

CURRENT TOPICS in review

Professional Standards Review Organization and Pedodontics: A Status Report

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Abstract

The Professional Standards Review Organization is a Federal quality assurance program for Medicaid, Medicare, and Crippled Children's Programs health services which was legislated in the early 1970s in response to administrative, economic, social, and professional concerns. The program is now fully implemented and provides local review of hospital admissions, including pedodontic admissions, through the mechanisms of concurrent review, medical care evaluation studies, and profiles. Extension to review ambulatory services, including dental services, is authorized by legislation. Dentists are precluded from membership. The future interaction between pedodontists and the PSRO is expected to increase as Federal health care programs and quality assurance programs expand.

Peer review, quality assessment, Medicaid "abuse," and third party review are topics of immediate interest to clinicians and health planners alike. Federal and state administrators, insurance carriers, and dental organization officials are involved in defining workable and appropriate methods of review. While this process will continue over the coming years, it is important to note that the dental practitioner is already subject to review through both private and public programs. One of the most far-reaching and institutionalized review mechanisms is the Professional Standards Review Organization (PSRO).

The PSRO is a specific legal entity currently in op-

eration throughout the United States which directly affects the professional activities of all hospital-affiliated dentists including many pedodontists who admit patients to hospitals. Since the PSRO's impact on dentistry is marginal at present, many practitioners disregard its existence or fail to become fully informed of its authority. However, the enabling legislation and ongoing governmental interest in services for children suggest that dentists will increasingly be affected by PSRO activities.

This paper briefly reviews the history and functions of the PSRO and identifies the current and projected relationship between PSRO and pedodontics.

History

Senator Wallace Bennett of Utah introduced legislation in 1970 to establish a nationwide system of health care review in which local physicians would evaluate federally funded medical services to assure "economical and quality" delivery. This proposal did not arise *de novo* but emerged from a constellation of health related concerns within government. These included:

1. The phenomenal rise in Federal health expenditures for personal health services. On July 1, 1966, with the introduction of Medicaid (Title XIX of the Social Security Amendments) and Medicare (Title XVIII) the government became the largest third party carrier in the health care marketplace. Both the dollar amount and the rate of increase in Federal spending were rising rap-

idly by 1970. Projections of accelerating rises were realized. By its tenth year of operation 40% of the personal health care market was funded by government, and government spending had increased sevenfold to over 48 billion dollars.¹

2. The demand for an increased role of government in providing funds for health care. A number of national health insurance bills were introduced, many more developed, and public agitation for national insurance was increasing. Congressional and Executive health planners recognized the need for cost control if expansion of Federally funded services was to be considered.
3. The need to work within the private fee-for-service medical care system. Alternative delivery systems were totally inadequate to meet demands generated by Medicaid and Medicare. By 1973 the Federal government had begun stimulating the development of alternative delivery systems through the Health Maintenance Organization Act.² These efforts continue with increasing intensity but such Organizations are generally not widely available to the consumer.
4. The conflict between the need to control costs and the need to avoid interference in medical practice. The fact that "Health is priceless" needed to be reconciled with limited funds. Government sponsored services could not be allowed to suffer in quality because of economy. Thus arose the juxtaposition of the words, "economical delivery of health care" and "services of proper quality" in the preamble to the PSRO legislation.

Bennett recognized the developing confrontation between the government as financial underwriter of care and the health professionals as care-givers who demand autonomy in the provision of that care.³ Imposition of cost controls were inconsistent with the professional model⁴ underlying the fee for service system on which the programs depend. What government needed was a surveillance system of quality and appropriateness of care. What providers needed was a system of internal review consistent with their own authority. The compromise was the creation of the PSRO,⁵ a federally-designed review system implemented exclusively by local physician groups.

Purpose and Organization

The purpose of the law is to determine for Medicaid, Medicare and Crippled Children's Program reimbursements whether services provided are medically necessary and in accordance with professional standards.⁶ All federally-sponsored services provided "by or in institutions" are monitored on a continuous basis.

Extension of review to ambulatory services is authorized upon approval by the Secretary of Health, Education and Welfare.⁷

Between 1972 and 1974 the Secretary designated two hundred and three PSRO areas and awarded start up grants to non-profit, non-insurance, non-American Medical Association groups which were not challenged by more than 10% of the local physicians as their PSRO. For coordination, states with more than three PSROs also formed statewide Professional Standards Review Councils. A National Professional Standards Review Council of 11 physicians was appointed to advise the Department of HEW through the Health Care Financing Administration. While physician membership in the PSRO is entirely voluntary, all health services provided to patients under Social Security Programs are subject to review. This includes services provided by non-member physicians and by all dentists, who are specifically excluded from membership. Thus "peer review" for the dentist is conducted by a group of physicians within an organization lacking dentist representation. The law provides for dentists only in the role of consultants through appointment to nonvoting statewide advisory councils.^{8,9}

Mechanisms

Three mechanisms are employed by the PSRO to assure appropriateness, quality and necessity of services:

1. *Concurrent Review*:¹⁰ Admission certification for necessity of admission and appropriateness of diagnosis is based on the patient's presentation and admission workup. This level of review is conducted by a PSRO authorized utilization coordinator. Under the contract system employed by some PSROs, this individual is a hospital employee who may be charged with review of all inpatients or only those subject to PSRO review. Where PSROs operate directly within area hospitals, the utilization coordinator represents the PSRO exclusively.

Should the coordinator find the admission unjustified or unsupported by the patient's clinical presentation, the PSRO may notify both patient and doctor of its disapproval. Under such circumstances the doctor may appeal the decision. Unless the PSRO approves the admission, remuneration for subsequent services is withheld from both hospital and provider.

The utilization coordinator also oversees the length of stay (LOS) for each patient. The LOS is usually based on standards established region-

ally by the American Hospital Association and is disease specific.¹¹ Extension of stay requires local review. Again, if deemed unjustified, remuneration is withheld.

2. *Medical Care Evaluation Studies*:¹² These retrospective studies of groups of patients are intended to refine standards of care. They may be utilized to investigate local problem areas, to evaluate procedures for benefit, or to determine the appropriateness of employing new procedures. These studies closely parallel "audits" advanced by the Joint Commission of the Accreditation of Hospitals and the American Hospital Association. Their underlying purpose is to allow progress in medical care to be reflected in changing standards.

3. *Profiles*:¹³ Profiles by patient, practitioner, and institution can be generated and analyzed from data collected from individual hospitalizations. At this writing the methodology for developing and interpreting profiles is being refined and most profile studies have been experimental. Currently, the most sophisticated claims review mechanism based on profiles describing patterns of outpatient care is the Physician Ambulatory Care Evaluation Program (PACE) of Utah. Efforts are underway to adapt PACE technology to ambulatory dental care.¹⁴

In the future, profiles of hospitals based on diagnoses will be employed to identify those conditions which will require continued concurrent review. After the program attains the necessary level of statistical validity, concurrent review will be limited to those diagnoses which are noted to be associated with excessive admissions, complications, extensions of stay or other disparities from the norm.

An additional mechanism for review, authorized by statute, is the examination of records and facilities of health care providers. These efforts will become of greater concern when active involvement in ambulatory care monitoring becomes commonplace. At this time few PSROs provide limited outpatient review under demonstration grants.

Dentistry's Role

While some dental services are already subject to review, and expansion to include outpatient services is anticipated, dentists are prohibited PSRO membership. In January of 1978, HEW Secretary Califano moved toward granting PSROs local option in allowing dentists membership. Local option was never instituted because the PSRO law specifically precludes non-physician membership, a restriction which can

not be overruled by regulation. An American Dental Association-backed attempt to amend the legislation was introduced in the Senate of the 96th Congress by Senator Matsunaga of Hawaii.⁸ The American Dental Association has worked vigorously at the legislative, promulgative and implementation stages to demand dental review by dentists.

Two reasons for the exclusion of dentists can be proposed. Firstly, the inclusion of dentists could be construed as a dilution of physicians' control in peer review and could detract from the attempt by government to respect the medical professional's autonomy. Admission of a dentist today might be viewed as an open door to additional providers or even consumers tomorrow. Secondly, the total impact of inpatient dentistry in Federal spending for personal health services is insignificant from a cost containment viewpoint. The ADA claims that "inpatient hospital admissions for dental care are well over a million per year"¹⁵ while an analysis of Social Security Administration data¹ shows that dental services, inpatient and outpatient combined, account for less than one cent of the public dollar for personal health care. Thus, it has not been in the interest of either government or organized medicine to include dentists in the PSRO.

Application to Pedodontics

A typical review of a pediatric admission for restorative dentistry under general anesthesia begins with admission certification by a utilization coordinator relying upon PSRO criteria for appropriateness of hospitalization. These criteria may include age, medical status, caries severity, and emotional/psychological health. The patient's presentation and admission workup including history, physical examination and admission note must support the admission. The reviewer then assigns a length of stay, usually two days. During or immediately after hospitalization, diagnostic, therapeutic, and discharge criteria may be used to evaluate the course of the patient's stay.

A hospital or PSRO may choose to conduct a Medical Care Evaluation Study of pediatric dental admissions. One such confidential study of 50 admissions is illustrative of the review method. Exceptions from criteria were noted and evaluated for cause. Among these were the failure to obtain a complete blood count which was deemed unjustified, and the occurrence of post-operative cardiopulmonary arrest which was deemed justified in that "critical management criteria" were met.

While the author is not familiar with any profile studies specific to pedodontics, such studies could be conducted to compare individual dentists with their peers in hospital utilization, frequency of complica-

tions, compliance with criteria or patient selection.

It should be noted that all three review mechanisms may be employed at the hospital's discretion to include both publicly and privately funded patients.

Implications for the Future

The majority of dental services are provided in an outpatient setting. This characteristic has sheltered dentistry from PSRO activities to date. However, federal interest in providing dental services to children has increased markedly in the past decade. As the scope of children's services increases and ambulatory review expands, pedodontic services are likely to become the major target of review within dentistry.

Evidence of governmental interest in dental care for children abounds. While restrictions and cutbacks in adult dental services have characterized Medicaid, expansion of children's services has been mandated under the Early, Periodic, Screening, Diagnosis and Treatment Program (EPSDT).¹⁶ All but one state, Arizona, have instituted such programs.¹⁷ The Crippled Children's Program also provides dental services for select children. At present over 12 million children, approximately one in six, are covered by one of these programs. Further interest in children's services is evidenced in the Child Health Assurance Program (CHAP) which would strengthen and expand EPSDT. The Senate twice has passed a Children's Dental Health Act. Many national health insurance proposals call for dental care for children. Vermont has expanded its Health Department dental care activities through its Tooth Fairy Program to include many children not otherwise eligible for Medicaid-type benefits. The trend is clear for increased involvement of government in providing dental care for children. With each such program, the monitoring of dental services by PSRO becomes potentially more significant to the pedodontist.

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