1977-06-22

P/S/R/O update: June 22, 1977 no. 33

P/S/R/O Update

Boston University Medical Center

June 22/77
Number 33

The Medical Cost/Quality Newsletter

IOM study on reliability of hospital discharge abstracts--background and an opinion

Early this year the Institute of Medicine issued a report on a study of the "Reliability of Hospital Discharge Abstracts," which found that information on diagnoses was inaccurate in more than one-third of the cases examined and information on procedures was inaccurate in more than one-quarter of the sample.

The revelation that hospital discharge data are flawed to this degree raises the concern of hospital administrator Geoffrey Jackson, whose opinion about the problem and its solution follows a brief outline of the report.

THE REPORT

Abstracts on Medicaid, Medicare patients at 50 nonfederal short-term hospitals compared

The Institute of Medicine was asked by the DHEW Office of Quality Standards to "assess the reliability of hospital utilization data compiled by private abstracting services during calendar year 1974," according to the 113-page report. The stated purpose was "to assist in identifying an existing and accurate source of data to

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Abrupt administrative move by Califano cuts four members of Council, trims terms of three

With a swift administrative stroke, DHEW Sec. Joseph A. Califano, Jr., this month ended the terms of office of four National PSR Council members and shortened those of three others. He did this, he told them, to stagger the terms of service and to "facilitate a yearly influx of individuals with different backgrounds and points of view."

The four whose terms will end June 30 are Donald C. Harrington, M.D., Alan R. Nelson, M.D., Raymond J. Saloom, D.O., and Willard C. Scrivner, M.D.

NO WARNING

The decision to stagger the terms was no surprise, for there is legislation pending to do just that, but what came as a jolt is that Califano took this action with no warning to the Council members or to the DHEW staff of the Council. Ironically too, the process of making what is a change in the Council's charter was under way in Califano's office at the very time the secretary was addressing the National PSR Council May 24, reiterating his support for the PSRO concept and program (see separate story).

He sent letters dated June 10 to all 11 Council members thanking them for the time they had "generously donated over the past four years." Apparently, the Council members had received no prior notice of Califano's decision.

The three members whose terms have been shortened to two years--that is, to serve

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PSRO Update, which covers the federally mandated Professional Standards Review Organization program and the broader field of medical cost and quality, is published monthly by Boston University Medical Center. Address editorial inquiries to **PSRO Update,** 720 Harrison Avenue, Suite 300, Boston, MA 02118. Telephone (617) 247-5606. Address subscription inquiries to **PSRO Update,** 306 Dartmouth Street, Boston, MA 02116, Telephone (617) 267-7100. Executive Editor/Donald R. Giller. Managing Editor/Owen J. McNamara. News Editor/Barbara Mackey. Contributing Editors/Nancy Haslam, Lorraine Loviglio, John Blum. Correspondents throughout the nation. Staff assistant / Rose Razzino.

IOM study on reliability of hospital discharge abstracts--background and an opinion

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serve as a baseline for measuring the impact of Professional Standards Review Organizations."

The study did not purport to compare the relative reliability of the participating abstract services (which remained anonymous).

3,301 ABSTRACTS STUDIED

Fifty short-term nonfederal hospitals were chosen, by a controlled selection technique, to be representative across the country, and a total of 3,301 abstracts of Medicare and Medicaid patients discharged during 1974 were examined.

"The accuracy of seven information items from the original abstract was determined by comparing those items with the results of an independent abstracting of medical records by a trained field team and noting the frequency and type of discrepancies," the report says.

"The analysis showed that information on hospital admission date, discharge date, patient's date of birth or age, sex, and anticipated principal source of payment was highly reliable," according to the report. "However," it continues, "for all principal diagnoses combined, when codes were compared to four digits, the original abstract and Institute of Medicine re-abstract agreed for only 65.2 percent of the records; for all procedures the level of agreement was 73.2 percent.

Among the recommendations, at the outset, is the warning that "one must assume that abstracted hospital data contain errors and use them with caution."

WARNING ON USE

For describing "general utilization patterns, such as age or sex differentials" or for comparing average lengths of stay among hospitals, the quality of the data appears to be adequate, says the report. "However, if such data are to be used for research or evaluation and, in particular, to assess the effects of specific changes in the health-care delivery system such as the imposition of utilization review or PSRO program on patterns of patient care, then more stringent precautions should be taken," it concludes.

Another conclusion is that "If quality assurance programs discontinue the current practice of reviewing all patients and physicians and move to a more targeted review of cases likely to be associated with poor quality (as recommended in the basic study report), in many cases, this will require improving the data base in order to detect changes in utilization patterns. As an example, it is quite likely that criteria for hospital admission and continued stay for a patient with uncomplicated diabetes mellitus (code 250.0, using the H-ICDA system) would be quite different from criteria for a diabetic with acidosis or coma (code 250.1). In order to evaluate the effect of review, it is essential that diagnostic information be accurately coded to the fourth digit."

CAREFUL REVIEW URGED

Other specific recommendations are for the PSRO program managers in DHEW to build into the management information system periodic assessments of the reliability of PSRO data; for physicians to "use more care in completing the medical record," and for medical record department personnel to "review the body of the medical record and not just the face sheet before abstracting information on diagnoses and procedures."

This Institute of Medicine report, published in February 1977, is available from: Printing and Publishing Office, National Academy of Sciences, 2101 Constitution Ave., N.W., Washington, D.C. 20418. ■

OPINION
Flawed data, as highlighted in IOM study, could affect critical decisions in medicine

The Institute of Medicine study provides startling evidence of the level of inaccuracy in the capture of medical data from patient medical records after discharge of the patient. In the aggregate, the principal diagnosis was found to be inaccurately reflected in 34.8 percent of the cases. The principal procedure, which was almost invariably a surgical procedure, was found to be inaccurately reflected in 26.8 percent of the cases. Perhaps more shocking was the revelation that in 10.7 percent of the cases it was impossible to identify from the medical record the principal diagnosis, and, in 16.3 percent of the cases, it was impossible to determine the principal procedure used. There can be no serious questioning of the study methodology or the analysis of the

findings, for the study was carefully conceived, executed and reported.

DANGER IN 3 AREAS

I believe this IOM study has clearly indicated the magnitude of the problem of faulty data. The danger now looming is that such flawed data will be used increasingly by government regulators in making critical decisions that will affect medical practice and institutional reimbursement. Continued inaccuracies in medical data to the degree reflected in the Institute of Medicine study have the potential to affect adversely PSRO surveillance, health systems agency planning activities, and the establishment of hospital reimbursement allowances by state rate-setting agencies.

The key to a PSRO's surveillance mechanisms is the use of abstract data, especially those specifying diagnoses and procedures. Using this type of data, PSROs have been establishing length-of-stay norms and, before long, will be developing physician profiles.

It is also abundantly clear that discharge-abstract data will be utilized increasingly by HSAs in their mandated planning/regulatory role.

The third area of impact of these data is the hospital reimbursement rate established by the state. In the past several years there has been accelerated activity in several states (Massachusetts, Pennsylvania, New Jersey and perhaps others) to use these data to develop hospital case-mix profiles with the ultimate objective being the application of these analyses in setting hospital rates. It is clear, therefore, that PSROs, HSAs and hospitals have a large stake in seeing that the data they work from are accurate.

WHERE ERRORS CREEP IN

Assigning the blame for data inaccuracies is not easy, as the IOM study points out. Essentially, there are three points in the process of recording and reporting data at which errors may occur: with the physician-recorded medical record; with the encoding procedures employed by hospital medical records departments; and with the computer processors of the abstracted data.

It appears to me that the most important area needing improvement is the medical record itself. Indeed, the study report spoke to this problem, noting that "abstracted information clearly can be only as accurate as the record from which it is drawn. If important information is ambigiously noted or absent, the abstract will be equally inadaquate."

The study indicates that, besides the cases where principal diagnoses and procedures could not be determined from the record, there were significant problems in determining the order of importance of multiple diagnoses and/or procedures: that is, in determining which of several notations was the principal or primary diagnosis or procedure. Secondary or teriary diagnoses and/or procedures were frequently reported as principal or primary.

The report also provides evidence of inaccurate coding (using the International Classification of Diseases) of diagnoses and procedures by medical records department personnel when the medical record did contain the appropriate diagnoses and procedures. This raises serious questions about quality-control procedures in hospital medical records departments. At a minimum, hospitals should maintain a sampling procedure wherein the medical records administrator or his or her professionally trained assistant or supervisor (qualified as an RRA--registered records administrator--or ART--accredited records technician) would encode a suitable number of records and compare them to the original abstract.

TAKING CORRECTIVE ACTION

The IOM study dealt with five representative data processors and found variations in the level of inaccuracies among them ranging from 23.4 percent to 35.2 percent for diagnoses and from 10.5 percent to 26.5 percent for procedures. A variety of causes for the inaccuracies makes it difficult, if not impossible, to ascertain what portion of inaccuracies can be assigned to data processors alone. It is evident, nonetheless, that since input of the data to the data processing systems requires converting information to a machine-readable document, such as a keypunched Hollerith card or an optical scan document, the process should be scrutinized closely for errors in this step. Furthermore, and perhaps of more significance, programmed editing functions do vary from system to system; clearly, the more practical the editing features a systems has--such as a system that rejects the incompatible variables of a diagnosis of prostatitis for a female--the better the data output.

The IOM study has provided sufficient evidence of the need to improve the accuracy of hospital discharge data. It is now incumbent on hospitals and medical staffs to take steps to improve medical abstract data. Missing or ambiguous diagnostic and pro-

cedural information in medical records should be dealt with in the way many hospitals now deal with delinquencies in discharge and operative summaries--by temporarily removing hospital admitting and/or operating privileges. Medical records departments should institute appropriate quality control procedures. Rigorous procedures may be necessary to assure the accuracy of data that will, without doubt, be used increasingly in government regulation of hospitals and physicians. ■

Geoffrey G. Jackson
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Administrative Services
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Califano tells National Council PSRO is a key lever in DHEW effort to control costs, utilization

To reinforce his stated commitment to the PSRO program, DHEW Sec. Joseph A. Califano, Jr., addressed the May meeting of the National PSR Council, telling its physician members that "if anything is done, it will be to strengthen" the program.

"The PSRO system is one of the important levers we have to get more effective control over health costs and health utilization and over quality of care," he said.

Califano also took the opportunity of his appearance before the Council to point out the necessities of the current departmental activities geared to control costs, especially hospital costs. "The health area is not only of critical human importance, it's a big business without any of the inhibitions of the free enterprise system. Hospitals are essentially cost-plus operations," he said. "There is no competition."

CITES HCFA CREATION

According to the secretary, DHEW is just beginning to piece together the various federal health-care components. In his view, significant progress has been made in creating the Health Care Financing Administration which, for the first time, unites the Medicare and Medicaid programs. Noting that critics have viewed the move as a downgrading of the assistant secretary for health, Califano countered with the point that the assistant secretary, who had previously had little impact on the Medicare and Medicaid programs, will now have a strengthened hand in working with the entire Health Care Financing Administration. ■

Abrupt administrative move by Califano cuts four members of Council, trims terms of three

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until June 30, 1978--are Merlin K. DuVal, M.D., Cornelius L. Hopper, M.D., and Ruth M. Covell, M.D. With the exception of Hopper, all seven members whose terms were shortened have served since the Council started.

The four who will serve out the full three-year term were new to the Council last July. They are Wyndham B. Blanton, Jr., M.D., Robert L. Hare, M.D., Robert T. Kelly, M.D., and William Fred Lucas, M.D.

TWO COMMENT

Two of the four terminated Council members who were available at press time for comment indicated the two-weeks' notice was an abrupt termination. Harrington said, "I do not argue with the rationale; in fact, the Council had discussed this staggering of terms and had been supporting a change in the legislation to accomplish that."

Saloom, who made the same point, was clearly annoyed, however, at the summary action of the secretary. He was considering bringing suit against the secretary for acting arbitrarily, a violation of an administrative law that incurs liability, Saloom told PSRO Update.

Saloom said, "I figured that after four years on the Council we'd get more than two weeks' notice."

One of the reasons for Saloom's annoyance was that Califano listed no criteria for choosing the members for the one- and two-year terms.

Harrington made his own interpretation, saying, "Obviously, the four just appointed should be left on. And obviously, the Council needs more women and blacks, so [Covell and Hopper] were left on. And then, of course, [DuVal] is the chairman and he should stay on longer."

The July 18-19 Council meeting will be held as scheduled, even if four new members have not been appointed by that time. Officials in Califano's office are working on the new appointments and hope to have them made by the beginning of their three-year terms, July 1. ■

Draft transmittal calls for cooperation between PSROs, End-Stage Renal councils

PSROs will be asked to begin exploring areas of agreement with local boards of the End-Stage Renal Disease program, according to a draft transmittal brought before the National PSR Council at its May meeting.

The instructions prepared by the Bureau of Quality Assurance describe the ESRD program, recommend areas of integration between the two programs, and offer draft guidelines for developing written agreements between PSROs and the ESRD medical review boards.

In reviewing the ESRD program for the National Council May 23, Roy Crystal of BQA explained that it was created under Public Law 92-603 (which also created the PSRO program) to provide Medicare coverage for individuals suffering from end-stage renal disease that required either maintenance dialysis or kidney transplant.

Under the ESRD program, 32 network coordinating councils were to be set up across the country to run the program; 30 of these are now in place. Nine hundred facilities are expected to participate at the outset. Within each network coordinating council, a medical review board is to be established. The MRB's functions are to

--assess the appropriateness of patient treatment procedures;

--assemble profiles on physician performance;

--conduct medical care evaluation studies in the area with the coordinating council;

--delegate the performance of MCE studies to appropriate parties;

--recommend changes, where necessary, involving physician and institutional treatment; and,

--report annually on its activities to the coordinating council and the secretary of DHEW.

The MRB is to assist the PSRO by providing advice on the quality of medical services given to ESRD patients and by developing procedures to integrate its review activities with PSRO medical review. These arrangements between the MRB and the PSRO are to be included in the MRB's written plan and the PSRO's revised formal review plan. The draft transmittal calls for these agreements to be flexible because of the developing nature of both programs.

MRBs are to take the lead in coordinating review activities for renal disease by working with PSROs in performing appropriate areawide studies, setting criteria and standards, collecting and integrating relevant data and instituting corrective action when needed. Crystal pointed out that, of the two organizations, the PSRO has the primary responsibility for inpatient review. Jurisdictional difficulties could arise over review of noninstitutional services (these constitute the majority in the ESRD program) because there is conflicting statutory authority providing both organizations with review power. Early adoption of the draft transmittal and subsequent development of a functional integration plan should prevent future jurisdictional disputes between PSROs and MRBs.■

Cost-containment program would need two to three years to become effective, Council told

Presenting highlights of the administration's hospital cost-containment bill, William Fullerton, a special consultant to the DHEW secretary, told the National PSR Council at its meeting May 23 that while the administration is pledged to begin a national health insurance program, it realizes that prior to such a program, health-care costs need to be controlled. Cost containment for hospitals, he noted, will take at least two to three years before it is effective.

What the legislation would do, Fullerton said, is restrict third-party payments to hospitals in such a manner that it would limit patient-care cost increases to nine percent over the previous year (using 1976 as the initial base accounting year). Exceptions would be granted for hospitals experiencing higher or lower utilization rates. For those hospitals whose cost increases fall below the nine-percent limit (of which there are presently about 22 percent), the differences can be carried over to the next year.

States that have cost-containment programs in place, such as Massachusetts, Maryland, Connecticut and Washington, would be exempted from the program, he indicated. In the capital-costs area, annual expenditures would be limited to $2.5 billion nationally to be parcelled out through health systems agencies. State certificate-of-need agencies would also have to comply with the capital-expenditures limits.■

$142 million in Medicaid funds being withheld, but administration moves to change requirements

WASHINGTON, D.C.--The Carter Administration has announced it is withholding $142 million in federal Medicaid payments in July from 20 states for inadequate utilization review in nursing homes and mental institutions, a move expected to have no impact on state relationships with PSROs.

The penalties were announced with admitted reluctance by DHEW Sec. Joseph A. Califano, Jr., who said he is considering an additional $377 million in penalties for 27 states, including some on July's penalty list. The differing penalties apply to different periods of time. But Califano said the administration was drafting legislation to ease the requirements for federal withholding of Medicaid funds. The proposed legislation would restore any funds withheld while setting "new, more meaningful" enforcement measures for the future, Califano said.

URGENT NEED FOR CHANGE

"I hope the legislation can be acted on as rapidly as possible," he said. "The Medicaid program already makes heavy fiscal demands on the states. The law must be enforced, but it urgently needs to be changed to be reasonable, equitable and effective."

The American Health Care Association, representing nursing homes, pledged its support for a change in the legislation that now requires the fund cutoffs. Rep. John Moss (D-Calif.), whose House investigation subcommittee had accused the previous DHEW secretary of flouting the law in refusing to withhold federal aid from states inadequately reviewing the $18 billion-a-year Medicaid program, also is considering legislative changes.

LITTLE OR NO IMPACT

Larry Sobel of DHEW's Bureau of Quality Assurance said the DHEW penalties would have little or no impact on PSROs, primarily because peer review hasn't moved into long-term care yet. He said that proposed rules and instructions were sent to the states by DHEW's Medical Services Administration (Medicaid) about a year ago, informing them that once PSRO assumes binding review responsibility in an institution, the intermediary, state agency and hospital are no longer responsible for utilization review. The regulations are not yet final.

The largest amount withheld, $53,806,152, will be in New York State, followed by California at $15,359,223 and Pennsylvania at $13,593,459. Other states scheduled to lose Medicaid funds are Alaska, Indiana, Kansas, Montana, Nebraska, Tennessee, Colorado, Iowa, Maryland, Massachusetts, Michigan, Missouri, New Jersey, North Carolina, North Dakota, Ohio and Wisconsin.■

Data-sharing system should be decentralized, flexible, spokesmen for agencies tell Council

The issues surrounding the collection of hospital discharge data continue to receive attention from many quarters in the federal health establishment.

At its meeting last month, the National PSR Council heard a lengthy oral report from representatives of key agencies involved in data collection questions. In general, these representatives stressed the need for a sharing of health statistics by the many actors involved in health care and regulation. Ideally, this would be accomplished through a data broker or consortium, many indicated, but the data system should be decentralized where possible and flexible enough to meet local needs.

A MASSIVE TASK

Speaking at the meeting were representatives of the U.S. National Committee on Vital Health Statistics, the Office of Management and Budget, the Bureau of Quality Assurance, the Medicaid program, the Medicare program, the Health Data Policy Committee and the National Center for Health Statistics. Most acknowledged that the task of centralizing the collection and use of health care data that are responsive to the needs of both providers and regulators is a massive one, and that completion of a working system is some time away.

William Cresswell of BQA expressed the need for quality data in the PSRO program as a prerequisite for developing useful profiles. It was pointed out that currently 10 PSROs are involved in negotiations to establish cooperative health statistics systems in their area.

ENUMERATES ESSENTIALS

The essentials of a Uniform Hospital Discharge Data Set, as enumerated by James Cooney of the U.S. National Committee on Vital Health Statistics, include minimum agreed-upon data elements on discharge, usefulness to a group of multiple users, readily collectable data, the ability of the information to be collected continually, a means of ensuring confidentiality and a

unique method of identifying patient records.

While significant progress had been made in the development of the UHDDS, it was indicated that the package had not yet received general approval by OMB, and that resistance to the mandatory nature of the Uniform Hospital Data Abstract had caused it to be abandoned for the time being.

James Robey, from the National Center for Health Statistics, described the progress being made in the Cooperative Health Statistics System. At this time, the Center has contracts with 43 states to establish various CHSS components, of which there are six.

COVERS THE 'UNIVERSE'

The CHSS is geared to cover the whole "universe" of health providers and not to serve just a sample; it is to be flexible and locally based, and designed to encourage multiple use and the protection of confidentiality. A key component of the CHSS is the Hospital Care Data System, which has been established in 16 states.

The National Center for Health Statistics has also been involved in running the Hospital Discharge Survey, which includes 425 hospitals with approximately 225,000 discharge records yearly. The discharge survey generates data that identify average length of stay in acute-care facilities by diagnosis, sex, race, size of hospital and area of the country. The Hospital Discharge Survey can be helpful to PSROs in assisting the development of norms; serving as a baseline for evaluation; conducting a national MCE study, if desired; extracting samples in areas where PSROs do not exist; and developing comparisons with nonfederal patients. ■

D.C. leadership conference to center on key issues in health-cost containment

Cost-containment is the theme for a national leadership conference on health to be held June 27-28 in Washington, D.C., sponsored jointly by the National Journal and Senators Edward M. Kennedy (D-Mass.) and Jacob K. Javits (R-N.Y.).

"The conference will address the health-cost issue through six critical areas which impact on the problem: health manpower, planning, reimbursement, quality, delivery systems and technology," according to the sponsors.

HOW MUCH QUALITY?

The sponsors note specifically that the legislation that created PSROs was an attempt to answer the public's concern for the quality of federally financed health care. "There is a direct correlation between the quality of care delivered and its cost. Government must ask itself how much quality it is willing to pay for. Where does a society that values human life as highly as this one come down on the quality versus cost question?" say the sponsors.

More information about the conference is available from: Controlling Health Care Costs, 1730 M St., N.W., 11th floor, Washington, D.C. 20030; telephone: 202/857-1400. ■

Self-interest or public interest? IRS ruling on Virginia PSROs heats up long-running debate

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under Public Law 92-603, and the activities that are construed as promoting physician self-interest are, in fact, carried out to comply with legislative and contractual obligations. If one sees the PSRO this way, as a physician group formed to carry out the mandate of a federal law, and with self-interest operating only in so far as there is an attempt to develop as professional a program as possible, then it seems that 501(c)(3) status could be awarded. It appears that the IRS, in the case of the Virginia PSROs, applied, very strictly and very literally, the organizational test. In fact, the nonexempt purposes of the PSRO are substantial only if one views these groups as physician organizations engaged in furthering their own professional interests.

Under the new Tax Reform Act of 1976, PSROs do not have to conduct a major lobbying effort to get their tax status altered. A PSRO that wishes to appeal its status through administrative channels can proceed under Section 7428 of the Internal Revenue Code, either in the U.S. Tax Court, the U.S. Court of Claims or the U.S. Court for the District of Columbia, to obtain a declaratory judgment, which could be appealed directly to the Supreme Court.

In the final analysis, the differences between 501(c)(3) status and 501(c)(6) status have very little effect on the actual operations of the PSRO. The potential impact on physicians' attitudes toward the PSRO program may be significantly affected, however, by the way in which the IRS views these organizations. Thus, the debate concerning (c)(3) versus (c)(6) may be one in which PSROs may have to participate. ■

John Blum, J.D.

ANALYSIS

Self-interest or public interest? IRS ruling on Virginia PSROs heats up long-running debate

In a recent ruling by the Internal Revenue Service, PSROs appear to have been placed in a category that defines these organizations as professional self-interest groups, not as organizations devoted wholly to a public purpose. While this judgment may have no effect on the operations of a PSRO, it may seriously affect physicians' willingness to cooperate in a pursuit that the IRS sees as primarily self-interest, not public interest.

Since the inception of the program, PSROs have been engaged in a debate with the IRS over whether their organizations should be given a 501(c)(3) tax status or placed in the 501(c)(6) category. Both apply to nonprofit organizations, but the (c)(3) status is given to organizations engaged in a totally public purpose, such as a charitable, educational, religious, scientific or literary endeavor. Contributors may deduct gifts to these corporations, and the organizations receive reduced postage rates. On the other hand, the (c)(6) status is assigned to a corporation whose primary purpose is to promote the common business/professional interests--that is, the self-interest--of its members. The (c)(6) organization may engage more extensively in lobbying, while this activity is restricted for the "public interest" organization.

UPHOLD PROFESSIONAL INTERESTS

In a ruling that was two years in coming, several Virginia PSROs were informed they were to remain designated as 501(c)(6) corporations. The IRS took the position that the primary purpose of the PSRO entity was to uphold the professional/business interests of its members in the practice of medicine. While this decision was particular to the Virginia PSROs that had raised the question, it seems likely that PSROs that received the (c)(3) designation originally will lose it in the event of an audit.

The Virginia PSROs and others throughout the country are upset over the fact that the IRS does not see these organizations as professional associations whose key function is to carry out medical review in the interests of the public. They feel that the IRS view of PSROs as physician self-interest groups will make it more difficult to develop good relationships between the review groups and the medical community.

A MATTER OF HAIR-SPLITTING

The distinction between 501(c)(3) and other categories of nonprofit corporations is often a matter of hair-splitting. The case of Better Business Bureau v. U.S., ruled on by the Supreme Court in 1945, stands as the key precedent in this area. In the decision, the Supreme Court ruled that, in order to fall under a 501(c)(3) status, the organization in question had to be devoted exclusively to tax-exempt purposes. "The presence of a single non-exempt purpose, if substantial in nature, will destroy the 501(c)(3) status regardless of the number or importance of truly exempt purposes."

The Better Business Bureau test has been somewhat expanded, so that currently a corporation, in order to qualify for 501(c)(3) status, must meet either an organizational test or an operational test. The organizational test is essentially the one developed in the Better Business Bureau case that holds that (c)(3) status designation can be awarded only when the organization is created exclusively for one of the exempt purposes (educational, charitable, religious, scientific, literary, etc.); if there is another substantial purpose, the exemption will not hold. The operational test says that if a corporation is operated exclusively for one or more exempt purposes it will be classified as a (c)(3).

If one applies either the organizational or operational test to PSROs, one could argue that a substantial purpose of the PSRO is to foster professional interests (or, as the IRS did rule, to foster the business interests of physicians in the practice of medicine). Indeed, developing and enforcing peer-review guidelines, appraising the appropriateness of care and sanctioning physicians (as a PSRO is authorized to do) can be viewed as activities that are significantly tied into the business and professional interests of the medical community.

SERVES A PUBLIC PURPOSE

However, in reflecting upon the issue of PSRO tax status, one can make a reasonable argument for 501(c)(3) status: The PSRO is mandated to serve a public purpose

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