTH CAROLINA

Eight PSRO Areas

PLANNING

Area II	Piedmont Medical Foundation, Inc. 2240 Cloverdale Winston-Salem, North Carolina 27103 Phone: (919) 723-6916 Executive Director: William C. Park, Jr.	HSA-105-74-124
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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	HSA-105-74-81
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NORTH DAKOTA

Single PSRO Area

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	HSA-240-75-98
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OHIO

12 PSRO Areas

PLANNING

Area II	Area II Peer Review Organization 1030 Fidelity Medical Building Dayton, Ohio 45402 Phone: (513) 223-3180 Executive Director: August Sisco	HSA-105-74-135
Area VI	Region Six Peer Review Organization 430 Grant Street Akron, Ohio 44311 Phone: (216) 535-2387 Executive Director: Mary Barley	HSA-105-74-152
Area X	Region X Professional Review Organization 3720 Jolentangy River Road Columbus, Ohio 43215 Phone: (614) 481-8874 Executive Director: Robert P. Stone	HSA-105-74-131
Area XII	Physicians Peer Review Organization 10525 Carnegie Avenue Cleveland, Ohio 44106 Phone: (216) 421-5900 Executive Director: Donald Mortimer	HSA-105-74-123

CONDITIONAL

Area I	Medco Peer Review, Inc. 208 Lytle Towers Cincinnati, Ohio 45202 Phone: (513) 721-2345 Executive Director: Edward Willenborg	HSA-105-74-125
Area IV	Fourth Ohio Area PSR Council 3550 Secor Road, Suite 202 Toledo, Ohio 43606 Phone: (419) 535-0537 Medical Director: Robert L. Hauman, M.D.	HSA-105-74-134

SUPPORT CENTER

Medical Advances Institute 1225 Dublin Road Columbus, Ohio 43215 Phone: (614) 481-8871 President: Edward A. Lentz	HSA-105-74-76
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OKLAHOMA

Single PSRO Area

PLANNING

Oklahoma Foundation for Peer Review
 601 N.W. Expressway
 Oklahoma City, Oklahoma 73118
 Phone: (405) 842-3361
 Project Director: Edward Kelsay

HSA-240-75-96

OREGON

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

HSA-105-74-168

Area II

Greater Oregon PSRO
 2164 S.W. Park Place
 Portland, Oregon 97205
 Phone: (503) 226-1555
 Executive Director: Robert Dervedde

HSA-105-74-52

PENNSYLVANIA

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

HSA-105-74-130

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.

HSA-105-74-145

PENNSYLVANIA (CONT'D)

Area VIII	Highlands PSRO Corporation 325 Swank Building Johnstown, Pennsylvania 15901 Phone: (814) 539-7077 Executive Director: Bernard G. Koval	HSA-105-74-59
 <u>CONDITIONAL</u>		
Area VI	Allegheny PSRO, One Allegheny Square, Suite 1730 Pittsburgh, Pennsylvania 15212 Phone: (412) 231-1706 Executive Director: John F. Kuhn	HSA-105-74-161
Area VII	Southwestern Pennsylvania PSRO 825 North Main Street Greensburg, Pennsylvania 15601 Phone: (412) 836-5858 Executive Director: Sandra Levine	HSA-105-74-153
Area IX	Southcentral Pennsylvania PSRO 2401 North Fourth Street Harrisburg, Pennsylvania 17110 Phone: (717) 233-0273 Executive Director: Harold Diehl, Jr., FACHA	HSA-105-74-132
Area XI	Montgomery/Bucks PSRO, Inc. 650 Blue Bell West, Suite 209 Skipack Pike Blue Bell, Pennsylvania 19422 Phone: (215) 628-2121 Executive Director: Ralph Rolan, II	HSA-105-74-54
Area XII	Philadelphia PSRO 2100 Spring Garden Street Philadelphia, Pennsylvania 19130 Phone: (215) 567-2792 Executive Director: Tom DiVincenzo	HSA-105-74-162
 <u>SUPPORT CENTER</u>		
	Pennsylvania Medical Care Foundation 20 Erford Road Lemoyne, Pennsylvania 17043 Phone: (717) 238-1635 Executive Director: Larry R. Fosselman	HSA-105-74-14

PUERTO RICO

Single PSRO Area

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.

HSA-105-74-128

RHODE ISLAND

Single PSRO Area

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

HSA-105-74-158

SOUTH CAROLINA

Single PSRO Area

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

HSA-105-74-104

SOUTH DAKOTA

Single PSRO Area

PLANNING

South Dakota Foundation for
Medical Care
608 West Avenue, North
Sioux Falls, South Dakota 57104
Phone: (605) 336-1965
Executive Director: Robert Johnson

HSA-105-74-58

TENNESSEE

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

HSA-105-74-90

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.

HSA-105-74-167

TEXAS

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

HSA-105-74-110

VERMONT

Single PSRO Area

PLANNING

Vermont PSRO, Inc.
 P.O. Box 415
 Shelburne, Vermont 05482
 Phone: (802) 985-8716
 Executive Director: Dr. Robert Aiken

HSA-105-74-143

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	HSA-105-74-133
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Area V	Colonial Virginia FMC 976 Norfolk Square Norfolk, Virginia 23502 Phone: (804) 623-5314 Executive Director: William S. Grant	HSA-240-75-83
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<u>SUPPORT CENTER</u>	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	HSA-105-74-73
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WASHINGTON

Single PSRO Area

<u>CONDITIONAL</u>	Washington State PSRO 2150 North 107th Street, Suite 504 Seattle, Washington 98125 Phone: (206) 364-9700 Executive Director: Terry G. Kelley	HSA-105-74-200
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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

HSA-105-74-28

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

HSA-105-74-160

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.

HSA-105-74-60

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

HSA-105-74-146

APPENDIX J

STATISTICAL REPORTS ILLUSTRATING

COST SAVINGS RESULT OF

MCF REVIEW ACTIVITY

FOUNDATION FOR HEALTH CARE EVALUATION
YEARLY REPORT-1973

J-1

	CASES	FEE	UTILIZATION	REDUCED	APPROVED	AVERAGE TURNOVER*	REDUCTION
JANUARY	203	179	24	118	61	48	\$ 10,055.25
FEBRUARY	139	117	22	80	37	50	11,372.45
MARCH	281	253	28	155	98	40	14,210.95
APRIL	170	151	19	97	54	38	9,636.00
MAY	250	239	11	158	81	38	9,348.00
JUNE	236	229	7	163	66	42	11,340.90
JULY	185	184	1	117	67	36	9,398.50
AUGUST	195	183	12	118	65	32	7,131.85
SEPTEMBER	233	234	4	146	88	35	9,110.25
OCTOBER	220	219	1	149	70	30	12,450.50
NOVEMBER	158	157	1	106	51	49	8,092.75
DECEMBER	155	155	0	96	59	39	7,595.00
TOTAL	2430	2300	130	1503	797	39	\$119,692.45

*approximate

Source: Anonymous Medical Care Foundation and Operational PSRO

FOUNDATION FOR HEALTH CARE EVALUATION
YEARLY REPORT-1974

MONTH	CASES	FEE	UTIL.	REDUCED	APPROVED	TURNOVER	REDUCTION
JANUARY	247	218	29	139	79	47	\$11,435.65
FEBRUARY	136	111	25	78	33	30	5,605.88
MARCH	156	142	12	104	38	34	6,299.77
APRIL	124	106	18	71	35	40	4,306.90
MAY	134	114	20	74	40	35	5,878.85
JUNE	125	101	24	65	36	39	4,911.32
JULY	154	104	50	74	30	31	5,465.90
AUGUST	113	98	15	63	35	31	6,181.85
SEPTEMBER	119	101	18	70	31	37	4,897.19
OCTOBER	144	127	17	80	47	25	10,892.75
NOVEMBER	57	44	13	32	12	26	3,364.00
DECEMBER	74	54	20	42	12	29	2,617.88
TOTAL	1,583	1,320	263	892	428	Average T.O. 33	\$71,757.94

Source: Anonymous Medical Care Foundation and Operational PSRO

