3-1974

Professional Standards Review Organization: Past, Present and Future

Robert M. O'Bryan

Follow this and additional works at: https://scholarlycommons.henryford.com/hfhmedjournal

Part of the Life Sciences Commons, Medical Specialties Commons, and the Public Health Commons

Recommended Citation
Available at: https://scholarlycommons.henryford.com/hfhmedjournal/vol22/iss1/3

This Article is brought to you for free and open access by Henry Ford Health System Scholarly Commons. It has been accepted for inclusion in Henry Ford Hospital Medical Journal by an authorized editor of Henry Ford Health System Scholarly Commons.
Professional Standards Review Organization: Past, Present and Future

Robert M. O'Bryan, MD*

PROFESSIONAL Standards Review Organization (PSRO) is a public law giving practicing physicians the responsibility for reviewing the appropriateness and quality of services provided under Medicare, Medicaid, and the Maternal and Infant Care Programs. The law stipulates that objective standards of care must be developed; patient care must be reviewed for compliance with these standards; and results must be reported to local, state, and national Professional Standards Review Councils. Unless services comply with these standards, physicians and/or institutions will not be paid. The law applies to a significant number of Henry Ford Hospital patients and already is being implemented. The deputy assistant secretary for health said that PSRO is the most important piece of health legislation ever enacted. The medical profession accepts its importance but questions its wisdom. This article reviews the development of PSRO, its present requirements, and its possible future.

To understand how PSRO evolved, it is helpful to reflect upon the health programs introduced by the 89th Congress during the mid-1960s. In a very broad sense, these programs were designed to plan, deliver, and pay for health care services. Comprehensive Health Planning, (Public Law 89-749 enacted 3 November 1966), was designed to coordinate all aspects of health care, including services, manpower, and facilities into a comprehensive health care delivery system. Public Law 89-239, (Regional Medical Programs enacted 6 October 1965), was designed to regionalize the health systems so as to enable all patients to obtain the benefits from the most recent advances in medicine. Finally, Medicare, (Public Law 89-97 enacted 30 July 1965), provided health insurance to pay for services provided to the aged. Congress was aware that health care costs were rising at a rate four times greater than the consumer price index, and in order to discourage improper and unnecessary utilization of services, the law required utilization review programs for all participating hospitals. The utilization review programs were hospital-based and were required to review patterns of patient care, extended length of stay, and recertification by the attending physician of the patient's need to remain in the hospital. The law did not require the use of objective criteria or the reporting of results to state and federal agencies.

However, health costs continued to increase. Monthly premium costs for Part B of Medicare rose from $6.00 per person in 1966 to $11.60 per person in 1972. At that time, the Senate Committee on Finance predicted that the cost of Medicare would overrun the 1967 estimate by some $240 billion over a 25-year period. The
committee's conclusion was that utilization review activities had been, generally speaking, of a token nature and were ineffective as a curb to unnecessary uses of institutional care and services. The committee quoted a state medical society in these words, "Where hospital beds are in short supply, utilization review is fully effective. Where there is no pressure on the use of hospital beds, utilization review is less intense and often a token."

Forces behind the increasing costs of health care are certainly far more complex than those implied by the aforementioned state medical society. It is generally recognized that technical advances have generated many new types of services that are ordered for patients and the cost for these services has increased. Forces that are not as well recognized have been described recently by Feldstein: "Insurance reduces the net cost to the patient of the greater cost per day. This induces the patient and the physician to utilize more units of service per day of hospital care, thereby increasing daily costs." He further states: "Medical care is produced not only in hospitals, but also at home. The rise in value of time to the working man and the decline in number of adults available at home to provide home care services tend to increase hospital utilizations and expenditures." By enacting Public Law 92-603, Congress has placed the responsibility of controlling health care costs directly upon the medical profession. The law charges the medical profession with restructuring the utilization review process and increasing its effectiveness.

PSRO applies to all federally funded health care programs, including Medicare, Medicaid, and the Maternal and Infant Care Programs. When fully operative, it will supplant all previous utilization review requirements. It will operate on a local basis, but will be required to report violations and recommendations to the state-wide Professional Review Council, which in turn will report to the Secretary of Health, Education, and Welfare (HEW) (Figure 1). The National Professional Standards Review Council will arrange for collection and distribution of data and other information useful to the state councils and local PSROs, particularly norms of care employed in various geographic or medical service areas with methods of utilizing and applying such norms. The council will have the initial guidelines available early in 1974.

Where the actual norms of care, diagnosis, and treatment in a PSRO area are significantly different from professionally developed regional norms approved for comparable conditions, the PSRO concerned will be so informed. In the event that appropriate consultation and discussion indicate reasonable basis for uses of other norms in the area concerned, the PSRO may apply these norms in such areas as are approved by the National Council. Similarly, each PSRO has the option to utilize the services of and accept the findings of hospital utilization review programs that are known to be effective.

The primary responsibility of PSRO is to review health care services provided by or in institutions. Outpatient care review will be phased in at a later date. PSRO is regularly to review provider and practitioner profiles of care and service and other data for evaluation of the necessity, quality, and appropriateness of services. Also, it will analyze patterns of care, concentrating its attention upon situations in which unnecessary, sub-
standard, or inappropriate services are most likely to exist or occur. PSRO requires attending physicians to certify the need for hospital care of patients beyond the regional norms for similar patients with similar diagnoses based upon credible criteria. It is expected that the checkpoint will be established at the 50th percentile. PSRO disapprovals would not mandate discharge, but determine the extent of benefit payment. If, after efforts to inform the provider about the accepted norms of practice, the PSRO determines there is gross or continued overuse of services, payments can be terminated and HEW can assess an amount reasonably related to the excessive costs involved, but not to exceed $5,000, against the person or institution at fault. A summary of the duties and requirements of PSRO is presented in Figure 2.

At the present time, the PSRO law has been widely circulated, a chief of the Office of Professional Standards Review has been appointed and 203 PSRO regions have been designated. Michigan has been divided along county lines into ten PSRO areas, one of which is Wayne County. The reactions of the medical profession to the legislation and its initial implementation have been, at best, mixed. Many new organizations have been formed to study and report reactions to PSRO; these include committees in nearly every state and county medical society and professional organization. Some states, including Utah and Ohio, have functioning PSRO prototypes; while in other states, including Michigan, the medical societies have passed resolutions opposing PSRO.

The final form for a PSRO, or some other utilization review mechanism, remains to be seen. It is evident, however, that some form of peer review, based on objective norms, will be established. There are many reasons, other than public demand for accountability, to support this conclusion. In 1972, the Joint Commission on Accreditation of Hospitals said that all hospitals must assess quality of care through a continuing, objective, critical, and corrective analysis of clinical work. It called for each hospital to establish a base of objective criteria against which effectiveness, timeliness, appropriateness, accessibility, acceptability, and economy of medical care could be evaluated. There is no requirement to report to state or federal agencies, but hospitals are required to provide educational methods of correcting practices which fall outside the norms and sanctions for consistent nonconformity. The American Hospital Association promotes the Quality Assurance Program in which hospitals do the following:

1. Review admission requests;
2. Conduct preadmission testing;
3. Certify admissions;
4. Approve length of stay;
5. Assure discharge planning;
6. Conduct retrospective reviews of patterns of care.

These concepts are similar to PSRO with the exception that there is no requirement to report to extramural agencies.

In July, 1973, the Joint Commission on the Accreditation of Hospitals extended its requirements for review to the outpa-
O'Bryan

tient department. Hospital clinics are to review at least the number of patient visits, the number of patients seen, the clinical diagnosis, the types and number of operative procedures, and the age and distribution of patients. The most recent proposed federal regulations were published in the Federal Register on January 7, 1974. It was proposed that prior to elective admission, or within one working day of an emergency admission, the physician provide the utilization review committee with the following documentation:

1. Identification of attending physician;
2. Diagnosis or complaint indicating need for admission;
3. Date of admission request;
4. Such supporting information as the committee would require, eg, history and test findings;
5. Treatment plan; and

The committee then would approve or disapprove the admission. If approved, it would certify specific length of stay, based upon objective criteria. In addition, one can speculate that with the current emphasis on Health Maintenance Organizations (HMO) and continuing ground swell for some kind of national health insurance, objective criteria for patient care will have to be developed by someone. PSRO says that the medical profession has a finite amount of time to develop these norms or they will be developed elsewhere.

A major concern widely discussed, but still unresolved, is the medical/legal implication connected with reviewing patient care against objective norms. While the PSRO legislation includes a waiver of liability for decisions made through the review system, there still exists a very real problem. Simply stated, if these criteria, generated by practicing physicians, are used or interpreted by anyone other than practicing physicians, misinterpretation could occur. The art and science of medicine cannot be reduced to a set of objective criteria, judgments regarding medical care cannot be based solely upon these criteria, and these criteria do not represent points of law.

My view is we must and should proceed with the establishment of norms, not because legislation dictates, but because it is our duty to tell PSRO, HMO, National Health Insurance (NHI), or whomever else is asking, what basic services are essential to ensure quality medical care. The stated intention of PSRO is to maintain quality services, and to reduce the increase in health care services by refusal to pay for what they consider unnecessary services. Let the medical profession determine what services are necessary. Let the medical profession demand that those who implement PSRO, or any health legislation, also be concerned with quality of care. I trust that institutions of medical care will not be forced to reduce standards in order to be eligible for HMO participation or to survive in a nationally financed health care system.

References

1. Professional Standards Review Organizations, Public Law 92-603, Section 249 F, Title XII of the SSA
2. Hospitals 47:24, Dec 1973
3. Conditions of Participation for Hospitals, US DHEW, SSA HIM-1, Feb 1966
4. Senate Finance Committee Report, Public Law 92-603, Sec 249F
5. Feldstein M: The Rising Cost of Hospital Care. NCHSRD, Wash DC Information Resources Press, 1973
6. Resolution 73-A2, October 1973, AMA
7. Bulletin 62, JCAH, Fall 1971