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DISCLOSURE OF MEDICAL INFORMATION— CRIMINAL PROSECUTION OF MEDICAID FRAUD IN NEW MEXICO

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In October of 1977, the Medicare-Medicaid Anti-Fraud and Abuse Amendments Act[1] was passed by the Ninety-fifth Congress. Its purpose is "to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs. . . ."[2] Pursuant to this Act, the establishment of a Medicaid Fraud Control Unit (hereinafter, Unit) in each state was authorized. New Mexico became the second state in the United States to establish such a Unit. Investigation by the Unit of provider-based fraud began in May of 1978. One of the first problems encountered was that of the ability of the Unit to gain access to all medical information necessary to properly pursue an investigation. That access is the subject of this article.

The crimes which are the subjects of this Unit's investigations result not only in improper billings to the State, but also in potential and actual abuses and injuries to patients. It is of paramount importance to insure that medical care provided is of the highest quality possible. When there exists a reasonable belief that a provider has engaged in criminal activity, it is in the best interest of the medical profession in general, as well as that of the State, to protect medical services recipients by diligently and fairly investigating colorable complaints. Complaints in the Medicaid area include, but are not limited to: false billings for services not rendered; multiple billings for the same services; improper billings for services rendered, but not covered as allowable under the regulations; overbilling; and over-provision of unnecessary services.

Two basic sources of resistance are encountered by those advocating total accessibility by the Unit to medical records. The first is based on what is generally referred to as the physician-patient privilege. Not only does that privilege not exist in New Mexico, but the principle would not apply by virtue of the fact that the investigations

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1. P. L. 95-142, 91 Stat. 1175.
2. *Id.*

are directed at one of the partners involved in the privilege. It is an established tenet that "[p]rivilege cannot be taken advantage of by [the] opponent."[3] The second instance is found where third parties offer resistance to disclosure of evaluation-type information found most commonly in peer-review committee deliberations. That resistance is not based upon privilege or patient confidentiality concerns, but rather upon policy considerations directed at preserving the autonomy and impregnability of peer-group deliberations. The theory relied upon by the medical profession in this area is that if such deliberations are not protected from all discovery, then medical service providers will not agree to submit to such reviews and a valuable evaluation process would become useless. It is difficult to comprehend why limited and justified discovery, not by the public, but by qualified investigative bodies charged also with monitoring the quality of medical care, should cause medical providers to withdraw support of reportedly beneficial review procedures.

Whatever arguments might be mustered for or against this theory, it is clear that non-disclosure policies must be supported by law if they are to be applied in criminal actions. A review of statutes and case law at state and federal levels fails to reveal the existence of any law applicable to New Mexico which clearly forecloses the Medicaid Fraud Control Unit from gaining access to committee deliberations relating to medical providers.

Adequate protection of personal rights can be found in New Mexico. The criminal law system presently incorporates extensive due process safeguards which protect the rights of the accused. Recipient rights are protected by the very nature of these investigations, which are largely geared toward eliminating the victimization of recipients. Furthermore, Medicaid recipients agree to unlimited access to their medical records as a condition of receipt of services under federal law.

Federal regulations relevant to State Medicaid Agencies, Professional Standards Review Organizations (PSRO's), and Medicaid Fraud Control Units contain ambiguous and seemingly conflicting guidelines regarding confidentiality of information. Although access to certain types of information in the possession of PSRO's is denied to State Medicaid Agencies, it is not clear that these restrictions should or presently do apply to independently empowered Medicaid Fraud Control Units. Resolution of this issue has been delegated by law to the Secretary of Health, Education and Welfare. Recent guidelines, although not as lucid as might be desired, appear to leave little

3. Annot., 2 A.L.R. 2d 645-66 (1948) at Later Case Service §10, 211 (1971).

question that Unit access to PSRO records is to be virtually unlimited. Essentially, there presently appears to exist no concrete restriction as to discovery of medical records including committee reports by a Medicaid Fraud Unit in New Mexico, aside from the Constitutional due process safeguards which apply in any criminal prosecution.

PHYSICIAN-PATIENT PRIVILEGE

In order to properly develop a criminal case in the Medicaid area, it is necessary for a Unit to gain access to all medical records which relate to the subject of the complaint being investigated. Procedurally-oriented complaints such as double billings and forgeries, as well as non-procedural complaints, such as the medical necessity of an operation, require detailed investigative analyses of medical records in order to determine whether or not relevant services were received as billed. The immediate resistance encountered when medical records are requested by the Unit is manifested by the person in possession of such records. The resistance is usually grounded in ethical and professional principles which question the requestor's right to sensitive information regarding patients. Medical personnel commonly rely upon the existence of a physician-patient privilege which protects confidential communications from disclosure.

> A confidential communication is information which is transmitted to a lawyer, physician, nurse or clergyman in confidence of the relation between him or her and the party making it, and under circumstances which imply that it shall remain undisclosed by the confidant. The communication may be the result of examination, treatment, observation or conversation relating to the confider. . . . The physician has a clear obligation to keep secret any information relating to a patient's illness which he obtains during the performance of his professional duties, unless the patient authorizes disclosure of the information or a competent court orders him to reveal it. This obligation is based first, on the ethics of the profession and second, upon legislative enactment in most states.[4]

At common law, no physician-patient privilege existed. "[A] physician called as a witness had no right to decline or refuse to disclose any information on the ground that it had been communicated to him confidentially in the course of his attendance upon or treatment of his patient in a professional capacity."[5] To overcome the effect of the common law, a relevant statute must apply because

4. E. Hayt and J. Hayt, Legal Aspects of Medical Records 73 (1964).
5. Annot., 7 A.L.R. 3d 1458, 1459 (1966).

the "legal relationship of privilege, as distinguished from the ethical, exists only by statute and is subject to change by the state legislatures."[6] The New Mexico legislature has explicitly adopted the common law in criminal cases when no statute applies.[7] In New Mexico, no statute on physician-patient privilege exists, although strict restrictions do exist as to disclosures of information relating to mental health clients.[8] As for non-psychiatric situations, not only does a physician-patient privilege statute not presently exist, but the absence of such a statute is the result of affirmative action taken by the New Mexico State Legislature in 1973. At that time the New Mexico legislature eliminated the then existing, albeit limited, physician-patient privilege.[9] Even in states where physician-patient privilege statutes do exist "[t]he privileged communications doctrine generally is not available in criminal cases. . . . The rule of privileged communications was not intended to shield the one charged with an unlawful act."[10]

A number of states have, pursuant to existing statutes, developed case law explicitly asserting that no physician-patient privilege in criminal cases exists.[11] A corollary of this effect can be seen in an Idaho case, where although a statute conferring a physician-patient privilege in civil cases did exist, the court found that application of the common law in a criminal case resulted in no privilege.[12]

A Unit can avoid the issue of the existence of the physician-patient privilege if a release of medical information can be obtained from the patient. There is no legal requirement that the release authori-

6. E. Hayt and J. Hayt, *supra* note 4, at 75.

7. N.M. Stat. Ann. §30-1-3 (1978) states that "In criminal cases where no provision of this code is applicable, the common law, as recognized by the United States and the several states of the Union, shall govern."

8. N.M. Stat. Ann. §43-1-19 (1978):

Disclosure of Information.

A. Except as otherwise provided in this code, [43-1-2 to 43-1-23 NMSA 1978], no person shall, without the authorization of the client, disclose or transmit any confidential information from which a person well acquainted with the client might recognize such client as the described person, or any code, number or other means which can be used to match the client with confidential information regarding him. . . . F. Information concerning a client disclosed under this section shall not be released to any other person, agency or government entity, nor placed in files or computerized data banks accessible to any other person.

9. N.M. Stat. Ann. §20-1-12 (Supp. 1975).

10. Hayt, Hayt, and Groeschel, Law of Hospital, Physician and Patient 1072 (3d Ed. 1972), citing Hauck v. State, 148 Ind. 238 (1897).

11. State v. Campbell, 210 Kan. 265, 500 P.2d 21 (1972); State v. Campbell, 146 Mont. 251, 405 P.2d 978, 22 A.L.R. 3d 824 (1965); People v. Combes, 56 Cal. 135, 363 P.2d 4, 14 Cal. Rptr. 4 (1961).

12. State v. Coburn, 82 Idaho 437, 354 P.2d 751 (1960).

zation by the patient be witnessed by either a notary public or by any other person.[13] Furthermore, much information in the possession of medical personnel can be obtained without a release.

> No authorization from a patient is necessary to disclose ordinary facts unrelated to treatment, such as the name of the attending physician, number of times and dates upon which the physician attended a patient, the name, age and address of the patient on admission, that the patient was ill and was operated upon, admission and discharge dates, names of relatives or friends given upon admission, whether the patient was sick, date of birth of a patient's child, and other facts which are obvious to anyone.[14]

The New Mexico Unit, therefore should consider itself unhindered in its investigations by the existence of any physician-patient privilege. In other states, where such legislatively enacted privileges do exist, legal means may nevertheless be available to allow such discovery in criminal actions.

COMMITTEE REPORTS AND DELIBERATIONS–PEER REVIEW IN NEW MEXICO

In hospital settings, different committees exist, by historical practice and by federal mandate, which review and pass judgment on various aspects of physician performance. In New Mexico, records of providers of medical services for the Medicaid program are extensively reviewed by the PSRO[15] by contract with the New Mexico

13. E. Hayt and J. Hayt, *supra* note 4, at 87.

14. *Id.* at 93.

15. A brief description of PSRO functions is found in the CCH Medicare and Medicaid Guide, ¶ 12,855:

> In the light of shortcomings believed to exist in the utilization review process (see ¶ 12,695, *et seq.*), the Social Security Amendments of 1972 (P.L. 92-603) added provisions to the Social Security Act that provide a review mechanism through which practicing physicians will assume full responsibility for reviewing the utilization of services. Under these provisions, the Secretary is required to establish independent Professional Standards Review Organizations (PSRO's), consisting of substantial numbers of practicing physicians (usually 300 or more) in local areas to assume responsibility for comprehensive and on-going review of services covered under the Medicare, Medicaid, and Maternal and Child Health Care programs (¶ 12,860).
>
> The purpose of these organizations, as stated in the law, is to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made . . . under the Act. The PSRO will be responsible (¶ 12,865) for assuring that payments for health care services under these programs will be made: (1) only when medically necessary, as determined in the exercise of reasonable limits of professional discretion; and (2) in the case of inpatient services, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient bases or more economically in an inpatient health care facility of a different type.

Department of Human Services. The PSRO reviews both hospital and ambulatory care. The reviews are conducted by the professional peers of the provider being reviewed. For many hospitals participating in New Mexico's Medicaid program, PSRO has, under permissible program parameters, delegated its Medicaid review functions to extant Utilization Review Committees within the institutions.

Committee reports and deliberations contain information which differs from that contained in a patient's formal medical record. Tissue committees, for example, study and report to the medical staff on the differences between preoperative diagnoses and postoperative reports by pathologists on tissue removed during an operation. Tissue committee reports:

> [D]o not constitute a recognized part of the patient's clinical record, which is divided into three sections: (1) nurse's record, (2) records and reports from adjunct and special departments and (3) the medical report proper, which is the direct responsibility of the physician. As such, the tissue committee reports have no bearing on what was wrong with the patient or what treatment should have been provided. It is rather a review of what was done for the patient, made after he has left the hospital, to evaluate the care which he received.[16]

The significance to Medicaid fraud investigations of the above-exampled committee report lies in the fact that a physician's performance has undergone an overall evaluation by his peers, as well as in relation to specific cases. These reports are not normally accessible to non-hospital personnel, but do bear upon the quality of care provided by, and necessity of procedures utilized by, specific providers who may be targets of investigation.

One peculiarly medical defense which will be raised by defendant-providers, in response to accusations of utilization of improper or unnecessary procedures will be an assertion that the procedure was, in the reasonable opinion of the physician, "medically necessary" at the time of its implementation. Such a defense, since a determination of "medical necessity" relies so heavily upon amorphous and often ill-defined professional standards, will under normal circumstances be difficult to overcome. To determine the existence of "medical necessity," recourse to professional practice norms must be had. When this occurs, it will be likely that the standards applied by PSRO will be deemed relevant. This would be especially true of the content of any peer review deliberation held at PSRO in regard to procedures utilized by the physician in question.[17]

16. E. Hayt and J. Hayt, *supra* note 4, at 151.

17. See Heilburn, *The Professional Standards Review Organization: Its Impact on Medical Litigation*, Utah L. Rev. 433, at 439-42 (1975).

As a criminal defendant, the physician will be afforded virtually unlimited discovery prerogatives by the courts and can be expected to be provided complete access to committee reports. Consequently, it would serve no purpose to deny such information to the prosecution unit. Furthermore, an important element in establishing a crime is willfulness. If a physician's record has been reviewed by PSRO, and if that physician has been criticized for utilizing improper procedures, yet continues his activities in spite of such knowledge, then such information is important evidence in establishing that the requisite intent for the commission of the crime existed.

Groups such as PSRO, which are charged with peer review responsibilities, generally express some concern that the confidentiality of their records and deliberations will be breached via court discovery processes. The issue of patient protection, and of protection against suits by patients for breach of confidentiality, is met in the application of the following principle:

> In states which have no privileged communications statute, a physician may disclose confidential information with the proper circumstances, as when third parties, such as insurance companies, have an interest in the subject matter, and the information is given in good faith, with reason to believe that these communications are true, and without malice toward the person affected. The public authorities, and particularly those enforcing the criminal law, have the right to such information if it pertains to a bona fide investigation.[18]

The remaining and primary concern appears to be that such records will be used against physicians, hospital staffs, or review committees in civil litigation such as a malpractice, defamation or negligence suit. As noted in this article excerpt:

> The issue of discoverability (accessibility) of hospital committee proceedings and reports is usually presented in the context of medical malpractice litigation. Hospital committee records that reflect upon the quality of a physician's professional performance obviously are tempting to the malpractice attorney; they may serve as a source of potential expert witnesses for the plaintiff, or may contain admissions by the defendant. There is a concern that reports of such committees as credentials or utilization review may be subject to pretrial discovery and thereby serve as a source of information to be used against the physician or hospital in litigation.
>
> But curtailing the candid deliberations of these committees because of a fear of the discovery process could eventually lead to the destruction of the benefits of committee review.[19]

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18. Hayt, Hayt, and Groeschel, *supra* note 10, at 1968.

19. Hall, *Hospital Committee Proceedings and Reports: Their Legal Status*, 1 Am. J. of L. and Med. 245, 266 (1975).

In New Mexico, however, extensive protection from civil suit against both complainants and peer review committee members is found in the decision of *Franklin v. Blank.*[20] In that case, the court found that professional societies exercising peer review were engaged in protected quasijudicial behavior. Since communications used in initiating and processing peer review were indispensable to the process, the court found that they also were absolutely exempt from use against the potential defendant in any civil action.[21] Further, a law currently in effect in New Mexico, entitled, *Health Information–Confidentiality–Immunity from Liability for Furnishing,* states that a custodian of confidential medical information may not only furnish such information upon request to a government agency or its agent, but is immune from suit for having done so.[22] Similarly, federal law specificially provides even more extensive protection for complainants and committee members involved in the PSRO review process.[23]

The above-noted state and federal protections essentially eliminate an important line of resistance which might be taken by peer review

20. Franklin v. Blank, 86 N.M. 585, 525 P.2d 945 (Ct. App. 1974).

21. *Id.*

22. N.M. Stat. Ann. § 14-6-1 (1978):
A custodian of information classified as confidential in Subsection A may furnish the information upon request to a governmental agency or its agent, a state educational institution, a duly organized state or county association of licensed physicians or dentists, a licensed health facility or staff committees of such facilities, and the custodian furnishing the information shall not be liable for damages to any person for having furnished the information.

23. 42 U.S.C. § 1320c-6 (1976):
(a) Notwithstanding any other provision of law, no person providing information to any Professional Standards Review Organization or to any Statewide Professional Standard Review Council 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 subdivison thereof) unless–
(1) such information is unrelated to the performance of the duties and functions of such organization or such Council, 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 of any Statewide Professional Standards Review Council or who furnishes professional counsel or services to such Organization or Council, shall be held by reason of the performance by him of any duty, function, or activity authorized or required of Professional Standards Review Organizations or of Statewide Professional Standards Review Councils 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 individuals, in taking such actions, was motivated by malice toward any person affected by such action.

organizations such as PSRO.[24] By law, they are immune from suit when properly exercising their duties and need not, therefore, fear civil actions, by patients or by participating providers, when required to provide committee information to appropriate government agencies, such as the Unit.

There does exist a small amount of case law relating to the denial of discovery of committee reports.[25] In instances where committee reports and deliberations have been denied to parties in a suit, the rationale presented for such denial by the courts has by and large been related to the existence within the state of a physician-patient privilege, and the infringement upon information affecting other nonplaintiff patients who have not provided disclosure authoriza-

24. It is interesting to note that just before this article was submitted for publication, the 34th Legislature of New Mexico passed a bill of potentially substantial impact in this area of disclosure, as relates to Professional Standards Review Organizations. 1979 N.M. Laws ch. 169, entitled, An Act Relating to Health Care Review; Providing a Penalty, has the practical effect of not only providing immunity from civil suit for members of peer-review committees, and for complainants providing information to such committees but, more importantly, this law makes all information in the possession of PSROs strictly confidential as against *all* inquiries and furthermore provides criminal sanctions against disclosure of such information. Two observations immediately come to mind in reviewing this law. The first is that this law, although theoretically applicable to all medical peer-review organizations in New Mexico, is practically speaking, applicable primarily to New Mexico PSRO, and offers greatest protection to that organization. In light of other information available in this article pointing up the medical profession's discomfort at disclosure developments, it should not be a surprise to anyone that physician-oriented PSROs are attempting to fill the breaches in their disclosure defenses. The second observation is that this attempt must fail, since it is well established that federal law prohibits any attempts by the States to legislate in an area which Congress has clearly already pre-empted, as it has here. This relates both to deliberation protections and to disclosure prohibitions, which *are* addressed in the Medicare-Medicaid Anti-Fraud and Abuse Amendments Act. Furthermore, New Mexico has already, by case law, supported the protections explicitly provided for in Federal regulation, in the area of peer-review participation. Franklin v. Blank, 86 N.M. 585, 525 P.2d 945 (Ct. App. 1974). The reasons behind the introduction of this bill, therefore, are open to speculation. It cannot, however, ultimately hurt a peer-review organization to possess the presumption of legality in refusing disclosure of information, thereby placing the costly and time-consuming burden of proof upon the shoulders of those rightfully seeking access to that information.

It is further interesting to note that although the Unit was aware of the existence of this bill prior to its submission, that knowledge had no perceptible effect upon its passage. This is due, at least in part, to the fact that the Unit was not consulted by the sponsors of the bill prior to its submission, even though the Medicaid unit of the Human Services Department was. That department, in turn, issued approval of the language of the bill without consulting with the Unit, although communication between the New Mexico Human Services Department and the Unit in such matters is clearly mandated in the Medicaid laws. This points out, purely as a side comment, the tremendous importance of diligent attention to, and aggressive involvement by the Unit in, passage of legislation. Add to this observations made by Units and proto-Units throughout the country regarding hostility and non-cooperation directed from older, established, physician-oriented State Medicaid agencies toward nascent Units, and a picture of quite a complex battleground situation emerges.

25. A similar review of the case law, although in a slightly different context, can be found in Springer, *Professional Standards Review Organization: Some Problems of Confidentiality,* Utah L. Rev. 361 (1975).

tions.[26] Even in states where the privilege does exist, however, if the records sought do not contain information relating to other patients, it would appear that the information cannot be withheld.[27] Case law in this specific area appears to be generally determined by whether or not a state has one or both of two statutes—a physician-patient privilege statute, and one adopted to partially or entirely forbid the use of committee reports.

In the federal arena, the law on this point is somewhat unclear. In a leading case, *Bredice v. Doctor's Hospital, Inc.*,[28] in which the court held that minutes and reports of committee meetings were not subject to discovery absent a showing of exceptional necessity. This policy was eroded in *Gilman v. United States*,[29] where the court allowed discovery of the statements of hospital personnel given to a board of inquiry.[30]

Various state courts have found that records pertaining to a physician's work could not be discovered. This decision sometimes has been based on the fact that the records contained privileged information on other patients.[31] Another reason for denying the discoverability of records is the existence of a specific state statute prohibiting disclosure of "proceedings, minutes, records, and reports of such committees, together with all communications originating in such committees. . . ."[32] Other courts have decided that tissue and executive committee reports were not discoverable under state law, but that hospital administration records were discoverable.[33] Other courts have been more liberal in holding that hospital reports prepared by members of the medical staff relating to the professional activities of other staff physicians were subject to discovery,[34] and in stating that broad latitude should be accorded pre-trial discovery in order to properly facilitate preparation of the case.[35]

26. *See generally,* E. Hayt and J. Hayt, *supra* note 4; Hayt, Hayt and Groeschel, *supra* note 10; Judd v. Park Avenue Hosp., 37 Misc. 2d 614, 235 N.Y.S. 2d 843 (Sup. Ct.), *aff'd,* 18 A.D.2d 766, 235 N.Y.S. 2d 1023 (1962).

27. Young v. King, 136 N.J. Super. 127, 344 A.2d 792 (1975).

28. Bredice v. Doctor's Hospital, Inc., 50 F.R.D. 249 (D.D.C. 1970) *aff'd,* 479 F.2d 920 (D.C. 1973).

29. Gilman v. United States, 53 F.R.D. 316 (S.D.N.Y. 1971).

30. *Id.* The court followed *Bredice* in part in denying access to the report written by the board.

31. Judd v. Park Avenue Hosp., 37 Misc. 2d 614, 235 N.Y.S.2d 843 (Sup. Ct.), *aff'd,* 18 A.D.2d 766, 235 N.Y.S.2d 1023 (1962).

32. Oviatt v. Archbishop Bergan Mercy Hosp., 191 Neb. 224, ____, 214 N.W.2d 490, 492 (1974).

33. Matchett v. Superior Court, 40 Cal. App.3d 623, 115 Cal. Rptr. 317 (1974).

34. Nazareth Literary and Benevolent Inst. v. Stephenson, 503 S.W.2d 177 (Ky. Ct. App. 1973). These included internal reports from hospital medical staff committees, and related to the professional competence of the physician.

35. Gureghian v. Hackensack Hospital, 109 N.J. Super. 143, 262 A.2d 440 (Super. Ct. L. Div. 1970).

It is interesting to note the results reached in California prior to its passage of the non-discovery statute. In *Kenney v. Superior Court in and for the County of Yolo,*[36] the patient-plaintiff was permitted to discover hospital records relating to disciplinary proceedings concerning the doctor-defendant. The court stated in regard to committee records that:

> Records of disciplinary proceedings, or of the status of a doctor on a hospital staff, or of his removal therefrom, may or may not be admissible in evidence. Even if inadmissible, such records may very well point the way to evidence admissible in a medical malpractice action . . .[37]

After the passage of a non-discovery statute, a California court found that the tissue and executive committee reports were not discoverable but that the hospital administration records were.[38]

If the reasoning found in the above cases are applied to the existing law in New Mexico, it is clear that liberal discovery of such records is indicated. New Mexico does not have a nondiscovery statute which could be relied upon as a basis to deny discovery. This state does not recognize the existence of a physician-patient privilege. The cases which denied discovery on other grounds are those which support extensive discovery, with the exception of *Bedrice,* which relied on public policy considerations which were subsequently liberalized by the *Gilman* case. Since New Mexico has determined that special confidentiality protection in physician-patient relations is unnecessary, the logical policy extension would appear to support a similar absence of discovery restrictions relating to professional evaluations and peer review. This position is supported by the fact that although many states have seen fit to insure non-discoverability of such information by passing a specialized statute, New Mexico has not. As discussed earlier, New Mexico has implicitly decided to extend civil suit protection to parties who find themselves legally compelled to disclose confidential information.[39]

FEDERAL REGULATIONS RELATING TO PSRO

Since the creation of the PSRO's it has been widely recognized that the laws and regulations in this area which relate to confidentiality of records have been almost hopelessly ambiguous. As related in a law review article:

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36. Kenney v. Superior Court, 225 Cal. App. 2d 106, 63 Cal. Rptr. 84 (1967).
37. *Id.* at ____, 63 Cal. Rptr. at 87.
38. 40 Cal. App. 3d 623, 115 Cal. Rptr. 317 (1974).
39. Franklin v. Blank, 86 N.M. 585, 525 P.2d 945 (Ct. App. 1974). See also, *supra* note 24.

> The federal legislation which creates PSRO and defines its scope and functions is yet another experiment in cost containment which has not been sufficiently tested. The legislation, as it stands, raises important legal and practical problems, and creates profound ambiguities which must be analyzed and clarified. Nowhere is this more evident than in the provisions of the law governing confidentiality. In addition, the sometimes secretive manner in which the PSRO law has been implemented by promulgations and pronouncements without sufficient prior comment and critical analysis, should give everyone pause. When the PSRO regulations are promulgated, the problems arising under this new system of peer review will hopefully be resolved so that patients, health care providers, and practitioners can reap the benefits promised by the proponents of the law.[40]

The basic records requirement for persons or institutions providing services under the State Medicaid Plan[41] is qualified by the specific directive contained in another section, in which data disclosure to the State by the institution known as PSRO is delineated.[42]

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40. Springer, *Professional Standards Review Organization: Some Problems of Confidentiality*, Utah L. Rev. 361, 379-80 (1975).

41. 42 C.F.R. 450.21 (1977):
> A State plan for medical assistance under Title XIX of the Social Security Act must provide for agreements with every person or institution providing services under the State plan under which such person or institution 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 (or the Secretary) with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency (or the Secretary) may from time to time request.

42. 42 U.S.C. 1320 c-15 (1976 Supp. I):
> (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, (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, or (3) in accordance with subsection (b) of this section.
>
> (b) . . . A Professional Standards Review Organization shall provide, in accordance with procedures established by the Secretary, data and information (1) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse, which data and information shall be provided by such organization to such agencies at the request of such agencies at the discretion of such Organization on the basis of its findings with respect to evidence of fraud or abuse.
>
> . . .
>
> (d) . . . No patient record in the possession of a Professional Standards Review Organization, a Statewide Professional Standards Review Council, or the Nation Professional Standards Review Council, shall be subject to subpena [sic] or discovery proceedings in a civil action. . . .

None of the language of those sections, however, clearly spells out the rights of a Unit to information in possession of a PSRO, although it is indisputable that confidential information may under no circumstances be demanded of a PSRO for use in civil litigation. Subsection (b) of Section 1166 muddies these waters even more in its assertion that the "Organization" (PSRO) may provide information to agencies investigating fraud and abuse upon their request, but at *its* discretion.[43] One might interpret this phrase to indicate that PSRO has total control of the release of confidential information, even in criminal cases. A more accurate reading of this language, however, is derived by noting the last few words of that sentence in particular, and by reviewing the role of PSRO in referring cases for investigation. PSRO is charged with the responsibility of referring potential fraud and abuse cases to the appropriate state agency.[44] It is in this context that the clause, "provide . . . data and information . . . at the discretion of such Organization on the basis of its findings with respect to evidence of fraud and abuse . . ." makes the most sense. This section can be read to confer discretion upon PSRO to make referrals based solely on its judgment of the possibility of fraud as derived from the information available to it. The discretion does not extend to the appropriateness of information available to the Unit where a case has already been opened for investigation.

The Secretary of DHEW is empowered to promulgate regulations specifying the conditions under which confidential information may be released.[45] Unfortunately, a void exists in this area for guidelines relating to PSROs and Units. Such is not the case as between Units and the State Medicaid Agencies, however:

> In a State with a State Medicaid Fraud Control Unit established and certified under Section 450.310, . . . the State agency will:
>
> (i) Refer all cases of suspected fraud to the Unit.
>
> (ii) Comply promptly with a request from the Unit for access to, and free copies of, any records of information in the possession of the Medicaid Agency or its contractors if the Unit determines that it may be useful in carrying out its responsibilities under this section.
>
> (iii) Comply promptly, and without charge, with a request from the Unit for computerized data stored by the Medicaid agency or its contractors in such form as the Unit may request, if the Unit

43. *Id.*

44. This requirement is reiterated most recently in proposed regulations reported in [1978 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶29,237, at §474.3 and §474.10(e)(2).

45. 42 U.S.C. 1320c-15 (1976 Supp. I).

> determines that this data may be useful in carrying out its responsibilities . . .[46]

It would appear from (ii) and (iii) that the Unit is being encouraged in its investigations by being granted as complete access to Medicaid records as is possible. This conclusion is supported by another guideline, which reiterates that a fraud-control program can only be effective through full cooperation involving full access to information, and which conditions the existence of the Unit upon the availability of such records.[47]

At first glance, it would appear from the regulations that the Unit is to have a free hand in acquiring all data relevant to its investigations. That impression, however, is contradicted if one accepts the assumption that the Unit's access to PSRO data will be channeled strictly through the Medicaid Agency. A PSRO action transmittal provides clarification as to the limited data access available to the State Medicaid Agency:

> Based on the legislative change of P.L. 95-142, PSRO's are now required to provide information, upon request, to the state Medicaid agency if the disclosure is authorized by the Secretary or if the information is submitted by the PSRO to the Secretary routinely on a periodic basis. It is the Department's intent to assure that the information PSRO's are authorized to disclose will be limited to that appropriate to state/PSRO interrelationships. Information applicable only to PSRO review, e.g., medical care evaluation studies, personnel management information, or health care practitioner profiles utilizing the entire PSRO data base does not meet this limitation and may not be shared with the Medicaid Agency.[48]

Furthermore, the Secretary has provided specifications for the development of additional regulations.[49] Extracting the Policy State-

46. 42 C.F.R. 450.80(a)(8).

47. Medicare and Medicaid Guide (CCH) ¶21,830, *Preamble to Ref. §450.8(a)(8) and (d) . . . Supplementary Information . . .*

> . . . 3. *Cooperation Between The Unit and The Medical Agency.*—It is evident that a comprehensive, effective fraud-control program can be achieved only through close cooperation between the Fraud Control Unit and the Medicaid Agency. The Unit must have access to information in the possession of or available to the Medicaid Agency. A Unit may not qualify unless the state permits access by the Unit to medical records of Medicaid patients, in order to determine the extent of the care provided. These records must be made available regardless of whether the patient or any other person consent. In amendments to existing regulations (42 C.F.R. 450.21) made necessary by Sec. 9 of Pub. L. 95-142, the Secretary will consider making direct access by a Unit to patient records a condition of participation by providers.

48. PSRO Action Transmittal No. 67, March 21, 1978. [1978 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶28, 924.

49. Medicare and Medicaid Guide (CCH) ¶12,882.12, PSRO Action Transmittal No. 16, as amended by PSRO Action Transmittal No. 41.

ments which appear to be most relevant to this discussion, it would appear that PSRO data, sanction reports and deliberations are not subject to subpoena or discovery in civil actions, nor can PSRO records be "physically removed from and/or [be] made available or transmitted outside the custody of the PSRO."[50]

The Secretary has provided some needed clarification on PSROs. A "draft transmittal" was distributed by the Director of that office for review and comment by PSROs throughout the country, in July of 1978.[51] At page two of the draft, the disclosure problem is summarized as follows:

> The Congress recognized that the confidentiality provisions (section 1166 of the Social Security Act, as enacted in P.L. 92-603), had been perceived as preventing the disclosure of information on fraud or abuse by a PSRO. To remedy this problem, Congress enacted section 1166 (b)(1) to specifically permit disclosure of fraud and abuse information when an agency requests it. Moreover, under section 1166(a)(1), the assistance of agencies recognized by the Secretary as having responsibility for the identification and investigation of fraud or abuse in the Medicaid or Medicare programs is a "purpose of this part" for which disclosures may be made without the necessity for a request from an agency or for regulations specifically authorizing this disclosure. To protect the confidentiality of the data and information the Act also provides that it can be released only to: 1) Federal or State agencies recognized by the Secretary as having responsibility for identifying and investigating fraud or abuse of the Medicare or Medicaid programs, and 2) that the agency receiving such information may not redisclose it, unless such redisclosure is made in a judicial, administrative, or other formal legal proceeding resulting from the investigation. Failure to adhere to this

50. *Id.*:

> 17. Disclosure: civil litigation–Subject to regulations governing administrative hearings under Section 205(b) of the Social Security Act, privileged data and information, PSRO sanction reports and PSRO deliberations shall not be subject to subpoena or discovery proceedings in any civil action; nor shall any PSRO member, employee or consultant be subject to subpoena or discovery proceedings for the purpose of obtaining information relating to the above.
>
> 18. Disclosure: claims appeals.–In claims appeals disclosure of privileged data for information to other than the claimant or his representative must be limited to those parties involved in the appeals process.
>
> 19. Disclosure: PSRO deliberations–PSRO deliberations concerning patients, practitioners and facilities which serve as a basis of PSRO decisions shall not be disclosed outside the PSRO except to federal program assessment personnel conducting on-site visits to the PSRO. The record of PSRO deliberations may not be physically removed from and/or made available or transmitted outside the custody of the PSRO.

51. Letter from Michael J. Goran, M.D., Director of the Office of Professional Standards Review Organizations, H.E.W., to: Planning and Conditionsal PSROs; Statewide Councils; Regional PSRO Project Officers (July 26, 1978).

> restriction on redisclosure may subject the individuals involved to civil or criminal penalties.

The clearest explication of the draft's contents is found in Section XI of the transmittal, where it is stated that there exist three critical requirements which must be satisfied before a PSRO is compelled to release information in its possession: 1) the requesting agency must be recognized by the Secretary as an appropriate Medicaid fraud and abuse agency, 2) the agency must be conducting an investigation relating to its request, and 3) there must be a determination by PSRO that the requested information is relevant to a determination of fraud or abuse. The first two requirements present no problems, since the Unit is recognized by the Secretary as New Mexico's Medicaid Fraud and Control Unit, and since verification of the Unit engaging in an appropriate investigation is merely a factual determination. The third requirement, however, involves a judgment call by PSRO as to whether or not the information request is "relevant." Fortunately, the draft contains clarification of what may or may not be relevant. In the draft, it is pointed out that "Only information that the PSRO has determined is relevant to an ongoing investigation of possible fraud or abuse may be provided." Definitions are then provided:

> Generally, the concept of fraud is one of misrepresentation of material facts related to Medicare or Medicaid billing. The most common type of fraud is the billing for services not rendered. . . . Abuse, on the other hand, generally concerns a determination that either excessive, inappropriate, harmful or poor quality health care has been provided to patients by a particular practitioner or provider. The most common type of abuse appears to be the provision and subsequent billing for excessive and unnecessary care.

The draft goes on to define relevancy, in the context of these investigations, in such a fashion as to make virtually all PSRO information related to the subject being investigated by the Unit available to the Unit upon request, and upon a minimal factual satisfaction of the disclosure requirements.[52]

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52. *Id.:*

> This finding is not limited to potential abuses that could result in a PSRO sanction report, but would encompass all indications of fraud or abuse of the Medicare or Medicaid programs.
>
> Additionally, this is not a finding that such information would be determinative of fraud or abuse, but merely that it may be relevant to such a determination of fraud or abuse if it would cause the PSRO to have reason to believe a fraudulent or abusive act had or had not occurred.
>
> . . . .
>
> The Act permits the PSRO to provide recognized agencies with relevant information of possible fraud or abuse.

It is possible, in view of PSROs consistent past stance in denying access to their information, that PSRO will attempt to resurrect the old issue of "discretion" as found in Section 1166. The language of this draft, however, is explicit enough to turn the "discretion" given to PSRO into a simple check-off procedure. It still remains for the draft to be formalized,[53] but in the July 26, 1978 cover-letter to the draft, written by the Director of OPSRO, PSROs are instructed that "The procedure set forth in this transmittal should be used immediately, without waiting for the end of the comment period, to determine if the provision of data or information for fraud and abuse in a particular situation is appropriate under the Act, as now amended."[54]

As the situation stands, it is clear that the *Medicaid Agency* may have information only as specified above. The *Unit,* however, is not the Medicaid Agency and is engaged in activities which are substantially different from those undertaken by the Medicaid Agency, which is primarily interested in program management. Consequently, the rationale behind restricting data access by the Medical Agency may not apply to the Unit. Logically, it should not, since considerations of importance in criminal prosecutions are quite different from those of importance in administering a Medicaid program. Under the circumstances, it is absurd to assume that regulations were passed which would restrict a criminal prosecutor solely to use data in the possession of the State Medicaid Agency. This interpretation of the ambiguous language must be rejected and a reasonable alternate sought. As for New Mexico, if its Medicaid Agency is restricted in its access to PSRO information, and if the Medicaid Agency is simply one of many information conduits to the Unit, as is logical, then separate and more complete access to PSRO information by the Unit

> This information must be provided where a proper request has been made, but only the PSRO has determined that the agency making the request is recognized as a fraud or abuse agency to the Secretary, that there is an ongoing investigation in progress and that the information is relevant to a determination of fraud or abuse. The PSRO must consider all information it receives from the requesting agency as confidential and protect it from improper disclosure.
>
> In addition, the PSRO may on its own motion provide such agencies with data and information as the result of the PSRO's finding that fraud or abuse has or may have occurred.
>
> The Regional Office of the Office of Program Integrity will assist the PSRO where there is a question of whether the agency making the request, or the information requested, is proper.

53. In a January, 1979, telephone discussion with the Director of the Dallas Office of Project Integrity, HEW, this writer asked concerning the status of the "draft." Although no specific citation was available, this writer was advised that the "draft" had gone into effect as a formalized Action Transmittal.

54. Letter from Michael J. Goran, M.D., *supra* note 51.

is not only feasible, but is absolutely necessary to guarantee the diligent pursuit of investigations of criminal cases.

CONCLUSION

Medicaid Fraud Control Units face interesting problems in their pursuit of medical information needed for full-fledged provider fraud investigations. Not only do restrictive information disclosure statutes and policies exist in some states, but Units also face stiff opposition from the medical profession by virtue of its incursions into heretofore sacrosanct areas of privilege.

As the analysis of this article shows, the New Mexico Unit should find itself in the enviable position of having to encounter virtually no legal barriers in its acquisition of desired medical information. New Mexico has no statutory physician-patient privilege, and only one law of dubious legal validity which might restrict access to committee reports and deliberations. A review of the federal law as related to the Unit discloses that the intent of the Act, as manifested by implementing regulations and guidelines, is to provide Units with total access to all information which is in the possession of PSRO's and which might be relevant to its fraud investigations.