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CAN PSRO PROCEDURES BE BOTH FAIR AND WORKABLE?

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The 1972 Amendments to the Social Security Act mandate the establishment of nonprofit associations of practicing physicians, called Professional Standard Review Organizations (PSROs), as part of the machinery implementing Social Security Act medical service programs.[1] Under these amendments, the Department of Health, Education and Welfare (HEW) must enter into agreements assigning certain administrative functions in implementing the Medicare, Medicaid, and Maternal and Child Health programs to PSROs.[2] The statute directs PSROs to develop and apply "suitable procedures" to ensure "that the services for which payment may be made under this chapter [the Social Security Act] will conform to appropriate professional standards for the provision of health care. . . ."[3]

Initially, PSROs will review services provided on an in-patient basis at acute care hospitals, for which payment is to be made under the Social Security Act, to determine if these services (1) are medically necessary, (2) meet professionally recognized standards of quality, and (3) are provided in the most appropriate and economical setting.[4] In exercising their review responsibility, PSROs are to establish "norms of care, diagnosis, and treatment" to be used as "principal points of evaluation and review."[5] They are also expected to develop and review "profiles" of patient care data and to decide whether medical services provided by doctors or institutions meet the

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In preparing this article, the authors visited pilot PSRO projects to determine what workable procedures might be developed for PSROs. A contract from the Department of Health, Education and Welfare partially supported their work. The views expressed are those of the authors.

1. Social Security Amendments of 1972 §§ 1151-1970, 42 U.S.C. §§ 1320c to 1320c-19 (Supp. III, 1973). Unless otherwise indicated, all subsequent citation to sections refers to the Social Security Amendments of 1972.
2. *Id.* § 1152(a), 42 U.S.C. § 1320c-1(a).
3. *Id.* § 1151, 42 U.S.C. § 1320c.
4. *Id.* § 1155(a)(1), 42 U.S.C. § 1320c-4(a)(1).
5. *Id.* § 1156(a), 42 U.S.C. § 1320c-5(a).

applicable standards of medical necessity, quality, and economy of setting to qualify for reimbursement.[6]

The targets of PSRO actions are the treating doctor and the institutional provider (often a hospital which orders or provides the health care services), but the sanction—nonavailability of Medicare, Medicaid, or Maternal and Child Health program funds to pay for the cost of services—has a most serious impact on the patient.[7] Thus the procedures adopted by PSROs in carrying out their adminstrative functions are of great importance to each of these parties.[8] While the statute recognizes the separate "interests" of the patient, doctor, and hospital in a PSRO determination, it provides sketchy procedural guidance for PSROs.[9] Patients, doctors, and hospitals are each

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6. *Id.* § 1155(a)(4), 42 U.S.C. § 1320c-4(a)(4).

7. Doctors and hospitals are themselves obliged to assure that services provided under the Social Security Act meet standards of medical necessity, quality, appropriateness, and economy of setting. *See id.* § 1160(a), 42 U.S.C. § 1320c-9(a). PSROs have other related functions—conducting studies, collecting and evaluating data, and educating.

PSROs are directed to use existing hospitals or other health care facility or organization review mechanisms, such as utilization review committees, *see* note 20 *infra*, subject to a PSRO decision that these bodies meet PSRO standards. *Id.* § 1155(e), 42 U.S.C. § 1320c-4(e). Institutional review committees must also meet all statutory and HEW imposed guidelines applicable to PSROs in performing these functions.

8. *See* pp. 418-22 *infra*.

9. Section 1159a, 42 U.S.C. § 1320c-8(a) (Supp. III, 1973) provides:

> Any beneficiary or recipient who is entitled to benefits under this chapter (other than subchapter 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 1320c-4(a) of this title shall, after being notified of such determination, be entitled to a consideration thereof by the Professional Standards Review Organization
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> . . . .

This provision applies to determinations under section 1155(a)(1), 42 U.S.C. § 1320c-4(a)(1) (Supp. III, 1973), which requires that the services (1) be medically necessary, (2) meet professionally recognized standards of quality, and (3) be supplied in the most economical setting. It also applies to determinations made in advance under section 1155(a)(2), 42 U.S.C. § 1320c-4(a)(2) (Supp. III, 1973), which requires that elective admissions to hospitals or other health care facilities and health care services consisting of extended or costly courses of treatment be medically necessary and supplied in the most economical setting. For the present, these review responsibilities are limited to services provided by or in institutions unless the PSRO has made a request to the Secretary of Health, Education and Welfare (HEW) that it be able to review other health care services and the Secretary has approved such request. *Id.* § 1155(g), 42 U.S.C. § 1320c-4(g).

Throughout the Act a patient is referred to as a "beneficiary" or "recipient" entitled to benefits under the Act; a doctor is a "practitioner," and a hospital, *inter alia*, is a "provider." It should be noted that the provider may have a dual role. Its utilization review committee may be delegated the PSRO's review functions; at the same time it has party status before this review committee.

entitled to be "notified" of a PSRO determination and to a "reconsideration thereof" by the PSRO.[10] Additionally, practitioners and providers are entitled to "notice" and an "appropriate opportunity for discussion and review" immediately after a proposal for providing a health care service has been denied.[11]

Because HEW has set as the PSRO's first task the review of in-patient services provided to Medicare, Medicaid, and Maternal and Child Health patients,[12] this article will explore procedures for making such determinations, and for providing notice and reconsideration which are required as part of PSRO in-patient service review.[13]

I. The Establishment of PSROs

A. Statutory Background

The congressional mandate for the PSRO program of "peer review"—review by practicing physicians of the appropriateness and quality of medical services provided by other practicing physicians—was the product of high expectations but very modest prior experience.[14] The provisions were intro-

10. The statutory language is murky, and it is not clear whether a notification of favorable as well as adverse PSRO decisions must be made. A possible construction, adopted by HEW, is that notification is only required with respect to an adverse decision because the statute speaks in terms of the rights of dissatisfied patients, doctors or providers. *See* pp. 426-29 *infra*.

11. *See* § 1161, 42 U.S.C. § 1320c-10 (Supp. III, 1973). The Act provides for review of PSRO reconsiderations, permitting an appeal to a statewide PSRO Council when the matter in controversy is $100 or more. A hearing before the Secretary of HEW under § 205(b) of the Social Security Act, 42 U.S.C. § 405(b) (1970), may then be sought by the beneficiary or recipient (but not by a provider or practitioner). The decision of the Secretary is subject to judicial review as prescribed in 42 U.S.C. § 405(g) (1970), only if the matter involves $1,000 or more. *See* § 1159, 42 U.S.C. § 1320c-8 (Supp. III, 1973).

12. HEW guidelines for PSROs are published in U.S. Dep't of Health, Education and Welfare, P.S.R.O. Program Manual (March 15, 1974) [hereinafter cited as P.S.R.O. Manual]. The Manual has not yet been published in the Federal Register. Thus the extent to which its directives are binding is open to question. *Cf.* Thorpe v. Housing Author., 393 U.S. 268, 274-76 (1969).

13. Because they may ultimately prove to be the most important of the PSRO administrative actions, procedures related to reviews directed at individual doctors, hospitals, or other providers, and determinations with respect to the use of institutional review committees, require a comprehensive discussion beyond the bounds of this article.

14. *See, e.g.*, S. Rep. No. 1230, 92d Cong., 2d Sess. 258 (1972) [hereinafter cited as Senate Report]; Proceedings of the American Medical Association's House of Delegates, *quoted in* American Society of Internal Medicine, PSRO—A Guide to Its Implementation Through Peer Review (1973). Medicine self-policing is not a novel concept. Nearly every hospital has a tissue committee checking reports on supposedly diseased organs to make sure their removal was necessary. Utilization review is now required for hospital accreditation. Medical records committees and death committees are common.

duced as part of the Social Security Act Amendments by Senator Charles Bennett of Utah, ranking minority member of the Senate Finance Committee.[15] PSROs are modeled after a few pilot programs established by doctors organized as "medical foundations."[16] Programs such as those in Sacramento, California (CHAP), New Mexico (HAPP), and Illinois (HASP) were performing out-patient claims and hospital utilization review using peer review mechanisms.[17] However, the claims and utilization review of these programs had a limited scope, usually applying fairly simple standards.[18] In most cases, reviews were based on published norms for typical lengths of stay (specified by diagnosis, age, sex, with or without surgery, and with multiple diagnoses).[19]

Although Medicare had required hospitals to perform their own utilization review,[20] the results were not impressive.[21] Congress, hoping that an-

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Practice by physicians organized into groups known as "medical foundations" is increasing, and peer review is an important function. *See id.* at 1-2. *See also* B. DECKER & P. BONNER, PSRO: ORGANIZATION FOR REGIONAL PEER REVIEW 14 (1973). For a critique of peer review, see L. Keelty, M. Lam, R. Phillits, J. Quirin & R. McCleery, One Life—One Physician; An Inquiry Into the Medical Profession's Performance in Self-Regulation (Center for the Study of Responsive Law, 1970).

15. The PSRO proposals were first introduced as an amendment to the pending Social Security Bill in 1970. 116 CONG. REC. 29605 (1970). No final action was taken on the bill and it was reintroduced as Amendment 823 to the Social Security Amendments of 1972 on January 25, 1972. 118 CONG. REC. 1017 (1972).

16. *See* SENATE REPORT 257-58. These foundation programs, along with similar pilot efforts in San Joaquin, California, and the states of Georgia and Colorado, were discussed in the Senate hearings in 1972. *See Hearings on H.R. 1 Before the Senate Comm. on Finance*, 92d Cong., 2d Sess., pt. 2, at 1049-50 (1970) (remarks of Senator Bennett); Testimony of F. William Dowda, Secretary, American Ass'n of Foundations for Medical Care, *id.*, pt. 3, at 2512-15.

17. Among the pilot PSRO projects were several funded by HEW under the name of Experimental Medical Care Review Organizations (EMCROs). For an evaluative study of the EMCROs, see U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, EMCRO PROGRAMS, (HEW Publication No. (HSM) 73-3017, 1973) [hereinafter cited as EMCRO PROGRAMS]. (This study was conducted by B. Decker and P. Bonner, for HEW. *See* note 14 *supra*).

18. *See id.* at 153-67, 176-77. *See also* Flashner, Reed, Coburn, & Fine, *Professional Standards Review Organizations—Analysis of Their Development and Implementation Based on a Preliminary Review of the Hospital Admission and Surveillance Program in Illinois*, 223 J.A.M.A. 1473 (1973), and the critique of this enthusiastic appraisal in an unpublished letter from David M. Kinzer, Executive Vice-President, Illinois Hospital Ass'n, to the Editor of the *Journal of the American Medical Association* (May 29, 1973). This observation was strengthened by the authors' visits to some of the projects.

19. *See* B. DECKER & P. BONNER, *supra* note 14, at 39.

20. These requirements, implementing the Social Security Act, 42 U.S.C. § 1395x(k) (Supp. III, 1973), *amending* 42 U.S.C. § 1395x(k) (1970), are the subject of HEW regulations recently amended. 39 Fed. Reg. 41604-18, *amending* 20 C.F.R. § 405.801-.872 (1974). HEW's regulations contemplate that utilization review requirements are superceded by PSRO procedures as the PSROs become operational. There are no specified

other approach might do better, therefore assigned responsibility to local practicing physicians.[22] A very ambitious program was enacted providing for comprehensive PSRO review of the services provided each patient, as well as PSRO monitoring of the patterns of practice of doctors both inside and outside institutional settings. The object of these reviews is described by the legislation in sweeping terms; as noted above, PSROs are to decide if services are "medically necessary" and provided in accordance with "professionally recognized standards."[23] What is medically necessary and professionally acceptable will be defined by the PSRO programs themselves in their development of norms. However, evaluators of pilot review projects, now helping to prepare PSROs for their job, concede that there is an enormous gap between the task set for PSROs under the statute and the level of experience

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procedural safeguards for the decisionmaking of utilization review committees. However, when they act as delegates of PSROs, they must meet standards required for PSROs.

HEW's utilization review regulations are under challenge in American Medical Ass'n v. Weinberger, No. 75-C-56 (N.D. Ill., filed Feb. 20, 1975). The AMA contends (1) that the utilization review programs violate the constitutional right of physicians to practice medicine and the constitutional right of patients to receive medical care in accordance with their doctor's best judgment, and (2) that institution of the program without specific statutory authorization exceeds the Secretary's authority, contravening sections of the Social Security Act. Just prior to the printing of this article, Judge Julius J. Hoffman granted a preliminary injunction prohibiting HEW from implementing the new regulations which were to become effective July 1, 1975. *See* N.Y. Times, May 28, 1975, at 24, col. 1 (city ed.). The court enumerated many grounds upon which it believed the AMA was likely to prevail. These included serious doubts that the format for utilization review is workable, with particular doubt that admission review within one day of such admission will force a decision by the reviewing physicians even before they can receive the results of "tests required to judge the correctness of the decision to admit." *Id.* at col. 3.

Another recent challenge to the PSRO law, raising similar questions of the constitutional rights of doctors and patients, was defeated; a three judge district court ruled that the PSRO law in which Congress explicitly established a medical utilization review program meets all constitutional standards. Association of Am. Physicians & Surgeons v. Weinberger, No. 73-C-1653 (N.D. Ill. May 8, 1975). *See* note 35 *infra.*

21. *See* SENATE REPORT 255-56. Generally these efforts were successful only where there was a shortage of hospital beds. An Evaluation of the Effectiveness of Utilization Review Activities in Hospitals and Extended Care Facilities 10-12 (HEW study, published by Arthur D. Little, Inc., Cambridge, Mass., Dec. 21, 1972).

22. A goal of the PSRO program, as of the utilization review program, is to curb the rising costs of health care by eliminating unnecessary utilization. *See* SENATE REPORT 260. This is viewed as improving the "quality" of medical care because "[u]nnecessary hospitalization and unnecessary surgery are not consistent with proper health care." *Id.* at 254. However, it is also possible that a PSRO could find underutilization of health services and facilities. *See* Brook, *A Skeptic Looks at Peer Review*, PRISM, October, 1974, at 29. Passage of the PSRO amendments increased HEW's power to impose sanctions for overutilization and for provision of unnecessary services. *See* Mount Sinai Hosp. v. Weinberger, 376 F. Supp. 1099, 1135 (S.D. Fla. 1974).

23. *See* note 9 *supra.*

of the prior programs. They explain that "the scope of the review program envisioned is literally enormous, clearly straining, if not exceeding, the state of the art and the resources of most areas."[24] Moreover, they point out that the money needed in order for PSROs to do a good job may not be available.[25]

This lack of needed expertise and finances, coupled with a wide-ranging mandate for action and strong pressure for results, provides a shaky foundation for the development of fair and workable procedures for some 203 new administrative bodies.[26] The pilot review projects used simple administrative procedures. Controversies were handled at conferences between the attending doctor and the physician reviewer. In a few cases a more senior doctor or medical committee was brought in, but the patient was not involved.[27] PSROs cannot expect that such measures will suffice.

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24. B. DECKER & P. BONNER, CRITERIA IN PEER REVIEW 8 (HEW study, published by Arthur D. Little, Inc., Cambridge, Mass., 1974). In the House of Representatives, it had been proposed that HEW further develop experiments and demonstrations of peer review systems. *See* H.R. REP. No. 231, 92d Cong., 2d Sess. 16 (1972). HEW Secretary Richardson supported peer review efforts, but stressed the need for further development. *See Hearings on H.R. 1*, *supra* note 16, at 45. The Senate Finance Committee apparently experienced no such qualms. It concluded, "Experience by these organizations [the pilot foundation programs] has provided the committee with convincing evidence that peer review can—and should—be implemented on an operational, rather than merely an experimental basis." SENATE REPORT 258.

25. B. DECKER & P. BONNER, *supra* note 24, at 8.

26. HEW has designated 203 PSRO areas. *See* 42 C.F.R. § 101 (1974).

27. Major PSRO prototype programs report as follows:

Programs	Number of Cases "Appealed" Beyond a Discussion With the Physician Advisor
Program One:	
One of two major PSRO prototypes: began implementation of hospital admissions review on pilot basis circa 1971.	Two cases since program began.
Program Two:	
One of two major PSRO prototypes: began implementation of hospital admissions review on pilot basis circa 1970.	Currently one or two cases monthly, out of approximately 4,000 hospital admissions monitored monthly.
Program Three:	
38 months of program operation.	One case since program began.
Program Four:	
Information unavailable.	"Less than 1%;" refused to supply clarifying data.
Program Five:	
18 months of program operation; approximately 2500 reviews.	None.

The PSRO program contemplates the application of diverse and relatively untried criteria.[28] More comprehensive procedural safeguards must be implemented in order to protect affected patients, as well as doctors and hospitals.[29] Naturally, the more complicated the administrative procedures and safeguards, the greater the cost of the program. The best response to a concern that such procedures are too expensive and, therefore, defeat the cost-saving purposes of the program, is for PSROs to proceed cautiously, beginning with the application of simple criteria in limited circumstances and pro-

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During a recent month, one of the major prototypes reported for one typical hospital a total of 2,836 discharges:

755 of these discharges were cases in which length of stay extensions were granted, 75% were granted by a nonphysician review coordinator without seeking the physician advisor's approval;

355 cases were reviewed by a doctor;

204 of the 355 cases were cases in which the advisor approved a length of stay extension; and

151 cases involved disapprovals of the attending physician's proposal.

The other chief prototype explained that out of approximately 3,900 hospital admissions monitored monthly, there are 50 cases in which the attending physician's proposal is not approved (over 80% of these concern length of stay).

For comparison, a recently implemented program offered the following data:

5,691 admissions monitored in one month;

3,131 length of stay extensions granted;

1,702 cases reviewed by physician advisor—55 involved denials and approximately two cases were appealed.

Series of telephone interviews with the pilot projects, October, 1974. For a detailed account of one of the major PSRO prototypes, see Nelson, *Relation Between Quality Assessment and Utilization Review in a Functioning PSRO*, 292 NEW ENG. J. of MED. 671 (1975) (out of 34,000 cases screened by the program, approval of the proposed stay or treatment was withdrawn in 47 cases).

28. Moreover, PSROs are expected to "take full advantage of rapidly evolving computer technology." SENATE REPORT 257. The congressional expectation was that the development of standards as well as the screening processes applying these norms could be automated, thus conserving "physician review time." SENATE REPORT 264-65. For a discussion of the "sweeping trend" toward a heavy reliance on statistically derived indices of care, see Coulter, *Peer Review Tutor of Judge*, 230 J.A.M.A. 1161-63 (1974). *See also Your Peer, The Computer*, MED. ECON., May 14, 1973, at 15.

29. The P.S.R.O. Manual explains that the review system is to be "comprehensive . . . simultaneously pursu[ing] the assessment and assurance of quality across a spectrum of disease entities, service and service delivery problems while also operating as an ongoing mechanism to assure appropriate utilization of services." P.S.R.O. Manual ch. VII, § 701, at 3. Some PSROs appear to be planning to use complicated and broad ranging criteria—standards which are newly developed, and need to be proved and refined. *See* B. DECKER & P. BONNER, *supra* note 24, at 104-06, 138. Decker and Bonner set out criteria developed by the EMCROs. A quick look suggests the magnitude of the problem facing PSROs which attempt to develop procedures of review to ensure fair and correct decisionmaking. There are 50 general operations (surgical procedures), 232 general diagnoses, and 217 specific diagnoses (many with subsets) for which one or more of the EMCROs have developed criteria.

gressing step by step, rather than in leaps and bounds.[30] Such caution seems appropriate on both medical and legal grounds.

B. Legal Framework for PSRO Procedures

PSROs are designated and funded by the government to carry out governmental tasks assigned to them by statute. Their educational functions are often stressed, and this emphasis may make the program more acceptable to physicians.[31] But educational objectives cannot mask the fact that PSRO tasks are adjudicatory and rulemaking in nature, encompassing such related functions as investigating, supervising, prosecuting, advising and declaring. Such activities are hallmarks of the administrative process. When governmental bodies exercise powers of adjudication or rulemaking by virtue of statutory authorization, they are to that extent an administrative agency.[32] PSROs are private organizations performing self-regulatory functions with respect to doctors and providers of medical care, but they are performing these functions for the Secretary of HEW under a congressional delegation of authority. Thus, PSRO determinations are an integral part of the governmental administrative process, and PSROs must conform to the basic principles which govern administrative agency procedures.[33]

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30. The EMCRO evaluators agree:

> We believe that the complete requirements of P.L. 92-603 exceed the capabilities of the current state-of-the-art of medical care appraisal and the resources of most areas. While planning for full functional implementation, most PSRO's will have to carefully select specific programs for early implementation. Care will be required to relate these choices to the needs and resources of each designated area.

B. DECKER & P. BONNER, *supra* note 14, at 30.

31. EMCRO PROGRAMS, *supra* note 17, at 174. The authors explain that "medical care appraisal, by peer review techniques, requires the willing participation of physicians" and observe that the major control over EMCROs by organized medicine resulted in "a major emphasis on nonpunitive educational outputs." *Id.* *See* Claude E. Welch, M.D., 289 NEW ENG. J. of MED. 291 (1973) (Dr. Welch is the Chairman of the American Medical Association's Task Force on Guidelines of Care); Coulter, *supra* note 28. To the extent that doctors are *required* to change their patterns of practice by the PSRO —whether by "education" or "policing"—these PSRO activities fall within the well-worn tracks of administrative determinations.

32. *See* K. DAVIS, ADMINISTRATIVE LAW TREATISE § 1.01 (1958).

33. There is the additional question of whether the "intimate involvement" of PSROs with the secretarial implementation of the Social Security Act subjects the PSROs to the requirements of the Administrative Procedure Act (APA), 5 U.S.C. § 551-59 (1970). This difficult question—whether a PSRO is an agency under the APA—is further complicated by the controversy over whether the Secretary of HEW is subject to the APA. The latter question was raised in Richardson v. Perales, 402 U.S. 389 (1971), in which the Court sidestepped the issue on the ground that "the social security administrative procedure does not vary from that prescribed by the APA." *Id.* at 409. Provisions in the Social Security Act for formal hearing procedures would not govern PSROs since § 1159

The most basic of these principles is that of procedural due process; in many cases, persons who may be adversely affected by an agency determination must be given notice of the proposed action, a fair opportunity to know the record on which the action is based, and an opportunity to be heard in response.[34] These essentials of "fair procedure" must be furnished by private agencies performing regulatory functions[35] even in the absence of spe-

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of the Amendments, 42 U.S.C. § 1320c-8 (Supp. III, 1973), specifies other initial procedures for PSROs, *i.e.*, notice and reconsideration, stating: "Any review or appeals provided under this section shall be in lieu of any review, hearing, or appeal under this chapter with respect to the same issue." § 1159(c), 42 U.S.C. § 1320c-8(c) (Supp. III, 1973).

APA strictures are applicable to an "agency" which is defined as "each authority of the Government of the United States." 5 U.S.C. § 551(1) (1970). Under the Agricultural Adjustment Act, for example, Agriculture Stabilization and Conservation Service Committees (ASCS Committees), local committees like PSROs whose members were elected by producers and who made determinations under the Act, were not subject to the APA although the Secretary of Agriculture's actions were. ASCS committees were required to provide fair procedures. *See* Kephart v. Wilson, 219 F. Supp. 801 (W.D. Tex. 1963).

34. *See, e.g.*, Goldberg v. Kelly, 397 U.S. 254 (1970); Morgan v. United States, 304 U.S. 1 (1938).

35. In Silver v. New York Stock Exch., 373 U.S. 341 (1963), the Supreme Court made it plain that the self-regulatory activity of stock exchanges cannot be carried out in a "fundamentally unfair manner." *Id.* at 364. *Silver* involved actions of the New York Stock Exchange cancelling the private wire connections of a member who was allegedly in violation of the antitrust laws. The court explained that self-regulation by exchanges was authorized by the Securities Exchange Act, but that the regulator must provide for notice and a chance to be heard, even though the Securities Exchange Act did not specifically mandate such procedures. Thus fair procedures were required as the quid pro quo of antitrust immunity for self-regulatory actions. An important factor was the regulatory agency's role as a part of the governmental machinery. *Id.* at 361-67. *See* Crimmins v. American Stock Exch., Inc., 346 F. Supp. 1256, 1259 (S.D.N.Y. 1972). *Cf.* Marjorie Webster Junior College, Inc. v. Middle States Ass'n of Colleges & Secondary Schools, Inc., 432 F.2d 650, 655-57 & n.28 (D.C. Cir.), *cert. denied*, 400 U.S. 965 (1970).

Shortly before this article was published, the decision of Association of Am. Physicians & Surgeons v. Weinberger, No. 73-C-1653 (N.D. Ill. May 8, 1975), upheld the constitutionality of the PSRO law. The three judge court held that various provisions in the Act which require notice and a hearing before a physician can be barred from participation in Medicare and Medicaid satisfied the doctor's rights to due process. It ruled that private organizations, such as PSROs, can be delegated administrative functions:

> Finally, it has been held permissible for agencies of the Federal Government to contract with private organizations in order to have such organizations perform governmental functions as long as the particular administrative scheme provides for a hearing on the determinations made by those private organizations. See *State of Texas v. National Bank of Commerce of San Antonio*, 290 F.2d 229 (5th Cir.), *cert. denied*, 368 U.S. 832 (1961), and *Coral Gables Convalescent Home, Inc. v. Richardson*, 340 F. Supp. 646 (S.D. Fla. 1972).

Id. at 16-17 (Senate Committee on Finance reprint).

cific congressional procedural mandates,[36] so that decisions in federal government programs will be made fairly, not arbitrarily.[37]

The court did not consider what standards were applicable to PSRO procedures. Thus it is not clear from the decision whether the "particular administrative scheme" must include a hearing during the PSRO reconsideration process as well as later at the secretarial level. The *National Bank of Commerce* decision, cited by the court, was solely addressed to the propriety of any delegation of governmental duties to outside agencies; the *Coral Gables* decision only discussed review by the delegating governmental agency. The *Association of Am. Physicians & Surgeons* court also focused on secretarial and judicial review, saying:

> These statutory provisions satisfy the demands of procedural due process by apprising the practitioner or provider of any adverse determination and by affording him an opportunity to be heard either by the Secretary or through the avenue of judicial review. Such safeguards are consonant with the concept of procedural due process as embodied in the Fifth Amendment.

Id. at 9. No issue of PSRO procedures was raised.

36. Recently the courts have considered whether disciplinary action against doctors by hospital or medical association boards, or refusal of staff appointments, met constitutional due process standards. In a number of these cases, the courts have found that some combination of substantial federal monies flowing to the hospital, tax exemptions, pervasive state regulation, and franchises entailed, in return, obligations of observance of federal constitutional mandates. *See, e.g.*, Duffield v. Charleston Area Medical Center, Inc., 503 F.2d 512 (4th Cir. 1974); Christhilf v. Annapolis Emergency Hosp. Ass'n, 496 F.2d 174 (4th Cir. 1974); O'Neill v. Grayson County War Memorial Hosp., 472 F.2d 1140 (6th Cir. 1973); Woodbury v. McKinnon, 447 F.2d 839 (5th Cir. 1971); Sams v. Ohio Valley Gen. Hosp. Ass'n, 413 F.2d 826 (4th Cir. 1969); Meredith v. Allen County War Memorial Hosp. Comm'n, 397 F.2d 33 (6th Cir. 1968); Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963); Poe v. Charlotte Memorial Hosp., Inc., 374 F. Supp. 1302 (W.D.N.C. 1974); Citta v. Delaware Valley Hosp., 313 F. Supp. 301 (E.D. Pa. 1970). *Contra*, Barrett v. United Hosp., 376 F. Supp. 791, 801-02 (S.D.N.Y. 1974) (summarizing cases in which state action was not found to be present).

Due process requirements were imposed by the courts because the hospital and medical boards acted as indirect instrumentalities of the government. PSROs are performing regulatory functions as the *direct* instrumentality of the federal government and are therefore plainly required to adhere to due process standards. Moreover, without regard to state action, courts have indicated that a doctor's interest in pursuing his profession may be a basis for imposing procedural requirements on a private professional organization's disciplinary activities. *See* Duby v. American College of Surgeons, 468 F.2d 364 (7th Cir. 1972). Some PSRO action will adversely affect such physician interests. *See* note 43 *infra*.

37. *See* Hannah v. Larche, 363 U.S. 420 (1960); Joint Anti-Fascist Refugee Comm. v. McGrath, 341 U.S. 123 (1951); Goldsmith v. United States Bd. of Tax Appeals, 270 U.S. 117 (1926).

An additional basis for imposing due process requirements on PSRO procedures is that parties have a right to fair procedures early in the determination process in order to effectuate later rights. Otherwise the provision of elaborate due process rights at the secretarial level or in judicial review is ineffective because it comes too late. Note, however, that de novo review or appeal may cure administrative procedural deficiencies, if it occurs before government action is final. *See* K. DAVIS, ADMINISTRATIVE LAW TREATISE § 7.10 (1958), which criticizes this principle.

The obligation of PSROs to meet standards of procedural fairness is even more apparent, since it rests additionally on specific statutory provisions. The notification and reconsideration requirements of the PSRO statute provide that patients, doctors and providers must be informed of the record on which the PSRO makes its decision and must be given an opportunity to respond to that determination.[38] Having specifically mandated that procedural safeguards be provided first at the PSRO level and extended finally to judicial review, the intention of Congress to provide at least the fundamentals of fair procedure is evident.[39]

The legal and constitutional bases of the PSRO's obligation to meet due process requirements could be explored at great length, and the jurisprudence concerning state action, the duties of private bodies performing governmental functions, and the right of individuals to public benefits continues to grow.[40]

As indicated in note 35 *supra*, the recent three judge court decision upholding the PSRO statute focuses on secretarial and judicial review and does not discuss the implications of such requirements on procedures at the earlier PSRO level.

38. The language used in § 1159(a), 42 U.S.C. § 1320c-8(a) (Supp. III, 1973), combining requirements of notice and reconsideration, is not a common statutory usage. When interviewed, congressional personnel who participated in the drafting of the bill recalled that the vagueness was deliberate in order to allow PSROs flexibility in devising suitable procedures. While there was no intention to invariably require formal evidentiary hearings, a person affected by the decision of the PSRO was to be allowed an opportunity to contest that decision in a manner suitable to the circumstances of the case. There is little legislative history of the "notification" and "reconsideration" requirements, but such as there is demonstrates this purpose. *See* SENATE REPORT 267-68. The provisions for notice and discussion with doctors and providers appears to have an educative purpose. *See* note 31 *supra*.

39. Such procedures have been held implicit in statutes with far less specific directives. *See* Juzek v. Hackensack Water Co., 48 N.J. 302, 225 A.2d 335 (1966), in which the court stated: "A statute often speaks as plainly by inference as by express words . . . . Where a statute which commands the exercise of a *quasi*-judicial function by an administrative agency, contains no specific provision for notice and hearing, such requirements may be implied." *Id.* at 315, 225 A.2d at 342. In *Juzek*, a statute which provided for water council "approval" of the exercise of the right of condemnation "also contemplate[d] all necessary requirements to satisfy due process . . . ." *Id. See also* Paulsen v. City of Portland, 149 U.S. 30 (1893); Standard Airlines, Inc. v. CAB, 177 F.2d 18 (D.C. Cir. 1949); Eisler v. Clark, 77 F. Supp. 610 (D.D.C. 1948). The narrow reading that a party is entitled only to notice of an adverse decision and the right to demand that the PSRO reconsider (on whatever basis it chooses), conforms to neither the evident congressional purpose nor to due process requirements.

40. *See, e.g.*, S. LAW, BLUE CROSS: WHAT WENT WRONG 135-44 (1974); Butler, *Medicare Appeals Procedures: A Constitutional Analysis*, 70 NW. U.L. REV. 139 (1975); Carey, *A Constitutional Right to Health Care: An Unlikely Development*, 23 CATH. U.L. REV. 492 (1974); Meyerhoff & Mishkin, *Application of Goldberg v. Kelly Hearing Requirements to Termination of Social Security Benefits*, 26 STAN. L. REV. 549 (1974); O'Neil, *Of Justice Delayed and Justice Denied: The Welfare Prior Hearing Cases*, 1970 S. CT. REV. 161 (1970).

In recent decisions, beginning with *Goldberg v. Kelly*,[41] the courts have focused on these issues, with special emphasis on developing fair procedures in public welfare programs. An extensive exploration of these issues is beyond the scope of this article; rather, its focus will be to translate the concept of fair procedures into practical terms. Deciding when and what sort of notice is to be provided, what materials and records should be used in making decisions, how these should be assembled, what the timing of the various steps in the process should be, who should do the considering and reconsidering, and what sort of hearing, if any, is required—these are some of the problems which must be resolved as the PSRO charts its procedural course. To do this, the PSRO must look at the possible consequences of a decision and the circumstances in which it is to be made and then decide what constitutes fair procedure.[42]

C. The Effects of PSRO Determinations

The statute recognizes that the doctor ("practitioner"), the patient ("beneficiary" or "recipient"), and the health care institution or organization ("provider") all have interests affected in diverse ways by PSRO determinations. The unadorned legal effect of an adverse PSRO decision is that a federal program will not pay for a particular treatment. A PSRO does not decide in any individual case that a patient should be discharged from or not admitted to a hospital, or given or not given certain treatment. Each of these decisions is made by the doctor, in some cases with the assent of the hospital.[43] An adverse PSRO determination with respect to care already provided could mean that the patient will be responsible for paying the bill; if the patient is without sufficient means, the doctor and the hospital consequently run the risk of not getting paid. An adverse PSRO determination with respect to proposed care could mean that the patient does not receive care.

Thus while the PSRO acts upon decisions made by doctors and hospitals,

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41. 397 U.S. 254 (1970).

42. The Supreme Court has observed: " 'Due process' is an elusive concept. Its exact boundaries are undefinable, and its content varies according to specific factual contexts." Hannah v. Larche, 363 U.S. 420, 442 (1960).

43. Although hospitals and doctors are unwilling to incur liability for denying needed medical care, the PSRO's decision affords them some protection. *See* § 1167(c), 42 U.S.C. § 1320c-16(c) (Supp. III, 1973). *See also* Comment, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 GEO. L.J. 1499 (1974). Hospitals can be expected to assure that doctors who are subject to a degree of departmental discipline (often, in the case of poor patients, residents on the hospital's staff) do not place the hospital at substantial financial risk by repeatedly refusing or delaying the discharge of patients. The case of Martinez v. Richardson, 472 F.2d 1121 (10th Cir. 1973) is illustrative: there the health service provider stopped providing care when notified by Blue Cross, on behalf of HEW, that it would not be reimbursed.

the immediate and primary impact of the PSRO determination is on the patient. There is a secondary financial impact on the doctor or provider if treatment which the PSRO determines to be inappropriate is nevertheless provided. There may be other significant impacts on the doctor or provider, however, since the PSRO is obliged to report failures to provide necessary and appropriate care to HEW, which may in turn impose sanctions.[44] Professionally imposed sanctions may also result since the PSRO must enlist the aid of medical societies or hospital disciplinary bodies in assuring that providers and practitioners meet these standards.[45] Even if formal sanctions are not imposed, adverse PSRO decisions may affect a doctor's professional standing.

D. The Setting In Which PSRO Decisions Will Be Made

Since the PSRO can decide that federal funds may not be used to pay for certain services, the timing of its decision will have a crucial impact on all affected parties. All sides wish to avoid retroactive denials for payment. For this reason HEW has issued guidelines which require that every PSRO plan which concerns review of in-patient, short-stay hospital care implement (1) concurrent admission certification, and (2) continued stay review.[46]

Under a concurrent admission certification, a determination is made of the medical necessity and appropriateness of the admission either before or shortly after a patient is admitted to a hospital. At the same time, an "initial length of stay" is assigned.[47] Continued stay review involves "assessment of the medical necessity [for continued hospitalization]." It may also include "assessment of the quality of care being provided."[48] HEW directs

44. *See* §§ 1157, 1160, 42 U.S.C. §§ 1320(c)-6, 1320c-9(b), (c) (Supp. III, 1973).

45. *See id.* § 1160(c), 42 U.S.C. § 1320c-9(c).

46. *See* P.S.R.O. Manual ch. VII. HEW is willing to consider alternative review proposals in a limited number of cases, but it is expected that most PSROs will adopt procedures consistent with the prescribed concurrent review format. *Id.* § 705, at 5. One alternative is precertification admission review by which length of stay review must be done on a current basis, and some admissions cannot be screened in advance. This works to the patient's advantage by permitting review before he enters the hospital, but it does require more time and paperwork by the attending doctor than concurrent review. HEW has been responsive to the doctors' problem in choosing concurrent review. For recent agency comments on utilization review regulations, see 39 Fed. Reg. 41604 (1974).

Another alternative, retroactive review, is particularly abhorrent to doctors since it increases their malpractice exposure. *See* Exhibit C filed by Ameican Medical Association House of Delegates, Resolution 36, *Hearings on H.R. 1, supra* note 16, at 2682-83. Patients may also be seriously harmed by retroactive review, *see* Harris v. Richardson, 357 F. Supp. 242 (E.D. Va. 1973).

47. P.S.R.O. Manual ch. VII, § 705.1, at 5-6.

48. *Id.* § 705.21, at 10.

that the "initial screening review" occur within the first working day following admission, or, in the case of elective surgery, before the surgery is performed.[49] Continued stay review must take place on or before the expiration of the certified initial length of stay period.[50] Because most PSRO decisions are to be made while patients are in the hospital setting, expecting initial or continuing treatment, there will be serious time and operational constraints on decision and reconsideration procedures.

1. The Patient's Quandary.—Congress apparently recognized that adverse PSRO determinations with respect to in-patient services for individuals would have a more significant impact on the patient than the doctor or provider.[51] A PSRO determination that proposed in-patient services are not reimbursable may require the patient, who is presumably ill, and, on the advice of the doctor who admitted him is in need of hospitalization, to make new plans for treatment or arrangements to leave the hospital. He must decide which of two conflicting "expert" judgments (his doctor's or the PSRO's) is correct. Then, if he wishes to contest the decision, he must secure effective representation with respect to technical issues, all within a very short time period. His doctor may help him reverse the PSRO decision,[52] or his doctor may have been persuaded by the PSRO to a position contrary to the patient's. The PSRO staff may wish to help, but will usually do so only in the context of effectuating its decision.

2. The Doctor's Dilemma.—The interests of a doctor and his patient are not necessarily congruent. While doctors sometimes see themselves as the patient's advocate and representative, they have their own individual interests and concerns at stake. There is, of course, a financial incentive.[53]

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49. *Id.* § 705.13, at 6.

50. *Id.* § 705.24, at 11.

51. Only the patient is given the right to appeal adverse PSRO determinations to the Secretary of HEW and to subsequently seek judicial review. *See* § 1159, 42 U.S.C. § 1320c-8 (Supp. III, 1973).

52. As in any bureaucratic system, there will be doctors who know how to "deal" with the system, and those who do not or will not. The patients whose doctors do not may be disadvantaged, since it is unlikely that PSROs will be able to design a manipulation-proof system. Length of stay review offers a good example. A doctor who requests a series of short extensions, has a good working relationship with the PSRO reviewer and, when pressed, takes advantage of the appeals process to secure extra time, can usually arrange for a longer stay for his patient than otherwise. A patient whose doctor reluctantly cooperates, if at all, and does not provide data to the PSRO is likely to fare much worse.

53. *See* Harris v. Richardson, 357 F. Supp. 242, 246 n.3 (E.D. Va. 1973): "The Court recognizes that the opinions of examining physicians in Medicare cases are usually entitled to less weight than in disability cases because said opinions are not free from self interest."

There is also a doctor's interest as a professional in doing his job as he sees fit.[54]

Doctors may not be motivated to contest PSRO requirements which deny certification for treatment of their patients. Doctors with hospital privileges are subject to professional discipline imposed by hospital review committees which may have been responsible for the adverse decision. They have an interest in remaining in good stead with their colleagues and may modify their judgment accordingly. To the extent that the PSRO decision is valid, this is desirable. However, although a doctor may become convinced that his initial determination was incorrect, the patient may, rightly or wrongly, wish to contest the PSRO's decision.

3. The Hospital's Position.—A chief concern of institutional providers is to avoid conflict between patients, doctors and PSROs, a conflict which may result in uncertainty over whether the patient will be discharged or whether treatment will be performed in the hospital. Above all, the provider wishes to avoid retroactive denials of payment, since Medicaid and Medicare patients may be unable to pay hospital bills from their own resources. Providers are also interested in keeping hospital beds full and their facilities in use.[55]

4. The PSRO's Position.—The PSRO has its own institutional concerns. It wishes to do its job as quickly and efficiently as possible, and to maintain its authority. A PSRO, like any other institution, is unlikely to admit its mistakes with enthusiasm.[56]

The starting point for PSROs in developing procedures to afford affected parties "notice" and "reconsideration" is the set of guidelines issued by HEW

54. This "interest" is often characterized as the doctor's "right" to practice his profession without undue interference and has been asserted in the recent court challenges to federal utilization review programs. *See* note 20 *supra*. In rejecting the claim that the PSRO law inherently invaded this right, Association of Am. Physicians & Surgeons v. Weinberger, No. 73-C-1653 (N.D. Ill. May 8, 1975) distinguished cases striking down criminal abortion statutes on this ground, such as Doe v. Bolton, 410 U.S. 179 (1973) and Roe v. Wade, 410 U.S. 113 (1973). The Illinois court observed that a doctor must comply with the PSRO program only if he wishes to be compensated by the Government. However, the court also recognized that the implementation of the PSRO statute could improperly interfere with the rights of doctors and providers, for example, if norms were developed without adequate flexibility to permit innovative progress in medical practice. Association of Am. Physicians & Surgeons v. Weinberger, *supra*, at 10-11, 17.

55. "Roemer's Law" proposes that utilization expands to fill the beds available. *See* M. ROEMER & M. SHAIN, HOSPITAL UTILIZATION UNDER INSURANCE (American Hosp. Ass'n Monograph No. 6, 1959). In one pilot program, the authors learned, the success of review efforts in shortening lengths of stay resulted in unoccupied hospital beds. The hospital's concern with possible loss of revenue was communicated to the physician reviewers—each a doctor in need of the hospital to service his patients.

56. *See* R. KHARASCH, THE INSTITUTIONAL IMPERATIVE (1973).

which are binding as part of the agreement between each PSRO and HEW.[57] HEW has set out the bare bones of a reconsideration process designed to give the patient a chance for reconsideration before having to leave the hospital.[58]

Having sketched in the setting in which PSRO determinations are to be made and having briefly described the possible consequences of PSRO decisions and the interests likely to be involved, the remainder of this article will explore specific problems facing PSROs in fleshing out their procedures. Reference to, and discussion of, the HEW guidelines will be made when appropriate, but the intention here is to go beyond a description of the basic procedural elements which PSROs must include. PSROs cannot hope to fashion procedures which will happily resolve all the conflicting interests described above and satisfy all competing considerations of cost, time, and soundness of decisions. A balance must be struck, but it must be struck at a point where the parties possibly adversely affected are given effective notice and a real chance to be heard.

II. Development of PSRO Procedures

A. Notice Requirements

1. The Need for Notice.—Generous compliance with the requirement that the PSRO give notice of a determination that proposed services cannot be certified as medically necessary and appropriate is essential if fair and workable procedures are to be developed. Notice serves a twofold function, that of (1) advising the parties of the action which the PSRO proposes, along with the basis on which its determination is made, and (2) informing the parties of their right to reconsideration. The giving of notice requires more than simply telling the parties what the PSRO has decided: an opportunity must be presented to ascertain and contest the basis of the action.[59]

57. *See* P.S.R.O. Manual ch. XIX. (This section of the Manual was issued on Nov. 10, 1974). A PSRO must obtain prior HEW approval before departing from these guidelines. *Id.* § 1900.2, at 3.

58. The PSRO determination may be subject to a 24-72 hour grace period for the reconsideration. P.S.R.O. Manual ch. XIX, §§ 1905.5, 1910.4, at 3, 7. "Elective procedures," a term which is not defined by the guidelines, are not reimbursable during this period. There is uncertainty how HEW will be able to reimburse for any costs of services or items provided during this grace period which the PSRO determines are medically unnecessary or inappropriate. *See id.* § 1907, at 6. One thing seems clear: when the patient has remained in the hospital pending review he will have to deal with further administrative procedures to secure reimbursement.

59. Morgan v. United States, 304 U.S. 1, 18 (1938). Notice must be tailored to meet the requirements of the situation in order to provide a real chance to prepare for and meet the opposition's case and should include notice of the right to reconsideration and to available assistance. *See* Escalera v. New York Housing Author., 425 F.2d 853 (2d

A specific and complete statement of reasons is particularly important because PSRO review will operate within an extremely short time frame in busy hospitals involving doctors who typically have full schedules. The more precise the notice, the sharper the focus of the determination and the more efficiently the review can proceed.

However, if the PSRO process is to succeed, PSROs must approach the notice-giving task with an understanding of the difficulties they face. Notice must go to the patients, doctors, and the hospital administration, since each has different concerns and backgrounds. Notice sufficient for a trained physician is unlikely to be adequate for a layman.[60] Indeed, the problems of providing meaningful notice to patients may prove insurmountable since patients usually lack substantive medical knowledge, as well as a familiarity with medical and hospital terminology and procedures. The compressed time period of review exacerbates these problems.[61] If there is to be any chance that patients can assert their rights in the reconsideration process, they need the fullest and most specific notice at the earliest possible time.[62]

2. *Written As Well As Oral Notice.*—A written notice is not the only way to inform parties of a PSRO determination, nor to sharpen the issues.[63] Con-

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Cir. 1970); Elliott v. Weinberger, 371 F. Supp. 960 (D. Hawaii 1974) (extensive analysis of notice requirements); Pregent v. New Hampshire Dep't of Employment Security, 361 F. Supp. 782 (D.N.H. 1973), *vacated and remanded on grounds of possible mootness*, 417 U.S. 903 (1974). The giving of proper notice is an integral part of the reconsideration process: "[T]he right to submit argument implies that opportunity; otherwise the right may be a barren one." Morgan v. United States, *supra*, at 18. Notice requirements include notice of the basis of the reconsideration decision. *See* Willner v. Committee on Character & Fitness, 373 U.S. 96, 105 (1963).

60. *See* Woodbury v. McKinnon, 447 F.2d 839 (5th Cir. 1971) (four "specifications" of surgical incompetence together with hospital case records held sufficient to permit doctor to answer charges).

61. The PSRO review process may flounder on constitutional shoals for this reason alone. *See* Goldberg v. Kelly, 397 U.S. 254 (1970), which analyzes the need to provide an *effective* right to be heard. The Court pointedly observed with respect to a seven day notice: "We are not prepared to say that the seven day notice currently provided . . . is constitutionally insufficient *per se*, although there may be cases where fairness would require that a longer time be given." *Id.* at 268. Here the projected time frame is 24-72 hours. *See* note 58 *supra*.

62. Consumer representatives have stressed the need to furnish beneficiaries with "prompt and specific information, including a specific statement of the facts of the case and the norms, standards, and criteria involved whenever they disallow any course of treatment." United States Dep't of Health, Education and Welfare, PSROs and Medical Information—Safeguards to Privacy 4 (July 22, 1974) (presentation of Robert E. McGarrah). "Beneficiaries must also be promptly informed of their right to any appeal of the PSRO's decision." *Id.* at 5. *See also* Wickman, *Public Welfare Administration: Quest for a Workable Solution*, 58 GEO. L.J. 46, 65 (1969) (stressing the importance of providing full, complete, and early notice).

63. HEW procedures properly contemplate both written notice of the "initial determi-

ferences and discussions are of great value, as has been recognized in the pilot programs and reflected in the statute. But oral techniques should never replace the need for a written notice.[64] The circumstances of in-hospital review, typified by busy reviewers, a heavy volume of cases, and the involvement of a large number of medical and administrative personnel—in short, the very circumstances likely to be cited as justification for "unnecessary" recordkeeping[65]—make keeping a permanent record of PSRO determinations essential. A written notice also permits review and appeal, which operate to assure consistent and evenhanded decisionmaking.[66]

3. Training In Notice-Giving.—Since judgments of medical necessity may rest on complex factors, or on a subjective evaluation of a patient's condition,[67] PSRO reviewers may find it difficult to articulate reasons for their determination. Difficulty in articulation may also mirror a lack of precision in thought. Notice-givers generally tend to shy away from specifics and to take refuge in generalities. PSROs are unlikely to be exceptions. It is therefore particularly essential to insist on the giving of a complete and precise notice at the beginning of the program—when standards and precedents will be developing—even though the volume of notice of adverse determinations

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nation" and consultations. The combination of written notice and oral conversation is "probably the most effective method of communicating with recipients." Goldberg v. Kelly, 397 U.S. 254, 268 (1970). However, when verbal notice is provided, notice is deemed effective from that point and not the time of written notice. *See* P.S.R.O. Manual ch. XIX, §§ 1905.4, 1905.5, at 5. Thus a party may be deemed to be on notice when all he knows is that the PSRO has determined not to certify particular treatment. Written notice of reconsideration decisions must be provided. *Id.* § 1910.6, at 8.

64. *Cf.* Goldberg v. Kelly, 397 U.S. 254, 268 (1970); Elliot v. Weinberger, 371 F. Supp. 960, 973 (D. Hawaii 1974). Williams v. Weinberger, 360 F. Supp. 1349 (N.D. Ga. 1973), *aff'd*, 494 F.2d 1191 (5th Cir. 1974), however, upheld procedures when only oral notice was provided, but warned:

> This is not to say, however, that every pre-termination notice will be constitutionally sound. There may be individual situations in which inadequate notice is given—in writing as well as orally—and the matter must be considered a factual question to be decided on a case-by-case basis.

Id. at 1353. Written notice here is needed if there is to be notice enabling sick patients to get adequate assistance on technical issues, and enabling busy doctors and hospital staffs to focus quickly on the problems. A good example of requisite special efforts are reflected in HEW guidelines requiring foreign language notice. *See* Sample PSRO Notification of Adverse Initial Determination, P.S.R.O. Manual ch. XIX, at 11.

65. *See* Meeting of the National Professional Standards Review Council, Sept. 9, 1974, Washington, D.C., at 62-63 (transcript on record at Office of Professional Standards Review).

66. The need for review and evaluation, both by the PSRO and outsiders in this new and virtually untried program, is apparent.

67. For all the projected reliance on objective criteria, these will only be guideposts. See p. 434-36 *infra*.

may be greater at the outset than it will be once the program is established.[68]

HEW guidelines require that PSRO reviewers use a form of written notice which leaves a blank space for the "basis for this determination"; PSROs are instructed to "state basis in detail, specifying the relevant norms and criteria."[69] Without proper training, PSRO reviewers may provide conclusory statements which do not explain the basis of the decision as to permit effective rebuttal, and which are therefore legally insufficient.[70] While visiting several of the operating program models, the authors observed pertinent illustrations of such difficulties. The programs visited had printed notice forms, but used them infrequently. (We should point out that few claims were formally disapproved by these projects; rather, controversies were "informally" adjusted.) In two programs the notice forms did not provide any space for listing reasons;[71] another left only two short (5½") lines. When

68. The greatest impact and volume of adverse determination can be expected at the outset because the initial review winnows out the most obvious problems. Further auditing tends to "keep the lid on." Interview with Dr. John Gentry, Executive Medical Director, Medical Assistance Program, New York City Dep't of Health, New York City, Sept. 16, 1974.

69. Sample Form of Notice, P.S.R.O. Manual ch. XIX, at 11. The instructions provide:

> The written notice shall state in detail the basis for the determination and specify the relevant norms and criteria which were applied in making such determination. The notice should contain sufficient detail to enable the parties to adequately prepare documentary or other materials to present for the PSRO's reconsideration.

Id. § 1905.5, at 5 (initial determinations). *See also id.* § 1910.6, at 8 (reconsiderations).

70. "[O]ne-sentence summary notices are inadequate [to inform a person of the evidence against him.]" Escalera v. New York City Housing Author., 425 F.2d 853, 862 (2d Cir. 1970) (housing). *See* cases cited note 61 *supra.*

71. In one program the printed reason given to the doctor stated:

> In line with this goal, we have repeatedly reviewed your patient's progress during the hospital confinement. This review has been conducted by the ———————— (Program name) Review Coordinator and myself. Based upon this complete review of the chart and your comments on your patient's medical progress, I have determined that continued confinement in this hospital is no longer necessary to improve your patient's medical well being. Accordingly, PSRO certification of your patient's hospital stay will no longer be in force after:
>
> ————————, ————————, 19—.

(Generally the doctor was asked to notify the patient).

In another, the form, sent to the patient, states:

> Based on your present medical condition, the Foundation has certified your stay in the hospital as being a responsibility of Medicare for payment up to and including ———————— (date). Continued hospital stay after that date most likely will be a personal expense chargeable to you rather than the Medicare program.

This material was viewed by the authors on site visits to the program models.

reasons for adverse decisions were articulated, the results varied. Some were murky, at best: for example, "length of stay exceeded norm; insufficient justifying material presented."[72] Others stated reasons more clearly:

> no temperature
> no sx except chronic illness
> no progress notes
> no history of physical
> no orders for anything but routine care
> Admitted over the telephone by one MD for another.

Written guidelines cannot provide adequate directions for what should be included in written notices. To do so would require reference to a myriad of particularized fact situations. This is why PSRO training programs could be of great use, permitting case by case analysis and asking the reviewers to put themselves in the positions of the patient, the doctor, and the hospital administrator when considering the kind of information needed in order to understand and evaluate an adverse PSRO decision.

4. When Should Notification Be Given: The Role Of The Informal Conference.—An important consideration in giving formal notice is the use and effect of an informal consultation. The question which arises here is whether each party entitled to notice under the statute should likewise be involved in or at least informed of discussions held between the PSRO and any other parties. The problem will usually emerge as the aftermath of a PSRO-doctor conference during which the doctor is persuaded to change his recommended treatment. HEW guidelines require that written notice be given when the PSRO makes an "initial determination."[73] But these guidelines also direct the PSRO to consult with the attending doctor "prior to the actual rendering of a PSRO determination."[74] It is left to the PSRO's discretion whether to consult with the patient or provider at this stage. According to the guidelines, consultations between the PSRO and the doctor

> [do] not constitute a determination by the PSRO, and if the attending physician changes his request for services or items to conform to PSRO requirements, there would be no adverse determination. In such case, no notice is required to be given the beneficiary or recip-

72. It is impossible to tell from this statement whether the doctor had simply failed to supply any material to the reviewer, or whether the material he presented lacked persuasive power.

73. P.S.R.O. Manual ch. XIX, § 1905.4, at 4. The notion of an "initial" determination, *id.* § 1905.1, at 3, and a "reconsidered determination," *id.* § 1910.6, at 8, are HEW glosses. The statute speaks of a "determination." *See* § 1159(a), 42 U.S.C. § 1320c-8(a) (Supp. III, 1973).

74. P.S.R.O. Manual ch. XIX, § 1905.1, at 3, requires this consultation "[i]n case of a disagreement between the attending physician and the PSRO."

ient, or the provider, and the beneficiary or recipient or provider has no right of reconsideration.[75]

The rationale is that the PSRO had made no "determination" until it sends its notice, and it need not send notice until it makes a determination. Therefore, if it simply convinces the doctor to change his order because of a threatened adverse determination, neither the patient nor the hospital need ever be told. This handy exercise in circular reasoning is likely to be attacked by a patient (if he ever finds out) upon the ground that the PSRO's position as expressed in the "dialogue" constituted a determination, adverse to the patient,[76] of which he was entitled to be notified, and to ask for reconsideration.[77]

The problem is a difficult one, for the statute makes separate provisions for PSRO consultation with doctors.[78] Informal consultation is usually to be

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75. *Id.*

76. That the views expressed by the PSRO are determinations—no matter how respectfully the PSRO listens to the doctor—is implicitly recognized by pilot PSROs. *See* Meeting of National Professional Standards Review Council, *supra* note 65, at 60-61. Donald C. Harrington of the San Joaquin, California program stated:

> For instance, a person is in the hospital for five days, and that is what the length of stay is. And there is no reason for the person staying on longer. The Nurse Coordinator takes that person to the physician in charge and says that patient is not going to be discharged. They call the physician on the case and he says, oh, yes, I guess I should . . . .
>
> If we start writing notices to every physician about this, I can see a great [number] of red flags popping up over the countryside.

Id.

77. At one point, the HEW guidelines seem to suggest that the patient, doctor, and provider are *not* parties to the "initial" determination, *i.e.*, the process of PSRO review of a proposed course of medical action. Section 1900.1 states that "the initial determination by the PSRO is the action which precipitates the rights of dissatisfied parties . . . to obtain further review of their claim." P.S.R.O. Manual ch. XIX, § 1900.1, at 1. This is nonsense; affected parties are given rights intended to assure them a significant chance to participate in PSRO deliberations.

As the courts have pointed out, when a party has a right to be heard, it has the right before, not after, the agency's decision has hardened. *See, e.g.*, Environmental Defense Fund, Inc. v. Ruckelshaus, 439 F.2d 584, 595 (D.C. Cir. 1971). The P.S.R.O. Manual recognizes that the "parties to the initial determination are all those who have the right to request PSRO reconsideration of the determination." P.S.R.O. Manual ch. XIX, § 1905.3, at 4.

78. Section 1161, 42 U.S.C. § 1320c-10 (Supp. III, 1973) reads:

> NOTICE TO PRACTITIONER OR PROVIDER
>
> 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 1320c-9 of this title,

desired, and in any event, difficult to avoid.[79] Moreover, an underlying premise of peer review is that it will work only to the extent that doctors view it as educative and are willing to cooperate. Yet, doctors' and patients' interests are not necessarily congruent. The real issue is whether any interest of the patient is served by informing him of the abortive dispute between his doctor and the PSRO. If the PSRO was right—and the assumption of the medical profession is that collective wisdom is usually better than individual judgment—should the patient be encouraged to press for unneeded services? But if, for example, local norms set by the PSRO deprive the patient of the best care possible for his condition, might not a useful exposure of the issue be avoided in order to avert professional inconvenience or embarrassment?[80]

Perhaps the solution lies in recognition of the fact that the doctor will be less likely to be persuaded against his better judgment to change his request for the patient's treatment if he knows that the patient will be told of the change and that he will have to explain his reversal. When the doctor is

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> 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.

The policy of this section favoring consultations may be urged to permit PSROs to consult with doctors before the PSRO gives notice of its determinations, as proposed by HEW. However, § 1161, 42 U.S.C. § 1320c-10 (Supp. III, 1973), *requires* discussions after—not before—decisions. It does not authorize PSROs to avoid responsibilities mandated by § 1159, 42 U.S.C. § 1320c-8 (Supp. III, 1973). The two are to be read in tandem. Note that the law gives providers the same rights to discussion and review as practitioners, but HEW guidelines give special rights to doctors. The guidelines give *only* doctors a right to be consulted *before* an "initial" determination, P.S.R.O. Manual ch. XIX, § 1905.1, at 3, and they give both doctors and providers a chance for discussion in addition to the rights to reconsideration. *Id.* § 1906, at 6.

79. Professor Davis offers a judicious appraisal of informal processes. *See* K. DAVIS, ADMINISTRATIVE LAW TREATISE § 4.11 (1958). These are informal in the sense that the trial-like trappings of normal hearings are avoided, but such procedures still involve all interested parties. Davis also takes a realistic view of ex parte contacts in informal adjudication. *Id.* § 13.12 (1970 Supp.). *See also id.* § 7.12-1 (1970 Supp.). The proponents of informal consultations argue that efforts should also be made to consult with patients and providers.

80. The possibility that this would occur was frankly acknowledged during a discussion at the National Professional Standards Review Council, when Dr. M. Duval, formerly Assistant Secretary for Health, U.S. Department of Health, Education and Welfare, stated:

> [I]f a physician is in a position to make one of a couple of decisions and he knows that by making one that he would like to make, he is going to run against the adverse [PSRO] decision, this is going to increase the liability problems.

Meeting of National Professional Standards Review Council, *supra* note 65, at 68.

sincerely convinced by the PSRO that he was wrong initially, he could explain this to the patient and, if the patient persisted, the doctor could indicate that he would be unwilling to provide treatment any longer.[81] While patients need not be informed whenever the PSRO staff wants to talk with their doctors,[82] patients are entitled to be informed when the result of a PSRO-doctor conference is a change in the doctor's request for services.[83]

The fact is that a doctor may change his recommendations because he knows that the PSRO is monitoring his decisions. This is the anticipated and probably desirable effect of PSRO review, but it is important to bear in mind that this kind of pressure has the effect of enforcing PSRO requirements in ways which are never subject to notice or reconsideration.

5. Using Notice As An Enforcement Mechanism.—Since one purpose of the PSRO notification is to inform the parties of their right to reconsideration before the adverse determination becomes effective,[84] it is important that notice not be given in a way which will induce a patient to give up that right.[85] The danger is particularly acute since, in addition to their review responsibilities, some PSROs expect to perform discharge planning services.[86] Thus

81. Recently, there has been a growing emphasis on respecting the rights of patients to participate in medical decisions which affect them. *See* Bunker & Wennburg, *Operation Rates, Mortality, Statistical, and the Quality of Life*, 289 NEW ENG. J. OF MED. 1249, 1251 (1973); Katz, *Caring for Research—Has Medical Education Failed?*, 48 HARV. MED. ALUMNI BULL., July-Aug. 1974, at 11-14. *See also* S. LAW, BLUE CROSS: WHAT WENT WRONG? 143 (1974). This emphasis should also be reflected in expanded conferences between the PSRO and the patient.

82. When the PSRO questions the physician's proposal, but accedes to it, the patient need not be informed. P.S.R.O. Manual ch. XIX, § 1905.1, at 3.

83. National Welfare Rights Organization v. Finch, 429 F.2d 725 (D.C. Cir. 1970), is illustrative. There, NWRO's right to participate in the administrative review of a secretarial decision concerning a state's Aid to Families with Dependent Children (AFDC) plan was recognized; NWRO did not, the court ruled, have the right to participate in the Secretary's informal efforts to bring the state into conformity with the law. However, HEW was directed to inform NWRO of its reasons for changing its initial requirements for the state, and NWRO was to be given a chance to respond.

84. P.S.R.O. Manual ch. XIX, § 1905.5, at 5.

85. In the pilot programs, the reviewing organization was sometimes asked by the doctor to inform patients of the requirement that they leave, thus removing the onus from the doctor. The patient notice form, *see* note 71 *supra*, plainly has the goal of notifying the patient of the need to leave the hospital and of the availability of planning help, even though the possibility of an appeal is mentioned.

86. *See* P.S.R.O. Manual ch. VII, § 705.29, at 13. One of the common problems encountered in the pilot programs reviewing Medicare and Medicaid patients was the fact that the patients' home situations were inadequate for followup care. It is often extremely difficult for Medicare patients to find space in long-term care facilities. For that reason doctors and hospitals face severe pressures to keep a patient who may not need hospitalization. The PSRO's assumption of this job offered the inducement of this help to doctors and hospitals in exchange for instituting the utilization review. As pres-

they have overlapping, and possibly conflicting, responsibilities.[87] When part of the PSRO's job is to make arrangements for patients to leave the hospital, patients may become confused by the PSRO's dual role of advisor and adjudicator. The patient may therefore assume that notice of an adverse determination is advice given in a fiduciary capacity.

The HEW sample notice takes pains to spell out the right to reconsideration.[88] Additionally, PSROs should explain that a reconsideration can take place before the certification period ends. But even the most carefully worded notice will act, in many cases, as an enforcement mechanism. It remains to be seen, then, whether the use of a PSRO as a discharge planner will identify it as an enforcer to such an extent that its ability to give fair notice of a chance for review is fatally impaired.

B. The Record On Which PSRO Determinations Are Based

1. Assembling the Record.—An important step in the administrative process is the collection of a body of relevant materials necessary for making a decision. Specification by the PSRO of which materials should be considered in all cases, together with a procedure for recording which materials have actually been considered in each particular case, will go a long way toward ensuring predictable, consistent, and evenhanded treatment.[89]

HEW guidelines specify that the persons reviewing an initial PSRO determination shall, at a minimum, make use of the following information:

(1) The case record which was submitted to the PSRO initially when the attending practitioner proposed to provide services or items;

(2) The findings of the PSRO which led to an adverse initial determination;

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ently planned, PSROs will trigger, but may not actually perform, discharge planning in hospitals which are providing this service.

87. Assumption of the discharge planning task raises a number of additional problems. The PSRO will be adjudicating the necessity for continued hospitalization. When the PSRO performs such planning, and it is unable to make needed arrangements, a PSRO decision could be contested on appeal by showing that its own failure to find suitable after-care makes hospitalization necessary. Moreover, because the same person may be doing the discharge planning and the initial PSRO reviewing, a possible conflict of interest may result. *See* pp. 440-41 *infra*.

When a hospital review committee performs the PSRO review, even more problems arise: because the hospital may incur financial risk if the patient stays, its interest in securing the patient's voluntary departure is even more immediate.

88. P.S.R.O. Manual ch. XIX, at 11-12.

89. "Consistency and predictability are values of a high order in the administrative process, even if they do not rise to the dignity of stare decisis by which courts are bound." O'Neil, *supra* note 40, at 189.

(3) The complete record of the hospital stay of the beneficiary or recipient;
(4) Any additional documentary information submitted by a party with its request for reconsideration; and
(5) Any oral presentation which a party or his authorized representative may choose to present to the physician or committee conducting reconsideration.[90]

Many pilot programs did not focus on the need to specify what should be utilized in the record, what sort of record should be kept of each PSRO initial determination that services should not be provided, and which materials should be placed before the reviewing body. One result of this haphazard process was that requests for review submitted by doctors or hospitals were often well documented and supported by needed records (gathered by the claimant), enabling reviewing bodies to make judgments in their favor. In contrast, reviews initiated by patients went largely unsupported because there was no regularized procedure for identifying what should be presented by the program staff to reviewers. In such a case, there may have been no doctor support or only a simple letter from the attending physician stating that there was a need for review. The medical record was not regularly made available to subsequent reviewing bodies. By recognizing the need to provide for assembly of a complete record, the PSRO has taken a significant step toward procedural fairness.

a. Use of the Review Coordinator.—While HEW guidelines do not specify the mechanics of PSRO decisionmaking, it is expected that many PSROs will follow the model of the pilot programs and use the nurse coordinator to do much of the staff work.[91] Under this procedure, the nurse coordinator

90. P.S.R.O. Manual ch. XIX, § 1910.5, at 8. By implication, the PSRO is expected to use such materials in its initial review. The guidelines state that on reconsideration the PSRO shall review any materials which were actually taken into account in making the "initial" determination. They also state that the PSRO can use "any additional evidence submitted to the PSRO or otherwise obtained by the PSRO." *Id.* However, if the party requesting review had not been notified of the materials submitted, such materials could not be used in the "reconsideration process" even if the PSRO initially considered them. *Cf.* Escalera v. New York City Housing Author., 425 F.2d 853, 862 (2d Cir. 1970). *See also* P.S.R.O. Manual ch. XIX, § 1905.7, at 6. This record of an initial determination is to include

> a copy of the attending physician's request for provision of services or items, the detailed basis of the determination of the physician or committee which conducted the review, and a copy of the Notice of Adverse Initial Determination sent to all the parties.

Id.

91. "Another way to conserve physician time would be through the use of other qualified personnel such as registered nurses who could, under the direction and control of PSRO physicians, aid in assuring effective and timely review." SENATE REPORT 264.

or other nonphysician does the initial screening, performs data collection and recordkeeping functions, and acts as a liaison between the hospital, doctor, patient, and PSRO.[92] When the coordinator questions the need for an admission or continued stay, he calls in the PSRO reviewing physician or hospital review committee. Even though an ultimate PSRO adverse decision will be made by a doctor,[93] earlier decisions not to question or challenge the length or type of treatment, which may be equally significant, are made by the coordinator.[94]

Because of their central role in the PSRO process, PSRO review coordinators must be trained to keep records which are useful not only for making initial PSRO determinations, but also for the purpose of affording notice and reconsideration. The record should indicate the source of data entered (*e.g.*, medical record, coordinator's observations, oral or written report of attending doctor or ward nurse) and the events which led to the initial determination. It should also document whether the coordinator checked with the attending doctor or sent out notices to affected parties. Finally, if several

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HEW guidelines also anticipate that a review coordinator will be used. *See* P.S.R.O. Manual ch. VII, § 705.24, at 11. The use of assistants to help in performing the administrative process has long been judicially approved. *See, e.g.*, NLRB v. Duval Jewelry Co., 357 U.S. 1, 7 (1958).

92. Typically, the coordinator (1) reviews each new patient's medical file on the ward, sometimes observing the patient and talking with doctors or nurses treating the patient at this stage; (2) copies data from the medical record onto the PSRO file; (3) checks the information secured against PSRO criteria and possibly against his or her own judgment or information; (4) assigns an initial length of stay for the admission based on established length of stay norms; (5) checks charts of patients previously admitted, particularly those who may be nearing the end of their length of stay; (6) reviews requests for extensions of length of stay or signals the possible need for such a request to the admitting doctor; (7) discusses problems with the physician advisor or hospital review committee; (8) performs additional data collecting and recordkeeping functions. The coordinators in pilot projects usually dealt with patient questions about PSRO decisions, and with minor doctor and hospital inquiries. Normally the PSRO reviewing doctors, staff director, and officials dealt with the more serious informal challenges by doctors and hospitals.

93. This is never explicitly stated in HEW guidelines, but is assumed. *See* P.S.R.O. Manual ch. VII, § 705.24, at 11. The statute specifies that only the "duly licensed doctor of medicine . . . [can] make final determinations . . . with respect to the professional conduct of [another] . . . doctor . . . or any act performed by any . . . doctor . . . in the exercise of his profession." § 1155(c), 42 U.S.C. § 1320c-4(c) (Supp. III, 1973). Both the "initial" and "reconsidered" determinations are final if not further challenged. *See* P.S.R.O. Manual ch. XIX, §§ 1905.6, 1910.7, at 6, 9. Thus it would appear that only a doctor could make an initial adverse decision. It is beyond question that only a doctor can make a decision on reconsideration. Indeed, it would be programmatically unacceptable for nonphysicians to formally reverse doctors.

94. In a major pilot program, approximately 10% of the cases screened by the nurse coordinator were referred to the physician advisor. *See* Nelson, *supra* note 27, at 671.

people participate in the determination through conferences or consultations (whether or not in the presence of the coordinator) the record should show what took place at these encounters, and whether they occurred in person or by telephone.

b. Use of Medical Record.—HEW guidelines anticipate that medical records will be a primary source of data.[95] The pilot projects did not often use the medical record itself, but relied on excerpts copied from the medical record. Such practices run the risk of added error in copying;[96] in addition, data which might be useful to the physician reviewer could be overlooked or misunderstood by the copier. PSRO determinations require a full picture of the patient's condition. Thus, in the initial as well as the review determinations, the medical record itself should be made available to, and used by, the decider. Even so, the PSRO reviewer must remember that the information recorded on the chart may not be extensive enough to allow a reliable judgment.[97]

c. Use of Physical Examination.—Since the scope of the PSRO investigative power has not been precisely drawn, the question arises whether PSRO delegates can or should be able to examine the patient (or even whether data collected by the PSRO from the patient may be used in its decisionmaking process).[98] It is not difficult to predict the source of a number of serious objections. Doctors may object on grounds that examination of the patient interferes with the attending doctor-patient relationship. Lawyers may inquire whether there is an impermissible overlap between adjudicatory and investigative functions. And the patient may argue that such an examination constitutes an invasion of his privacy. Certainly examination by the PSRO physician reviewer or data collection by the PSRO reviewer should be permitted when the patient himself requests it—even if his doctor opposes it.

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95. *See* P.S.R.O. Manual ch. VII, § 705.18, at 8-9. The guidelines also anticipate that the PSRO will document its actions in the medical record, thus creating a permanent record. *Id.* § 705.19, at 9. This is quite a departure from the usual procedure, since the medical record is generally believed to be the sacred preserve of the doctors and nurses who perform the treatment.

96. The potential for loss or inaccuracy increases each time the record is abstracted. *See* Henrickson & Myers, *Some Sources and Potential Consequences of Errors in Medical Data Recording*, 12 METHODS OF INFORMATION IN MED. 38-45 (1973).

97. Interview with Dr. Howard Katz, Medical Examiner, Medical Assistance Program, New York City Dep't of Health, New York City, June 25, 1974.

98. HEW guidelines are silent on this point. In Pippin v. Richardson, 349 F. Supp. 1365, 1369 (M.D. Fla. 1972), the court implicitly criticized the reviewing agency "which reviewed the medical records and never had any personal contact with the patient herself." *See also* Simms v. Weinberger, 377 F. Supp. 321 (M.D. Fla. 1974) (nonexamining review doctor opinion is not substantial evidence when contrary to medical opinions of examining doctors).

When the doctor requests a PSRO examination, the matter could be resolved as an ordinary consultation would be, by securing the patient's consent. However, the patient must be told of the purpose of the examination, so that the PSRO can decide if the proposed treatment will be reimbursable, and whether the examination is optional. At the present time, examinations play no part in existing review mechanisms.[99]

Since the condition of the patient is the basic subject of the proceeding, examination should be encouraged. The PSRO should request the cooperation of the doctor and patient, but should take care not to pressure the patient. If the patient does not agree, the PSRO would have to make the best decision possible on the basis of other available data. While it is not uncommon for patients to be required to relinquish their privacy rights,[100] PSRO regulation already imposes new burdens on patients. Since review examinations are not the usual practice, a modest consensual beginning seems in order.

2. *Use of Norms and Criteria.*—An important goal of the PSRO program is to develop norms and criteria based on patterns of practice in PSRO areas to serve as guideposts to PSRO decisionmaking. These measures are intended to provide a scientific and standardized foundation for PSRO review to replace the subjective judgments of individual reviewing personnel.[101] Objectivity is certainly a valid goal for administrative decisionmaking. The problem is that attempts to achieve this laudable ideal in peer review could result in serious unfairness simply because the state of the art in medicine does not permit the development of norms and criteria capable of replacing the need for case by case judgment.

The statute, however, directs PSROs to develop norms, criteria, and standards[102] with respect to the treatment of particular illnesses and health condi-

99. In rare instances, if any, have pilot programs used examinations as a fact-gathering technique. It is not the usual practice for doctors to examine private patients in the hospital without the permission of the attending doctor, but since the courts have imposed a greater measure of legal responsibility on hospitals for medical care taking place on the premises, this practice may change. When the appropriate length of stay is at issue, however, the condition of the patient is the major factor and a physical examination may be particularly significant.

100. Patients in teaching hospitals are often used as teaching subjects, and the government calls for examination of patients in disability cases. *See* Richardson v. Perales, 402 U.S. 389 (1971).

101. *See* SENATE REPORT 254. Thus the statute states that the PSROs "shall apply professionally developed norms of care, diagnosis, and treatment . . . as principal points of evaluation and review." § 1156(a), 42 U.S.C. § 1320c-5(a) (Supp. III, 1973).

102. In "PSRO-land" it is essential to know the difference between norms, criteria, and standards. All of these are defined in the P.S.R.O. Manual as follows:

Norms—Medical care appraisal norms are numerical or statistical measures of

tions, including the appropriateness of various facilities for services,[103] and for patient lengths of stay in hospitals.[104] These standards may be based on the consensus judgment of physicians in the community (as was generally the case with the pilot projects) or on empirical evidence that a given act results in a desired outcome.[105] Both methods, unfortunately, are seriously deficient. Since much of the practice of medicine is based on conventional wisdom, unproven by controlled clinical trials,[106] standards developed by consensus judgment may not relate to the patient's outcome and may tend to freeze the form of medical practice at less than an optimum level.[107] Empirically proven process standards, although preferable to consensus judgments, are extremely complex and difficult to develop and apply to individual patients.[108] Most patients do not present the classic symptoms. Thus, even if empirically based criteria were universally accepted, the way in which they were applied in individual cases could be a matter of honest disagreement among competent doctors.

Moreover, an important reason for questioning the value of norms and criteria in PSRO review is the result of a study which shows that whether a doctor's work is acceptable to reviewers varies with the kind of criteria that is used.[109] Thus the same doctor's performance could be rated acceptable under some kinds of criteria and unacceptable under others.

One area in which objective criteria may be more easily developed, how-

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usual observed performance.

Standards—Standards are professionally developed expressions of the range of acceptable variation from a norm or criterion.

Criteria—Medical care criteria are predetermined elements against which aspects of the quality of a medical service may be compared. They are developed by professionals relying on professional expertise and on the professional literature.

P.S.R.O. Manual ch. VII, § 709, at 16. Medical practice in individual cases is to be measured against a consensus of what doctors in the area did in similar cases.

103. 42 U.S.C. § 1320c-5(b) (Supp. III, 1973).

104. *Id.* § 1156(d)(2), 42 U.S.C. § 1320c-5(d)(2).

105. Standards which are based on descriptions of what doctors actually do for similar patients in the community are called process standards. It is expected that PSROs will use process standards. *See* B. DECKER & P. BONNER, *supra* note 14, at 15. An alternate method of developing standards is based on outcome measures (*i.e.*, whether the patient gets well), but these are even more complex and are too expensive to be used by PSROs. *See* Brook, *supra* note 22, at 30.

106. *See* Brook, *supra* note 22, at 30-31.

107. *See* White, *Caveats for PSROs*, 120 WEST. J. MED. 338, 343 (1974). Medical authorities question many of the assumptions behind the PSRO program, particularly the emphasis on "process" standards directed at physicians' practices.

108. *See* Brook, *supra* note 22, at 30.

109. *See* Brook, *Choosing a Method of Peer Review*, 288 NEW ENG. J. MED. 1323 (1973).

ever, is length of stay standards. Based on only one relatively uncomplicated set of variables, the number of days in the hospital, these standards would not necessarily be any more accurate than other consensus standards, but they would at least be easier to apply in practice.[110]

Because scientific precision in medical practice is still restricted, it would seem that PSROs should make only limited use of norms, standards, and criteria. Ideally these would be used in conjunction with more subjective considerations. This view is reflected by the pilot project evaluators who suggest that

> [t]he logistics of peer review . . . can be significantly aided through preliminary screening against explicit criteria by nurse coordinators or medical record librarians (with or without computer assistance). The limited subset of cases which fail to pass such screening require judgmental review by peers. Review programs which combine initial screening and peer review of detected exceptions utilize the best advantages of both explicit and implicit criteria.[111]

In implementing a system using both objective and subjective judgments, each PSRO will decide the weight it will give norms and criteria. Once attention is drawn to a case through use of a screening norm, should the attending doctor be required to justify each proposed departure from the norm, or should the PSRO be expected to justify why in the particular case it believes departure from the norm is not medically necessary or appropriate?[112] When a norm relates to a relatively uncomplicated set of variables,

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110. Extensive data on lengths of stay has been published by third party payors and service organizations such as the Commission on Professional and Hospital Activities, a nonprofit corporation sponsored by the American College of Physicians, American College of Surgeons, American Hospital Association, and the Southwestern Michigan Hospital Council. *See* Commission on Professional and Hospital Activities, Length of Stay in PAS Hospitals, United States, Regional 1969 (1970).

111. B. DECKER & P. BONNER, *supra* note 24, at 19. HEW guidelines reflect this view. The P.S.R.O. Manual states:

> Norms, criteria, and standards should be used in each type of PSRO review. They should, at least, be used for the initial screening of cases to select those cases requiring more in-depth review. In-depth review should be performed by peers using a combination of more detailed norms, criteria and standards and an assessment of a patient's individual clinical and social situation and the resources of the institution in which care is being provided.

P.S.R.O. Manual ch. VII, § 709, at 17.

112. The appropriate use of norms and standards may differ when the PSRO is looking at the pattern of practice of doctors and providers under § 1155(2)(4), 42 U.S.C. § 1320c-4(a)(4) (Supp. III, 1973). These decisions are not being made with respect to care for any individual patient, but rather whether the doctor or the institution is, in general, providing care which differs from others in the area. The extent to which it is appropriate to hold doctors to such a standard can be debated, but that is the aim of the PSRO law. *See* SENATE REPORT 262.

as in the case of hospital length of stay norms, it may be appropriate to require the doctor to explain why he proposes to depart from the standard. But when the norm relates to a complex and inexact set of variables, the PSRO should probably be expected to examine the individual case carefully and then justify its views to the attending physician.[113]

3. Norm-Setting As Rulemaking.—Even if the use of norms, standards, and criteria is limited, the process of their development is of tremendous importance to the doctors, hospitals, and patients who will be affected.[114] Statutory recognition of these interests[115] suggests that the parties should be given an opportunity to be heard during the developmental process.[116] Other interests groups, such as consumer groups and health care organizations, might also make useful contributions.

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113. This approach would follow from the warning of the Senate Committee on the use of norms:

> This professionally determined time of certification of need for continued care is a logical checkpoint for the attending physician and is not to be construed as a barrier to further necessary hospital care. Neither should the use of norms as checkpoints, nor any other activity of the PSRO, be used to stifle innovative medical practice or procedures. The intent is not conformism in medical practice—the objective is reasonableness.

SENATE REPORT 263.

114. The PSRO statute requires that norms be "professionally developed." § 1156 (a), 42 U.S.C. § 1320c-5(a) (Supp. III, 1973). A local PSRO's norms are to accord with regional norms set by the PSRO council. *Id.* HEW's contemplated procedure is that the Secretary of HEW and the National PSRO Council will supply sample norms, criteria and standards. P.S.R.O. Manual ch. VII, § 709.11, at 17. Each PSRO will set up local committees which will consult with specialty groups and determine appropriate guides. *Id.* § 709.12, at 17. (This was the procedure followed by the EMCROs. *See* B. DECKER & P. BONNER, *supra* note 24, at 40-41). Then the PSRO will approve and disseminate these guides. P.S.R.O. Manual ch. VII, § 709.21, at 19. The PSRO will also plan for periodic modification. *Id.* § 709.32, at 20. HEW guidelines do not provide for participation by providers, patients, or members of the public generally.

115. These are reflected in the provisions of section 1159, 42 U.S.C. § 1320c-8 (Supp. III, 1973), and section 1161, 42 U.S.C. § 1320c-10 (Supp. III, 1973). Evaluators of the EMCROs stress the need for the participation of as many doctors as possible to achieve valid and accepted criteria. B. DECKER & P. BONNER, *supra* note 24, at 105.

116. *See* American Airlines, Inc. v. CAB, 359 F.2d 624 (D.C. Cir.), *cert. denied*, 385 U.S. 843 (1966), which indicates a possible basis for this right. In that case, the airlines had a statutory right to a formal adjudicatory hearing on license applications. The agency had decided certain issues relating to the airlines' licenses (involving the extent of rights to sell cargo space at wholesale rates) by rulemaking procedures which did not include an adversary hearing, but did include a chance for an oral presentation. The court held that the rulemaking procedures were appropriate, and satisfied the applicant's rights. The analogous argument can be made that the PSROs decide certain issues by the issuance of norms, *i.e.*, which cases may require additional justification. Parties given a right to procedural protections in the decisionmaking process of PSROs, therefore, have a right to some procedural protections in the rule-adopting process.

The concept of administrative rulemaking offers appropriate procedural analogues for participation of these parties in the development of standards. Rulemaking is typically concerned with broad policy considerations rather than review of individual conduct, and is designed to permit the participation of many persons with different interests.[117] Procedures in rulemaking are simple—notice of the issues to be determined is provided and an opportunity to make written and, often, oral submissions is given.[118] Even if they are not required to do so, PSROs should adopt some variant of these procedures to safeguard affected interests and develop as accurate and widely accepted standards as possible.

III. THE "RECONSIDERATION" PROCESS

A. Who Should Consider—And Reconsider

PSROs are required to make determinations and then to provide an opportunity for reconsideration. An important issue is deciding who should

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117. *See, e.g.*, K. DAVIS, *supra* note 32, § 6.01. Davis strongly advocates wide use of rulemaking, *id.* § 6.13, (1970 Supp.), and believes it should be used by local agencies, particularly in administering public welfare programs. *Id.* § 6.20.

118. Such rulemaking procedures are required for some federal agencies. The question arises whether actions of the National PSRO Council, taken with the Secretary of HEW, in adopting national guidelines for norms, standards, and procedures may be subject to some rulemaking requirements. An argument can be made that they are, but the courts are likely to hold otherwise because of uncertainty of each of several steps in the argument.

Federal agencies must cope with rulemaking requirements of the Administrative Procedure Act unless subject to an exception. One such exception pertains to matters relating to grants or benefits. 5 U.S.C. § 553(a)(2) (1970). A threshold question is whether APA rulemaking procedures apply to the Secretary of HEW for Social Security Act programs. The answer is not clear. In Opelika Nursing Home, Inc. v. Richardson, 356 F. Supp. 1338, 1342 (M.D. Ala. 1973), *aff'd sub nom.* Johnson's Professional Nursing Home v. Weinberger, 490 F.2d 841 (5th Cir. 1974), the court, on the authority of Rodriguez v. Swank, 318 F. Supp. 289 (N.D. Ill. 1970), *aff'd mem.*, 403 U.S. 901 (1971) (AFDC), held that Medicaid rules were not subject to the APA because Medicaid is a grant program.

However, unlike Medicaid, Medicare is not a grant program to the states. Given the thrust of cases decided under Goldberg v. Kelly, 397 U.S. 254 (1970), emphasizing the entitlement of recipients of social security programs, it would seem that Medicare payments are not to be viewed as grants and that the exception to rulemaking requirements is not applicable to regulations which affect Medicare recipients. National guidelines for PSROs affect both Medicare and Medicaid recipients. Thus it could be argued that the exception to APA rulemaking requirements does not affect the Secretary's responsibilities here. Whether the participation of the National PSRO Council removes the matter from the ambit of the APA is another arguable question. In fact, the Secretary of HEW has rule-issuing authority under 42 U.S.C. § 1302 (1970), which does not provide for procedures similar to APA rulemaking. Furthermore, he has not issued regulations with respect to procedures for his rulemaking.

perform each function. The statute provides that licensed doctors shall make final PSRO determinations.[119] The legislative history reveals that the Congress anticipated that computers and nondoctor reviewers would also play a role in the decisionmaking process.[120] However, whether a nonphysician could make what HEW calls an "initial determination"[121] is almost academic since the program rests upon the concept of peer review and the medical community has made it plain that doctors will make the final decisions with respect to doctors' practices. But as already developed in the above discussion of the use of review coordinators, doctors will not be making all of the decisions, or even all of the important decisions.

In order to make a fair and reasonable determination, the reviewing physician must be thoroughly familiar with the record.[122] If, for example, the review coordinator collects the data, applies the norms, consults with the attending physician, and then after securing the doctor's approval, writes the notice, it would be questionable whether the physician had sufficiently performed his statutory duty of peer review. The authors' experience with the pilot programs suggests that such a limited physician's role may be contemplated by some programs. A significant number of physician advisors were found to have billed between 15 minutes and one hour a week.[123] Thus it

119. § 1155(c), 42 U.S.C. § 1320c-4(c) (Supp. III, 1973). *See* p. 432 *supra*. The most basic requisite is that any PSRO reviewer must be disinterested in the sense of having no preliminary interest in the case. *Id.* § 1155(a)(6), 42 U.S.C. § 1320c-4(a)(6). *Cf.* Gibson v. Berryhill, 411 U.S. 564 (1973). It should be noted that even if the reviewing doctor does not have a direct financial interest in the fee to be paid the admitting doctor, there may still be an indirect pecuniary interest. Reviewing doctors may be dependent on other doctors for referrals, or they may be reviewing the decisions of doctors for whom they "cover" at night or weekends. Particularly in some smaller communities, there may be no completely "disinterested" doctors.

120. SENATE REPORT 264.

121. The statute implies that nonphysicians could not make the "initial" determination since that decision is final unless reconsideration is requested.

122. *See* Pregent v. New Hampshire Dep't of Employment Security, 361 F. Supp. 782, 790 (D.N.H. 1973), in which the benefits were terminated by a certifying officer who "personally gathered no facts relative . . . to making his determination." The court criticized the separation of the factfinding from the decisionmaking process as fatal to the adequacy of the procedures.

123. Five pilot programs with admission review programs supplied the following data on hours billed by physician advisors:

Program One:	Of the 25 to 30 advisors doing the bulk of the work, 10 bill for 10 hours per week; the others average 1 hour per week.
Program Two:	The 24 advisors work ½ to 2 hours per week.
Program Three:	The advisors work a maximum of 1 to 1½ hours per week, and in the smaller hospitals as little as 15 minutes per week.
Program Four:	Hours range from full-time at a County Hospital to 5 minutes per day.

may be implied that the review coordinator rather than the doctor was actually doing the deciding.

Serious problems may be anticipated in securing enough PSRO physician reviewers to complete on the spot review of the record in the short time period established for PSRO initial determinations. These problems are likely to increase if PSROs increase the scope of their activities beyond relatively simple length of stay and admission reviews. Nevertheless, these difficulties cannot be solved by improper delegation of the PSRO physician reviewer's responsibilities, for this violates the affected parties' right to have the decider make his determination on the basis of the record and not on the basis of what someone else tells him is in the record.[124]

1. A Disinterested Reconsideration.—While a PSRO must take care not to separate its initial decisionmaking and factfinding functions, it must also be sure that these are kept separate from its reconsidering functions. A reviewer should not "reconsider" a decision in which he originally participated; the reviewer may be biased in favor of his own prior decision.[125] HEW guidelines caution that the reconsiderer "shall have had no previous association with the initial determination."[126]

Satisfaction of this requirement may prove difficult, particularly when the PSRO has delegated the reviewing function to an institutional review committee and the entire institutional review committee made the initial determination. Although a PSRO board could conduct the reconsideration, a question arises whether the use of a PSRO board improperly limits the statutory mandate for institutional review committees. HEW guidelines do nothing to clarify these issues. They require an independent reconsideration, yet also contemplate that the entire decisionmaking process (including the reconsideration) may be carved out by institutional review committees.[127] The use of a single member of the review committee as the initial decider, with the entire committee as a reconsidering body, may be a solution to this problem, at least as long as the initial decider does not participate as a member

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Program Five: In October 1974, 50 advisors billed for a total of 72 hours and 40 minutes, at a maximum of one hour per day.

Program Six: As little as 15 to 20 minutes per month in some cases.

See Nelson, *supra* note 27, at 671. In the On-Site Concurrent Hospitalization Utilization Review (OSCHUR) program, an average of 0.16 physician hours are spent reviewing each case referred to the physician advisor.

124. *See* Goldberg v. Kelly, 397 U.S. 254, 271 (1970).

125. *See id. See also* Gibson v. Berryhill, 411 U.S. 564, 578-79 (1973).

126. P.S.R.O. Manual ch. XIX, § 1910.4, at 7.

127. *Id.* at §§ 1900.1, 1910.2 & 1910.4, at 1, 7 (physician should be reconsidered).

of the reconsidering body.[128]

2. The Decider and Reviewer As Experts.—Doctors who sit as deciders or reviewers for PSROs may be disinterested in some sense of the term, *i.e.*, they may not have participated in the case before, but they will, of course, bring to the process their own expertise. This fact raises various problems. When, for example, the attending physician is a specialist, should his medical decisions be reviewed by doctors who do not have similar training and experience? On the other hand, can workable procedures be developed if the PSRO must find a similarly qualified specialist to review, and another to reconsider the initial decision in contested cases?[129] The appropriate answer is likely to be different in large urban areas with numerous specialists than in smaller communities. Certainly, if the reviewing doctor is not a similarly qualified specialist, greater weight should be given the attending doctor's judgment than in a situation in which a specialist performs the review.

A less recognized aspect of doctors bringing their expertise to bear in administrative decisionmaking is their tendency to supply their own knowledge of the facts.[130] It is true that a basic justification of administrative decisionmaking is that it permits qualified experts to apply their knowledge to complex problems needing specialized experience. Yet when doctors not only make use of their own knowledge of medical treatment but also of other mat-

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128. Since issuance of the directive in Goldberg v. Kelly, 397 U.S. 254, 271 (1970), that the decisionmaker be impartial, courts have considered its application in similar circumstances. Some degree of prior involvement has been permitted. In Escalera v. New York City Housing Author., 425 F.2d 853, 863 (2d Cir. 1970), the court permitted a panel to reconsider a decision even though it had approved the recommended initial decision. *See also* Arnett v. Kennedy, 416 U.S. 134 (1974).

The prior participation of medical staff in doctors' disciplinary proceedings was considered in Duffield v. Charleston Area Medical Center, Inc., 503 F.2d 512 (4th Cir. 1974). The doctor contended that members of the hospital's governing board were barred from presiding at the disciplinary hearing because they had approved the Surgery Department's recommendation to institute the proceedings. The court held that there had not been a due process violation, pointing out that administrative and judicial tribunals are often called upon to retry cases. *Id.* at 517. *Accord*, Woodbury v. McKinnon, 447 F.2d 839 (5th Cir. 1971). However, the degree of prior involvement is markedly greater where PSROs have already weighed the evidence. Moreover, the statute contemplates a new look at the case, which is best achieved by having a new reviewer. *See* Pregent v. New Hampshire Dep't of Employment Security, 361 F. Supp. 782, 797 (D.N.H. 1973).

129. HEW guidelines specify that the person reconsidering must "be of at least equal expertise to the physician or committee who made the initial determination." P.S.R.O. Manual ch. XIX, § 1910.4, at 7.

130. Professional bodies reviewing the competence of doctors are generally permitted to apply their own expert opinions in the decision process. *See, e.g.*, Woodbury v. McKinnon, 447 F.2d 839 (5th Cir. 1971); Jaffe v. State Dep't of Health, 135 Conn. 339, 64 A.2d 330 (1949).

ters—such as prior observation of another doctor's mode of practice[131]—great care must be taken to ensure that the parties get an adequate chance to rebut the basis of the PSRO decision. A PSRO must therefore be certain to include in its notice a full statement of all the factors (including the professional knowledge of the decider) on which the initial decision was based so that each party will have an opportunity to respond. During any oral reconsideration proceedings and in the actual reconsideration decision, the reviewers should similarly take pains to articulate any inputs of their own.[132]

B. The Form of Hearing Needed to Resolve The Issues Facing PSROs

The crux of the fair procedures mandated for PSROs is the statutory provision which affords the affected parties a "reconsideration."[133] One of the hardest questions to resolve is what should take place at this reconsideration. Can the PSRO conduct its reconsideration solely on the basis of documents and records before it? Is it necessary to permit oral presentations? Should a conference be held? Is a trial-type hearing with the taking of evidence and cross-examination required, and who should be present—the attending doctor, hospital officials, the patient or his representatives?

HEW guidelines provide only nominal guidance: they neither require nor bar a hearing involving cross-examination; they permit, but do not require, the presence of all parties. They do, however, direct that "any oral presentation which a party or his authorized representative may choose to present" be considered.[134] Pilot projects similarly offer little guidance as to the types of procedures likely to be required for PSRO reconsiderations. Review was considered a matter to be resolved by informal discussions among physicians. There were few, if any, records of the subjects of these discussions. Formal adverse determinations occurred infrequently.[135]

131. The authors observed that doctors sitting on a review committee did contribute their own impressions of the competence of the physicians involved. This is also a problem faced by review coordinators, physician reviewers and PSRO administrators. Nurse coordinators and physician reviewers confided that they "knew" which doctor's cases should be looked at carefully. Administrators familiar with reviews among several hospitals were often equally able to identify doctors they felt needed "special" oversight.

132. *See* Elliott v. Weinberger, 371 F. Supp. 960, 973 (D. Hawaii 1973), in which the court stressed the need for the agency to give the claimant "any additional information" it had which would clarify complex issues. Time constraints in the proposed PSRO process do not permit advance notice to patients by the reviewers of their inputs, but the extent to which such inputs are made may affect the fairness of the opportunity to be heard, at least when the patient has no expert help.

133. § 1159a, 42 U.S.C. § 1320c-8(a) (Supp. III, 1973), *quoted* note 9 *supra.*

134. P.S.R.O. Manual ch. XIX, § 1910.5, at 8. The Manual goes on to note, however, that "[a] reconsideration is not a formal adversary process." *Id.*

135. *See* note 27 *supra.*

Recent cases, beginning with *Goldberg v. Kelly*,[136] have considered what procedures are required to give recipients of government benefit programs a meaningful opportunity to be heard before those benefits may be cut off. In *Goldberg* the Court required

> that a recipient have timely and adequate notice detailing the reasons for a proposed termination, and an effective opportunity to defend by confronting any adverse witnesses and by presenting his own arguments and evidence orally.[137]

With welfare benefits the subject of the administrative procedures in *Goldberg*, the Court stressed the "brutal need" of the recipients in requiring procedures sufficient to ensure that sound decisions were made. Since the opportunity for timely medical care may be at stake in PSRO determinations, procedures should be fashioned to satisfy this objective.[138]

When applying *Goldberg* to other cases involving government benefit determinations, the courts have not uniformly required trial-type hearings.[139]

136. 397 U.S. 254 (1970). In *Goldberg* the issue before the Court was whether welfare recipients had a right to an evidentiary hearing prior, rather than subsequent, to termination of benefits. Since the Social Security Act required that a "fair hearing" be held by the states before termination was final, there was no question of the right to such a hearing at some point in the process.

137. *Id.* at 267-68.

138. Even though an adverse PSRO decision may be reversed at a later hearing by the Secretary, the patient may be seriously disadvantaged because no treatment was provided in the interim. For further discussion of the patient's need to be heard, see Silver, *Medical Care Delivery Systems and the Poor: New Challenges for Poverty Lawyers*, 1970 WIS. L. REV. 644.

In *Goldberg*, due process requirements were deemed to demand a prior hearing in part because of the "brutal need" of the welfare recipient. Significantly, however, the Court has rejected a narrow doctrine that would limit the due process requirement of a prior hearing to cases involving necessities. *See, e.g.*, Fuentes v. Shevin, 407 U.S. 67 (1972). However, the Court has stated that "medical care is as much 'a basic necessity of life' to an indigent as welfare assistance." Memorial Hosp. v. Maricopa County, 415 U.S. 250, 259 (1974). Moreover, in the case of PSROs, basic due process is mandated by the statute. *See* p. 417 *supra*. Thus, it is not necessary to discuss whether in-patient PSRO review involves a determination of entitlement (to which lesser due process requirements usually attach) or a termination of benefits. *See* Ross v. Wisconsin Dep't of Health & Social Services, 369 F. Supp. 570 (E.D. Wis. 1973) (need to give provider evidentiary hearing concerning patient removal).

139. The Supreme Court, in Richardson v. Wright, 405 U.S. 208 (1972), declined an opportunity to decide the constitutionality of regulations which did not provide for an evidentiary hearing prior to termination of disability benefits. Because the challenged regulations had recently been superseded, the Court vacated the lower Court's opinion with instructions to remand to the administrative agency, remarking that if the administrative process "results in a determination of entitlement to disability benefits, there will be no need to consider the constitutional claim that claimants are entitled to make an *oral* presentation." *Id.* at 209. But evidentiary hearings were required before medical related benefits were terminated in Martinez v. Richardson, 472 F.2d 1121 (10th Cir. 1973) (termination of Medicare); Eldridge v. Weinberger, 361 F. Supp. 520 (W.D. Va. 1973), *aff'd*, 493 F.2d 1230 (4th Cir. 1974), *cert. granted*, 43 U.S.L.W. 3383

They have required an effective opportunity for confrontation, which could include cross-examination of adverse witnesses when factual evidence is involved. However, the courts stress that this opportunity may be offered in informal and nontraditional ways. When the courts have not required cross-examination, the basic objective of cross-examination had been satisfied by less formal procedures.[140] The underlying question is whether the issues involved require cross-examination or confrontation of witnesses for a satisfactory resolution of the dispute, or whether the evidentiary materials developed with respect to medical care issues are so different from the materials presented in other public welfare programs as to eliminate the possible need for confrontation and cross-examination. An examination of recent cases involving medical care issues similar to those likely to arise in PSRO proceedings suggests that provision must be made for oral presentations by the parties, which, at least in some cases, will require confrontation or cross-examination or both. Medical evidence is neither inherently probative nor generally unconflicting, and it often raises factual issues of the sort that should be determined at an evidentiary hearing.[141] Naturally, if PSRO determinations

(U.S. Jan. 14, 1975) (disability); Williams v. Weinberger, 360 F. Supp. 1349 (N.D. Ga. 1973), *aff'd*, 494 F.2d 1191 (5th Cir. 1974), *petition for cert. filed*, 43 U.S.L.W. 3175 (U.S. Oct. 1, 1974) (disability). Providers have also been successful in claiming some hearing rights. *See* Coral Gables Convalescent Home, Inc. v. Richardson, 340 F. Supp. 646 (S.D. Fla. 1972).

The courts have not required hearings *prior* to a suspension of provider payments. *See* Wilson Clinic & Hosp., Inc. v. Blue Cross, 494 F.2d 50 (4th Cir. 1974); Langhorne Gardens, Inc. v. Weinberger, 371 F. Supp. 1216 (E.D. Pa. 1974); Russi v. Weinberger, 373 F. Supp. 1349 (E.D. Va. 1974).

140. *See* Woodbury v. McKinnon, 447 F.2d 839 (5th Cir. 1971), in which the court held that because of the nature of the charges (professional incompetence) and the nature of the hearing (informal discussion of medical records with no witnesses), cross-examination was not required. The court stated:

> Dr. Woodbury was in a familiar setting, with familiar people, discussing a familiar subject. His expertise and acquaintance with the facts of each case thoroughly qualified him to be effective in discussion with his fellow doctors
>
> . . . .

Id. at 844. In other cases involving disciplinary action against a doctor, courts have required more formal procedures, including cross-examination. *See, e.g.*, Duffield v. Charleston Area Medical Center, Inc., 503 F.2d 512 (4th Cir. 1974); Christhilf v. Annapolis Emergency Hosp. Ass'n, 496 F.2d 174, 178 (4th Cir. 1974).

141. For example, in Eldridge v. Weinberger, 361 F. Supp. 520 (W.D. Va. 1973), *aff'd*, 493 F.2d 1230 (4th Cir. 1974), *cert. granted*, 43 U.S.L.W. 3383 (U.S. Jan. 14, 1975) rights to disability payments were contested. Medical evidence on record was at the core of the dispute. The Government argued that no hearing was needed because medical evidence is highly probative and "justifies a different due process standard than in the case of welfare recipients in which 'rumor and gossip' are more likely to form the basis of an adverse decision." *Id.* at 524. But the court observed that in reality medical evidence is often conflicting and a hearing often helps resolve the issues. It concluded that the value of a hearing was "self evident" because the decider must use his own judgment in resolving conflicting medical evidence. *Id.*

do not involve contested factual matters, such procedural opportunities need not be given.[142]

As the Court emphasized in *Goldberg*, procedures "must be tailored to the capacities and circumstances of those who are to be heard."[143] If a patient has requested reconsideration, an informal medical conference may not afford due process, particularly in the absence of any representative capable of participating on the patient's behalf. More formal procedures, with the traditional safeguards of counsel and cross-examination are more likely to arrive at the truth.[144] Thus the decision about the kind of hearing which PSROs shall hold should focus on who is to be present and the ways in which each can meaningfully participate.

C. *Participation At Reconsiderations*

HEW guidelines do not require that any of the parties be present at a reconsideration.[145] But the presence of all involved individuals may be either useful or necessary for an intelligent reappraisal. PSROs should therefore be provided a means for requesting or requiring their attendance. They are not given subpoena power by statute, possibly a flaw fatal to their ability to offer fair proceedings if needed parties refuse to attend. However, they can make requests and use their powers of persuasion with doctors and hospital personnel. And attendance of their own employees (such as review coordinators) and the physician reviewers is within their control.

In Richardson v. Perales, 402 U.S. 389 (1971), the court pointed out that medical evidence is often conflicting and that cross-examination may therefore be needed. It recognized the reliability and probative worth of medical reports, and permitted their use subject to cross-examination at the request of the claimant. It did not, however, require the doctor to testify.

142. *See* Duby v. American College of Surgeons, 468 F.2d 364 (7th Cir. 1972) (no dispute about accuracy of medical records used in disciplinary proceeding).

143. 397 U.S. at 268-69.

144. The courts have observed that when factual issues are the basis of an appraisal of the quality of medical care, there is a need for an evidentiary hearing. Thus, in Citta v. Delaware Valley Hospital, 313 F. Supp. 301 (E.D. Pa. 1970), the court found a need for an evidentiary hearing on the underlying factual issues:

> [W]hat actually occurred on the operating table, *the patient's condition, what the surgeon observed and the reasons for the medical and surgical judgments made, are all matters determinable only by an investigation of their critical factual bases.* The operating surgeon is in possession of almost all the facts necessary to evaluate the decisions he himself made. He is responsible for the "paper trail" of the patient's treatment, the charts and other records prescribed by standard hospital procedure. All of the facts underlying his judgment must be known before his care of the patient can be evaluated with any certainty.

Id. at 308-09 (emphasis added).

145. The guidelines do direct that a single reconsideration be held "at a time convenient for all parties." P.S.R.O. Manual ch. XIX, § 1910.4, at 7.

The admitting doctor's participation should particularly be encouraged so that the PSRO educative function can best be performed. The doctor's own interests are also likely to be best served since he will be given a first hand opportunity to explain his actions.[146] Moreover, other parties' interests are served by his attendance. The patient is helped because the doctor is able to supply the needed information to aid in a correct determination of the patient's medical needs. Furthermore, the likelihood of a conflict between the doctor and the PSRO as to whether the patient should stay in the hospital will be reduced.

The review coordinator and the physician reviewer should also be present, particularly when they have developed factual materials which are in the record. If, for example, observations of the patient by the nurse coordinator or the reviewer are in issue, the claimants should be given an opportunity to test them by confrontation or cross-examination. The PSRO deciders themselves have an interest in defending their decision, an interest which they should appropriately represent, leaving the reconsideration reviewers free to consider the matter anew.

The patient's presence has two aspects. As the subject of the inquiry, he may be a source of evidence. As such, however, his actual presence at the reconsideration is not needed; only the chance for an examination prior to reconsideration is necessary. But his presence as a party advocate may also be relevant. In some cases he will be appealing together with his doctor. In others his doctor will either be neutral or will have been convinced by the PSRO to change his views. In any event, the importance of the right to present evidence and talk directly to the decider was stressed in *Goldberg*.[147] In practice, a patient may be too ill, as well as deficient in background and training, to do much effective advocating. HEW guidelines thus permit his acting through a representative.[148] Some patients may choose to retain a lawyer;[149] alternatively it has been suggested that a lay advocate may be use-

146. Informal talks between review board members and some of the parties prior to the hearing cannot replace their presence at the reconsideration, and may prejudice other parties' rights. Although there is a statutory mandate that the PSRO consult with the doctor and the provider after a determination that his proposed case is not necessary or appropriate, the PSRO should not permit these discussions to substitute for the parties' attendance at the reconsideration. Care should be taken not to prejudice the rights of other parties. For example, the PSRO should be sure to inform the parties of any additional data developed during the consultation which would be taken into account at reconsideration.

147. 397 U.S. at 269.

148. HEW guidelines point out that the costs of such assistance may be met by Medicaid. P.S.R.O. Manual ch. XIX, § 1910.3, at 7. No provision is made for Medicare patients who may also be unable to pay for such assistance.

149. Court cases indicate that there is a right to counsel at the party's option. *See*

ful as a patient representative.[150]

The need to provide an effective chance to be heard may require that PSROs aid patients in finding an effective means of representation, particularly when the attending physician will not be taking an active role in support of the patient's claim. One alternative might be to assign a reviewing physician having no prior connection with the particular determination to act as an advocate and advisor to the patient, and to bring out all that can be said in support of the claim. Interns or residents are possible candidates for this role.

IV. CONCLUSION

The PSRO program is ambitiously conceived. Pilot efforts applied relatively simple standards, were educational in emphasis, made few formal determinations, and experienced few appeals. PSROs are to operate more formally. More formal determinations mean more reconsiderations: as more complicated standards are applied by PSROs—standards developed locally and difficult to verify—even more requests for reconsideration can be expected.

Courts do not consider that the difficulty or expense of providing fair procedures permit the cutting of corners at the individual's expense.[151] The purpose of due process is to protect citizens from intemperate applications of government efficiency. Moreover, due process is not an abstract notion. It is the distillate of that which our legal system has learned about finding the truth. Its application to PSRO determinations should be welcomed as a means to reach this goal.

Goldberg v. Kelly, 397 U.S. 254, 270-71 (1970). *Cf.* Citta v. Delaware Valley Hosp., 313 F. Supp. 301, 311 n.6 (E.D. Pa. 1970) ("It is often very difficult to decide when a hearing requires the assistance of counsel.").

150. *See* S. LAW, *supra* note 40, at 144; Annas & Healey, *The Patient Rights Advocate: Redefining the Doctor-Patient Relationship in the Hospital Context*, 27 VAND. L. REV. 243 (1974). While lay advocates may have a role in helping the patients with questions concerning eligibility, intake, and the proposed treatment, the usefulness of a lay advocate in dealing with issues of the medical necessity of treatment seems questionable.

151. *See, e.g.*, Fuentes v. Shevin, 407 U.S. 67 (1972), in which the Court said:

> A prior hearing always imposes some costs in time, effort, and expense, and it is often more efficient to dispense with the opportunity for such a hearing. But these rather ordinary costs cannot outweigh the constitutional right. . . . Procedural due process is not intended to promote efficiency or accommodate all possible interests: it is intended to protect the particular interests of the person whose possessions are about to be taken.

Id. at 90 n.22 (citations omitted).