

**NATIONAL PRACTITIONER DATA BANK -  
HEALTHCARE INTEGRITY AND PROTECTION  
DATA BANK (NPDB-HIPDB)**

**INTERFACE CONTROL DOCUMENT (ICD) FOR  
QUERY XML TRANSACTIONS**

**Version 1.01**

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## DOCUMENT CHANGE HISTORY

The table below identifies changes that have been incorporated into each baseline of this document.

Date	Version #	Change Description
6/2008	1.00	Initial Revision.
9/2/2008	1.01	<p>Below is a summary of changes to the Interface Control Document (ICD) for Query XML Transactions version 1.01. Effective September 2, 2008, this ICD version 1.01 replaces version 1.00.</p> <p>Error Codes. See Table 4-14.</p> <ul style="list-style-type: none"><li>• Modified descriptions for error codes 20, 90, and 91.</li></ul>

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# 1. Overview

## 1.1 Introduction

This Interface Control Document (ICD) provides information concerning the format, structure, and content of electronic files for submitting queries via the Querying and Reporting XML Service (QRXS) client program to the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB). Queries are requests by statutorily authorized entities for information disclosure from the NPDB, the HIPDB, or both Data Banks.

There are three methods for requesting the disclosure of information (querying) and receiving responses from the NPDB-HIPDB:

- Interactively via the Internet using the Integrated Querying and Reporting Service (IQRS).
- Through an XML transaction file submission, the QRXS with data provided in the format specified in this ICD.
- Through an electronic transaction file submission, the ICD Transfer Program (ITP), with the data provided in the format specified in *Interface Control Document (ICD) for Query Transactions*, available at [www.npdb-hipdb.hrsa.gov/itp.html](http://www.npdb-hipdb.hrsa.gov/itp.html). For new users that wish to submit queries electronically, the QRXS is the recommended method.

The IQRS is the primary method of query submission. The IQRS allows queriers to submit queries through a Web-based interface using a browser. The IQRS also provides data validation capabilities and allows maintenance of a subject database for subsequent query submissions. Submission by QRXS is an alternative for those queriers who generate queries automatically from custom (third-party) software or other special purpose software.

To query the NPDB, an entity must be authorized under Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended, and 45 CFR Part 60, and must be registered with the NPDB. To query the HIPDB, an entity must be authorized under Section 1128E of the *Social Security Act* and 45 CFR Part 61, and must be registered with the HIPDB. Attempts to access the Data Banks by unauthorized entities or persons are punishable by fine and/or imprisonment under Federal statute. Do not attempt to access the IQRS or use this document until you are properly registered with the NPDB-HIPDB.

This document should be used only for requesting the disclosure of information (i.e., querying) from the NPDB, the HIPDB, or both Data Banks. To submit reports to the NPDB-HIPDB, use the ICDs for Judgment or Conviction Report (JOCR) XML Transactions, Medical Malpractice Payment Report (MMPR) XML Transactions, or Adverse Action Report (AAR) XML Transactions, as appropriate. These ICDs are available at [www.npdb-hipdb.hrsa.gov/grxs.html](http://www.npdb-hipdb.hrsa.gov/grxs.html). Only authorized and registered users are permitted to query the Data Bank(s).

Use of the procedures outlined in this ICD signifies acceptance of the Disclaimer in Appendix A and the Rules of Behavior in Appendix B. Should you have questions concerning your responsibilities, please contact the Customer Service Center immediately as specified in Section 1.5, Contact Information.

## 1.2 Types of Transactions

There are four types of transactions related to queries:

1. Query submission, confirmation and response transactions
2. Report change notification transactions
3. Password change transactions
4. Data Bank correspondence transactions

### **1.2.1 Query Submission, Confirmation And Response Transactions**

Single queries are queries submitted on only one subject. Multiple-name queries contain more than one subject in a single transaction file. Query transaction codes also differentiate between individual and organization subjects.

### **1.2.2 Report Change Notification Transactions**

Once a report has been accepted by the Data Banks, it may be corrected or voided by the submitting entity. The subject of the report may also choose to dispute the report, add a statement, or request that the Secretary of Health and Human Services (HHS) review the disputed report. This transaction provides the latest version of the report to the entity that received an earlier version of the report in a query response. This type of transaction is documented in this ICD.

### **1.2.3 Password Change Transactions**

This transaction enables a user and an administrator to change their passwords and enables an administrator to reset a user's password. This type of transaction is documented in the Password Change Transaction Specification, which includes an ICD, XML Schema, and sample files, and is available at [www.npdb-hipdb.hrsa.gov/qrxs.html](http://www.npdb-hipdb.hrsa.gov/qrxs.html).

### **1.2.4 Data Bank Correspondence Transactions**

This transaction enables the Data Banks to communicate important messages to an entity's users. This type of transaction is documented in this ICD.

## **1.3 Submission of Queries to the NPDB-HIPDB**

This ICD specifies the data elements (variables), data types, acceptable values and codes, organization, and format for submitting queries to the NPDB-HIPDB by the QRXS and for interpreting (i.e., parsing) electronic transaction responses received from the QRXS. QRXS files submitted to the NPDB-HIPDB system will be validated against the specifications in this document, which may be amended periodically. All mandatory fields must be completed, and only values specified in this ICD may be used in coded fields. The party submitting a transaction file to the NPDB-HIPDB is solely responsible for ensuring that the file adheres to the format specified in this ICD. The Data Banks recommend that submitters use an XML Schema validator to validate the structure and format of submission files. Any file that deviates from these specifications will be rejected.

### **1.3.1 The QRXS Client Program**

XML files are transferred electronically to and from the NPDB-HIPDB system via the QRXS client program. The QRXS client and user guide are available on the NPDB-HIPDB Web site at [www.npdb-hipdb.hrsa.gov/qrxs.html](http://www.npdb-hipdb.hrsa.gov/qrxs.html). For security, all communication with the QRXS is transmitted over a secure socket layer (SSL) connection.

## **1.4 User Account Security**

### **1.4.1 User Accounts**

Each entity has two types of accounts to access the Data Banks, the administrator account and user accounts. The administrator account is used to create and manage the user accounts. User accounts are used to submit transactions and retrieve responses from the Data Banks. The Data Banks have established security policies in order to reduce the risk of unauthorized access to user accounts and protect the confidentiality of practitioner reports.

### 1.4.2 New Entity Registration Passwords

New entities that register with the Data Banks will receive registration information via U.S. mail that includes a Data Bank Identification Number (DBID), the administrator account User ID, and a temporary administrator account password. A newly registered entity is required to log in to the IQRS or QRXS and change the administrator account password within 30 calendar days of the registration verification mailing date. If an entity does not log in to the IQRS, ITP, or QRXS within 30 calendar days of the registration verification mailing date, the registration password will expire, the account is automatically locked, and the administrator must contact the Data Banks to reset the password.

### 1.4.3 User Account Password Policies

A user must provide their organization's DBID, their user ID, and user account password each time they access the IQRS, ITP, or QRXS. If a valid password is not provided after five consecutive attempts, the user account is locked and the user must contact the entity administrator to submit a user account password reset request. For more information, see the Password Change Transaction Specifications.

Users are required to change their account password **every 90 calendar days**. An IQRS, ITP, or QRXS password change request can be submitted at any time to change an account's password. QRXS password change transactions must be submitted to the Data Banks using the Password Change Transaction Specifications. Once a password expires, a **30 calendar day** grace login period is available to allow the account password to be changed. Once a password has expired, the NPDB-HIPDB will not accept submissions and access will not be permitted to response files from that account until the account password is successfully changed. Once the grace login period is expired, the account is automatically locked and the user must use the IQRS to change the password or contact the entity administrator to reset the user's password.

NOTE: In order to use the IQRS to change a password once the grace login period has expired, a user must have an e-mail address stored in their user account in the IQRS. An e-mail will be sent to the user to enable the expired password to be changed.

**To ensure the security and privacy of user account passwords when using QRXS, the response to a password change request transaction can only be downloaded by the same user account that submitted the transaction.**

### 1.4.4 Resetting Password

When a user forgets his or her password, or is locked out of the IQRS, ITP, or QRXS, the entity administrator is responsible for providing a new Data Banks-generated temporary password to the user. A Data Banks-generated temporary password is valid for three calendar days and must be changed by the user before the user can submit transactions or retrieve response files. Only the administrator can submit and download transactions to reset user passwords using QRXS. The administrator cannot reset his or her own password. A password change transaction should be submitted instead of a password reset transaction.

To ensure that the current administrator is correctly identified in the Data Banks, he or she must log in to the IQRS and update the administrator's user account with the administrator's name, title, telephone number, and e-mail address.

If the entity's administrator forgets his or her password, or is locked out of the IQRS or QRXS, the administrator must call the NPDB-HIPDB Customer Service Center to receive a Data Banks-generated temporary password. If the administrator's name is not maintained in the administrator's IQRS user account, the company's certifying official will be required to submit a signed, faxed request for the change on company letterhead. The Customer Service Center will respond by immediately changing the old administrator password and contacting the new administrator with a Data Banks-generated temporary

password and instructions for updating the administrator's user account. These temporary passwords (user and administrator) will only be valid for three calendar days. The user/administrator should change his or her password immediately; and no grace login period will be permitted.

#### **1.4.5 Submission of Password Change/Reset Transactions to the Data Banks**

The password change transactions can be submitted to the Data Banks using the Password Change Transaction Specifications, which include an ICD, XML Schema, and sample files, and is available at [www.npdb-hipdb.hrsa.gov/qrxs.html](http://www.npdb-hipdb.hrsa.gov/qrxs.html).

### **1.5 Contact Information**

Periodic updates are made to the ICD for Query XML Transactions by the Data Banks. To receive advance notice of QRXS news and system changes, users should join the QRXS Mailing List at [www.npdb-hipdb.hrsa.gov/MailingListReg.html](http://www.npdb-hipdb.hrsa.gov/MailingListReg.html).

The Data Banks make an effort to notify users at least one month in advance of an update to code lists. Users should expect code lists to be updated quarterly. Additional updates to the XML Schema files are required periodically. Users will be notified six months in advance of updates to the XML Schema files. If you are already registered for the QRXS Mailing List and would like to be removed, contact the Customer Service Center.

For specific questions concerning registration or NPDB-HIPDB reporting requirements, contact the NPDB-HIPDB Customer Service Center by e-mail at [npdb-hipdb@sra.com](mailto:npdb-hipdb@sra.com) or by phone at 1-800-767-6732 (TDD 703-802-9395). Only authorized and registered users may report to or query the Data Bank(s). The *Entity Registration* form, information regarding NPDB-HIPDB policies and procedures, and the specifications are available at [www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov).

### **1.6 On-line Resources**

The QRXS resources are available for download at [www.npdb-hipdb.hrsa.gov/qrxs.html](http://www.npdb-hipdb.hrsa.gov/qrxs.html). The Web site contains:

- This ICD, in PDF format.
- The QRXS distribution package containing the stand-alone client program that transmits files containing report data to, and receives response files from the Data Banks, as well as supporting documentation for the client program Application Programming Interface (API).
- The QRXS Client Program User Guide, in PDF format.
- The XML Schema files for this ICD.
- Sample query submission and response files for each transaction type.
- The ICD for Password Change Transactions, in PDF format.
- The XML Schema files for the ICD for Password Change Transactions.
- Sample Password Change Transactions submission and response files.

## **1.7 Document Organization**

This document is organized into four sections and two appendices.

Section 1, Overview, contains a brief description of the ICD and information concerning user account security.

Section 2, Transaction File Formats, contains the general submission and response file formats and explains how to read the schema diagrams.

Section 3, Transaction File Data Records, contains the format for and the contents of the submission and response files.

Section 4, Data Definitions, contains the element definitions found within the schema and all query codes referenced in this document.

APPENDIX A: DISCLAIMER, specifies the terms and conditions for using this ICD. This appendix defines the limit of responsibility for the information contained in and the use of this ICD.

APPENDIX B: RULES OF BEHAVIOR, specifies the conditions that must be followed to gain access and obtain information from and report to the NPDB-HIPDB system.

## 2. Transaction File Formats

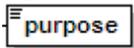
Queries sent to the NPDB-HIPDB system are referred to as submission files. A submission file may contain multiple subjects to be queried. Immediately upon accepting a submission file, the Data Bank(s) will send a response, referred to as the confirmation response, to the querier. The confirmation response will indicate whether the query as well as each subject in the query has been accepted or rejected for processing.

When processing of all subjects in a query is complete, the Data Bank(s) will send a response file, referred to as the query response. The query response will contain charge receipt information, the original query information, and any reports disclosable for the subjects queried on. For each query submission containing multiple subjects, there may be more than one query response file delivered.

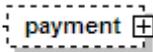
Submissions and responses are XML documents that conform to the Query schema written in the W3C XML Schema Language (version 1.0). The specifications (the schema and this ICD) for submission and response files are available at [www.npdb-hipdb.hrsa.gov/qrxs.html](http://www.npdb-hipdb.hrsa.gov/qrxs.html). Submission files should be checked for schema compliance using an XML Schema validator prior to submission.

Section 3, Transaction File Data Records, defines the format and content of data records within a transaction file. Section 4, Reports and Data Definitions, defines each of the data elements in the file formats. The data fields required for a file depend on the type of transaction submitted and the type of subject. For example, the transaction file format for submitting a query on a batch of individual subjects paid for by EFT debit contains a different set of data records than the transaction file format for submitting a query on an organization subject paid for by credit card. Data that are always required are indicated in the record formats in Section 3, Transaction File Data Records. Rules for data that may be optional or conditionally required are indicated in the data dictionary.

Below is a guide to the format diagrams:

A box with a solid line  surrounds required elements.

The little box on the right side of the element displaying a “+” or “-” indicates that the element is a complex type. The “+” means that the simple elements in the complex type are not displayed in the same figure where as the “-” indicates that the simple elements are displayed.

A box with a dashed line surrounds  elements that may be optional (depending on the type of transaction).

The cardinality of an element is indicated with a range **0..4** if more than one instance may be allowed.

The symbol  denotes a schema sequence; elements in the sequence must appear in the order shown.

The symbol  denotes a schema choice; only one of the elements shown may appear in the record.

## 2.1 Submission File Format

A Query Submission file consists of a submitter, payment, purpose and certification record followed by 1 or more individual or organization subject records. Record formats are described in Section 3, Transaction File Data Records.

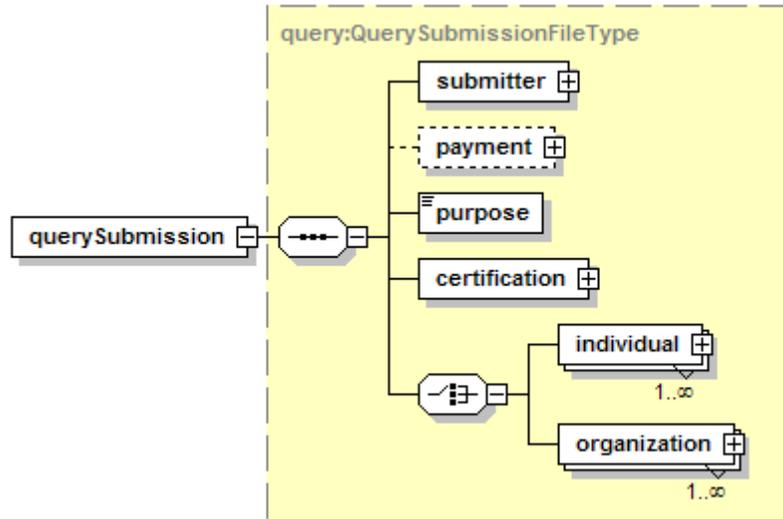


Figure 1: Query Submission File

## 2.2 Response File Formats

A valid Query Submission will immediately generate a Query Confirmation showing which subjects have been accepted or rejected for processing. If any subjects in the Query Submission are accepted for processing, the results of the query will be provided in a Query Response file. Report Change Notifications and Data Bank Correspondence transactions are not specifically based upon a previous query submission. Report Change Notification transactions result in a Report Change Notification Response File. Data Bank Correspondence transactions result in a Correspondence Response File.

### 2.2.1 Query Confirmation

A Query Confirmation file consists of a submitter, submission filename, certification and batch status record followed by 0 or more subject confirmation records. There will be one subject confirmation record for each individual or organization record in the Query Submission. If the query rejects for a batch level reason (e.g., bad certification or payment information) no subject confirmation records will be included in the Query Confirmation. Record formats are described in Section 3, Transaction File Data Records.

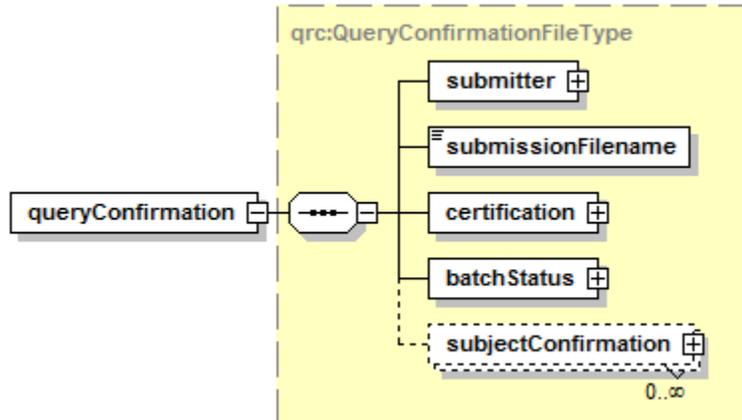
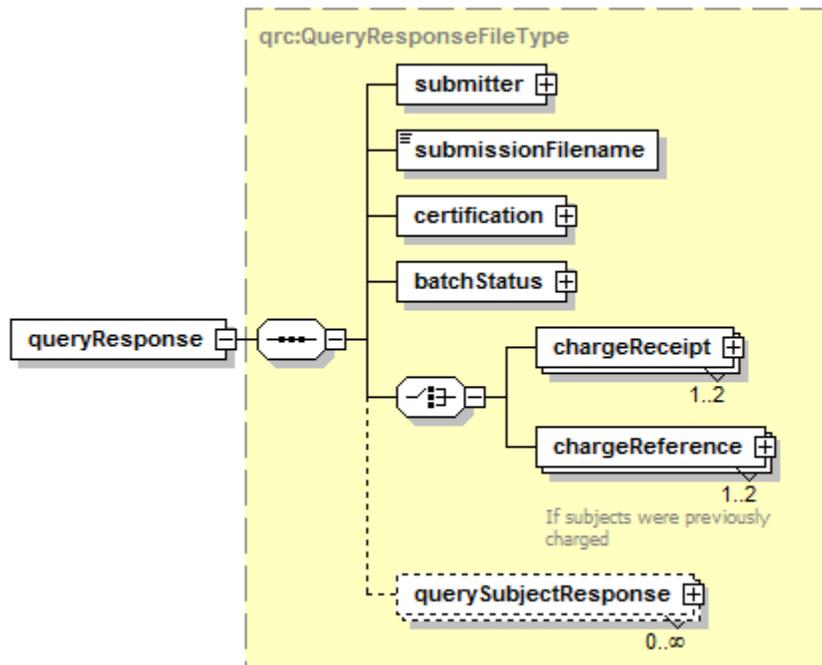


Figure 2: Query Confirmation File

### 2.2.2 Query Response

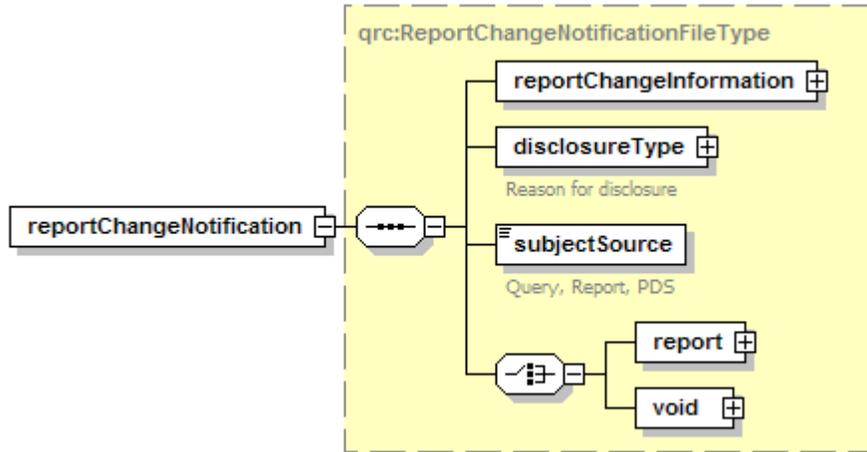
A Query Response file consists of a submitter, submission filename, certification, batch status, charge receipt or charge reference and 0 or more query subject response records. All subjects accepted for processing may not be returned in a single Query Response file. If the query rejects for a batch level reason (e.g., credit card refused) no query subject response records will be included in the Query Response. Record formats are described in Section 3, Transaction File Data Records.



**Figure 3: Query Response File**

**2.2.3 Report Change Notification**

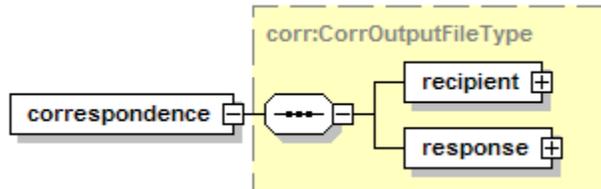
A Report Change Notification File contains one record providing general transaction information, and two records describing the reason for the notification and why the report changed, followed by one report or void record. Record formats are described in Section 3, Transaction File Data Records.



**Figure 4: Report Change Notification File**

**2.2.4 Correspondence**

A Correspondence File contains one recipient record identifying who the message is for and one response record. Record formats are described in Section 3, Transaction File Data Records.



**Figure 5: Correspondence File**

### 3. Transaction File Data Records

The format and content of data records within a transaction file are defined in the W3C XML Schema Language. The specifications (the schema and this ICD) for the data records can be found on-line at [www.npdb-hipdb.hrsa.gov/qrxs.html](http://www.npdb-hipdb.hrsa.gov/qrxs.html). A single data record type may be used in multiple transaction file formats.

Mandatory fields must be completed or the query **will be rejected**. If an element is 'mandatory if known' and the querying entity does not have the information, the field **must be omitted entirely** rather than contain a default or empty value. All elements in a data record are either mandatory, or mandatory if known, depending on the type of subject and the type of action. Refer to Section 4, Reports and Data Definitions to determine the specific requirements for the type of action.

The record elements are defined in Section 4.1, Data Dictionary – Elements. The description, format, and length are given for each element. An element may appear in multiple records.

Unless otherwise noted, the specified width represents the maximum number of characters allowed for the element. **All fields larger than the specified field width will be truncated**. Data values that are shorter than the specified field width should not be padded with additional characters. **Reports submitted using an incorrect record format or invalid codes will be rejected**.

The schema specifies that the UTF-8 character set must be used. Submitted queries must not contain American Standard Code for Information Interchange (ASCII) characters outside the range of 32 to 127 or the report will be rejected.

Record types are organized into logical groups using XML Schema types and namespaces. Simple and complex types (e.g., Individual Name, Address, Occupation and Licensure) that are common to the XML Query format specification are defined in lower-level schemas so that they can be used to define higher-level records. Some elements are described as being optional in order to provide a flexible schema that is usable to report all action types.

### 3.1 Submitter

The Submitter Record is required for every submission file and included in every response. The agent DBID is used by an agent submitting a report on behalf of an entity.

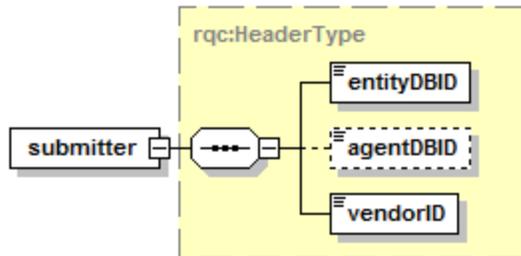


Figure 6: Submitter Record

### 3.2 Payment Method

The Payment Record is required unless the entity is statutorily allowed to query for no charge. It consists of either an EFT or a credit card record.

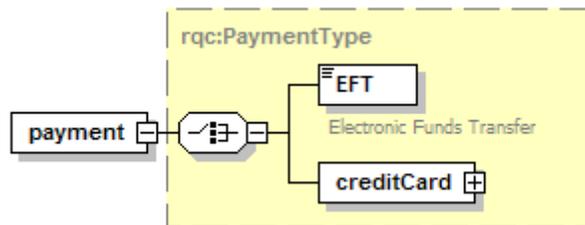


Figure 7: Payment Method Record

### 3.3 Credit Card

The Credit Card record consists of a 12 - 16 digit account number, an expiration date, the cardholder name and the cardholder address.

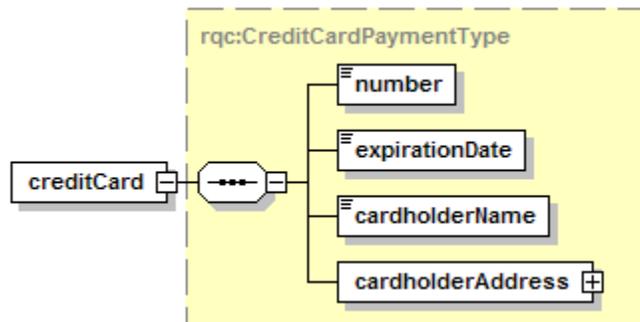


Figure 8: Credit Card Record

### 3.4 Address, Work Address, Home Address, Cardholder Address

The Address Type Record contains the information for a subject's address and an affiliate's address. For U.S. addresses, address, city, state, zip are required and country must be omitted. For non-U.S. addresses, country is required. See Section 4.2, Table 4-2: State Abbreviations and U.S. Territories for all rules regarding non-U.S. or military addresses.

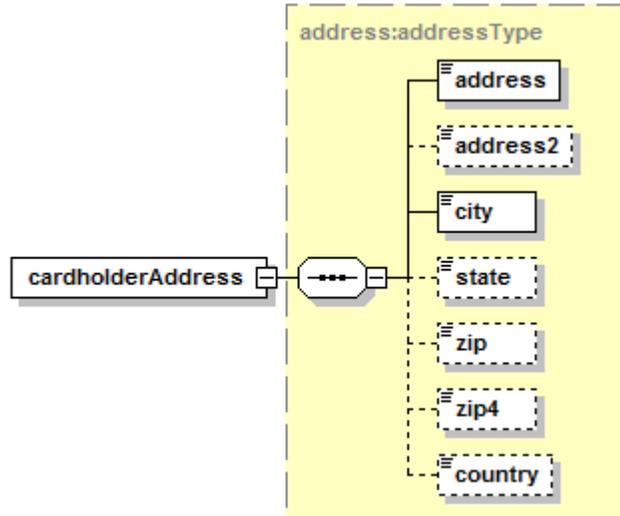


Figure 9: Address Record

### 3.5 Certification

The Certification Record contains the information for the authorized submitter of the transaction or the person to contact regarding the report.

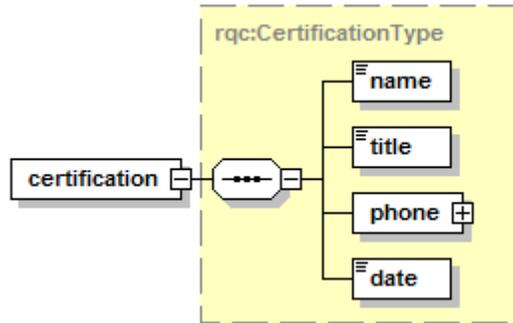


Figure 10: Certification Record

### 3.6 Phone

The Phone Record contains phone number information. The phone number is required (no formatting allowed) and an optional extension may be specified.

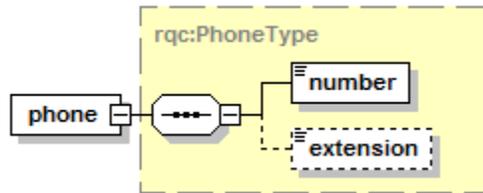


Figure 11: Phone Record

### 3.7 Individual (Query Submission, Query Confirmation, Query Response)

The Individual Record contains the subject information for an individual to be queried on. A valid individual query requires the name, home or work address, gender, date of birth, field of licensure and at least one of the following: SSN or ITIN or the license number, license state and professional school.

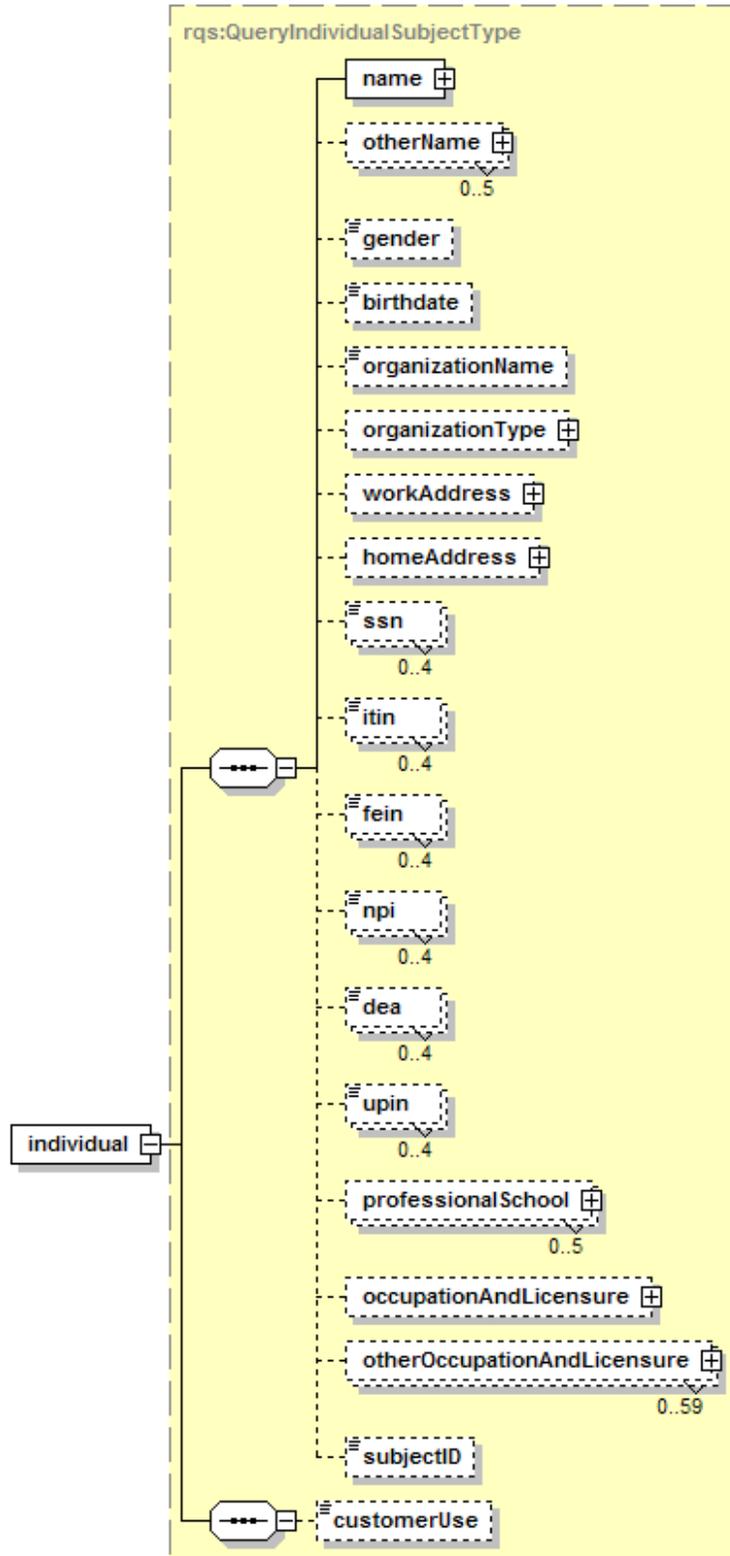


Figure 12: Individual Record

### 3.8 Name, Other Name

The Name Record contains the name data for an individual subject. First and last are always required for any name specified.

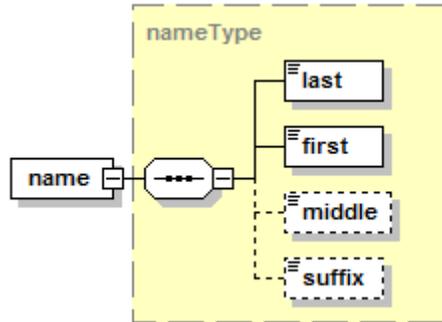


Figure 13: Name Record

### 3.9 Organization Type

The Organization Type Record contains the code that best describes the organization (for an organization subject) or the subject’s principal place of employment (for an individual subject). An optional description field is available for organization types not specified in the type code list.

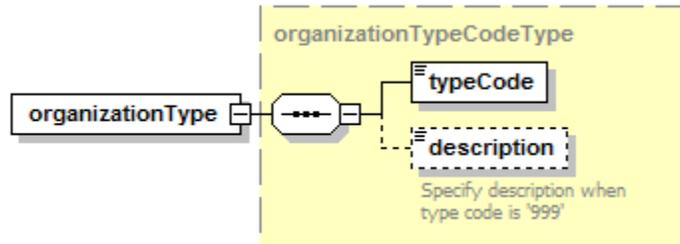


Figure 14: Organization Type Record

### 3.10 Professional School

The Professional School Record contains the school and graduation year of an individual subject. All fields are required when a school is specified.

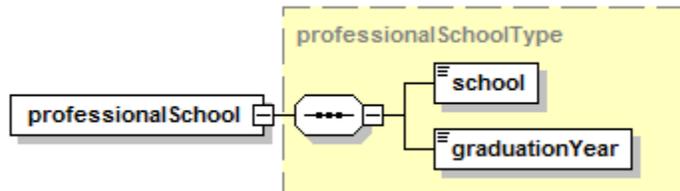


Figure 15: Professional School Record

### 3.11 Occupation and Licensure, Other Occupation and Licensure

The Occupation and Licensure Record contains the professional occupation and licensure information for an individual subject. Either number or noLicense is required.

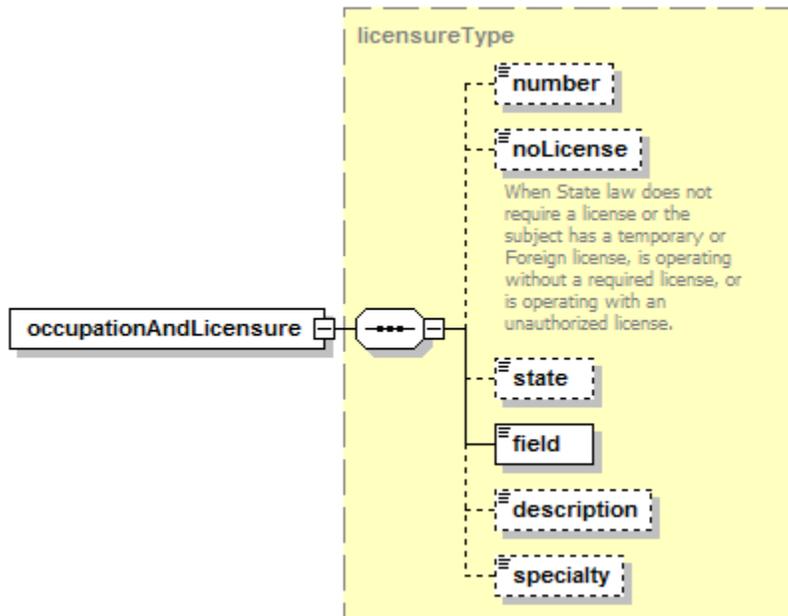


Figure 16: Occupation and Licensure Record

### 3.12 Organization (Query Submission, Query Confirmation, Query Response)

The Organization Record contains the subject information for a reported organization. A valid organization query requires the organization name, address, type and at least one of the following: FEIN or SSN or ITIN or license number and license state.

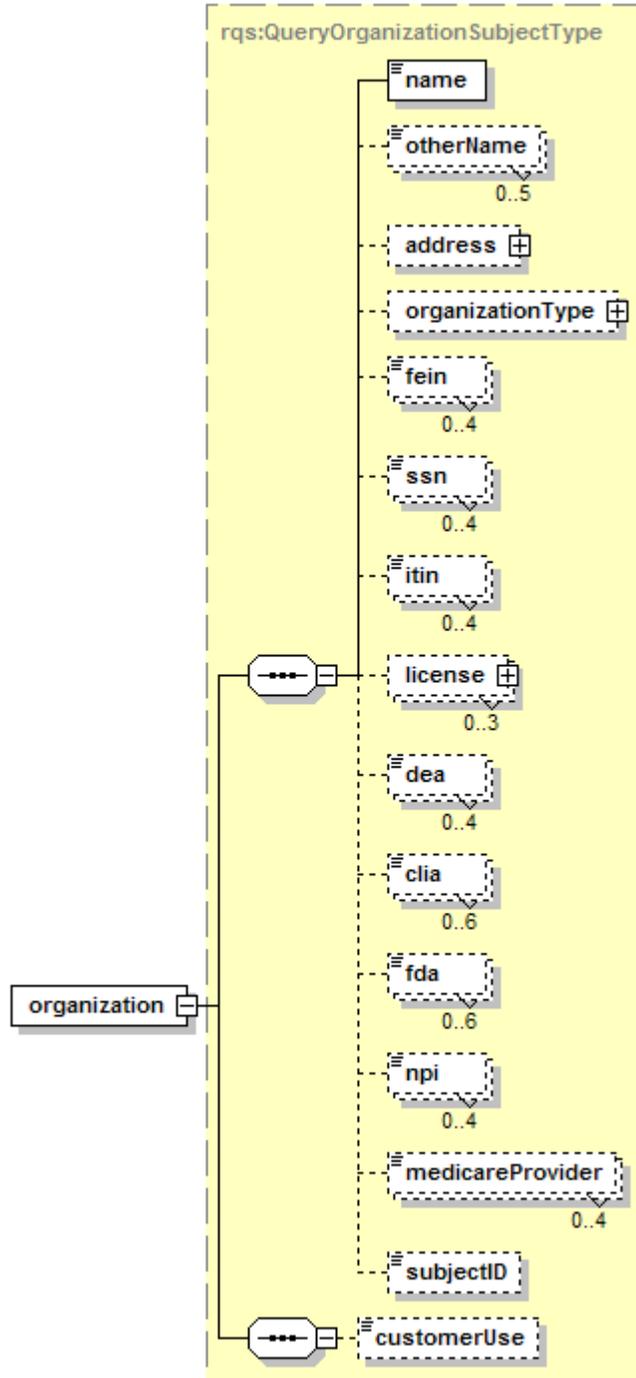


Figure 17: Organization Record

### 3.13 License (Organization)

The Organization License Record contains the licensure information for an organization subject. The state and either number or noLicense is required.

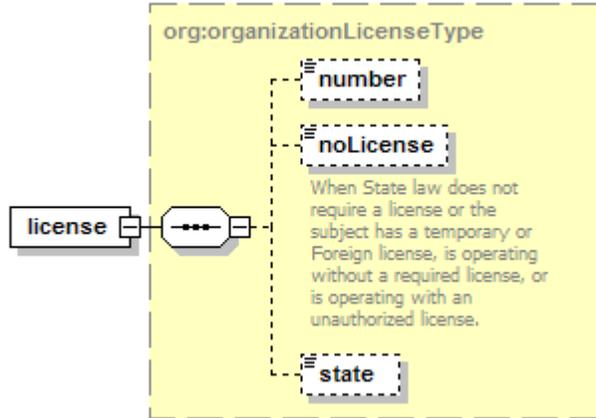


Figure 18: License Record

### 3.14 Status, Batch Status

The Status Record is returned as part of a Query Confirmation or a Query Response. It shows the Document Control Number (DCN) of the batch or subject, the date of processing, whether the batch or subject was successfully processed, and if not successful, one or more error records describing the processing problem.

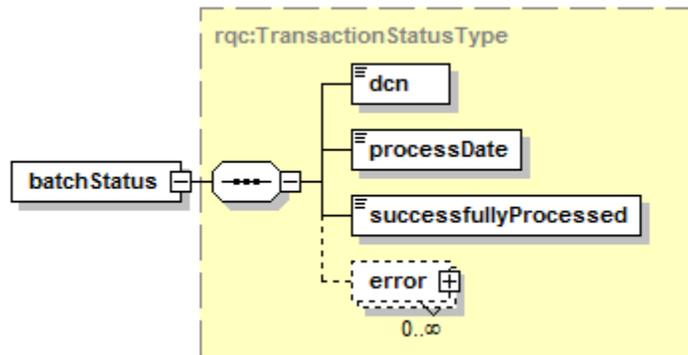


Figure 19: Batch Status Record

### 3.15 Error

The Error Record describes any processing problems encountered. For a complete list of error codes see Section 4.2, Table 4-14.

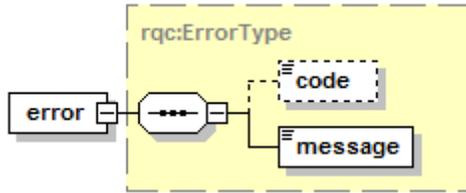


Figure 20: Error Record

### 3.16 Query Subject Confirmation

The Query Subject Confirmation Record is returned as part of a Query Confirmation. It shows whether the subject was accepted for processing, the DCN (if accepted) or one or more error records (if rejected). The Subject Confirmation also reiterates the individual or organization information that was queried on.

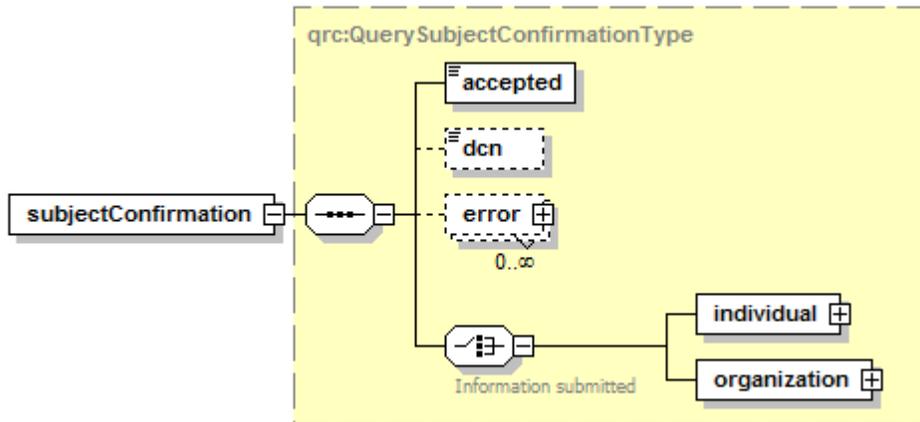


Figure 21: Query Subject Confirmation Record

### 3.17 Charge Receipt

The Charge Receipt Record is returned as part of the Query Response. It consists of a Payment record, the date charged (if successfully charged), a Charge Reference record, the number of subjects in the batch, the number of subjects charged, the price per subject and the total charge. In certain cases it may also include the number of subjects charged separately and not processed and the number and dollar amount of query credits used. See the element descriptions in section 4 for more information about these optional elements.

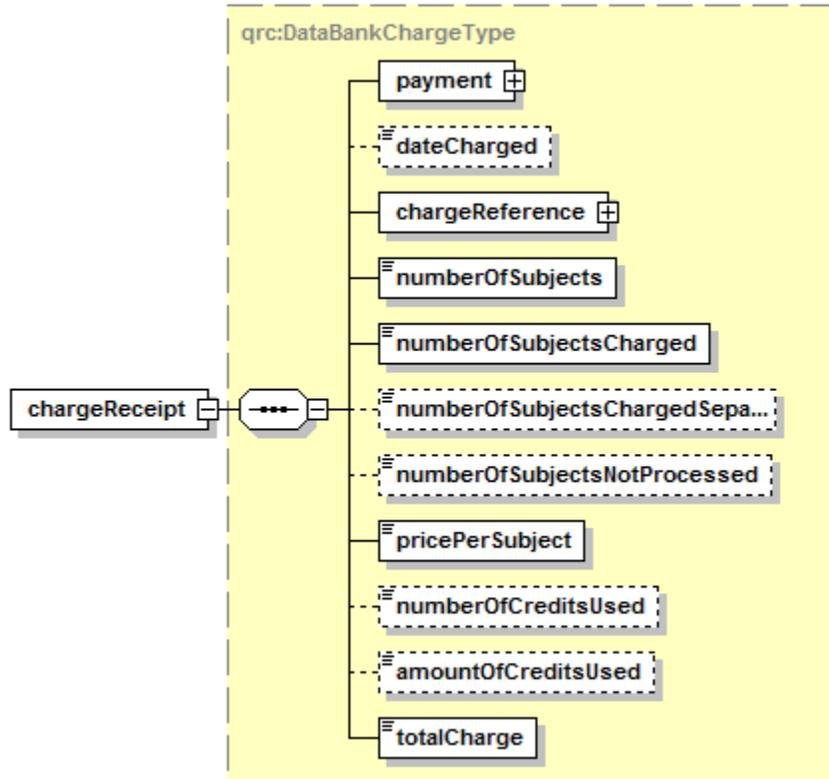


Figure 22: Charge Receipt Record

### 3.18 Payment

The Payment Record is returned as part of the charge receipt. It consists of either a no charge indicator or a Payment Method record.

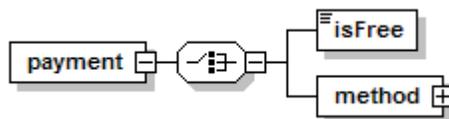


Figure 23: Payment Record

### 3.19 Charge Reference

The Charge Reference Record shows the Data Bank the charge applies to and a reference number of the transaction.

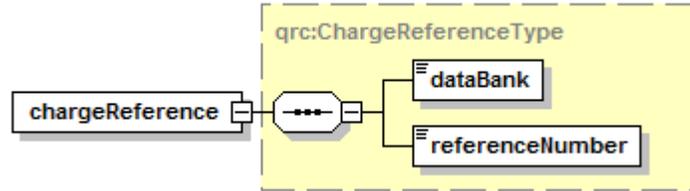


Figure 24: Charge Reference Record

### 3.20 Query Subject Response

The Query Subject Response record is returned as part of the Query Response. One Query Subject Response record will be returned for each Individual or Organization subject accepted for processing. The Query Subject Response record consists of a Status record, the Individual or Organization record that was queried on, and if any reports are found in the Data Banks for the subject, one or more Report records.

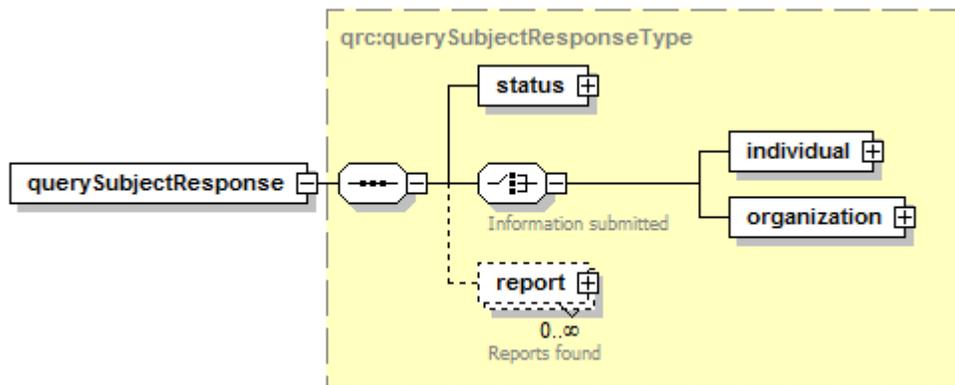


Figure 25: Query Subject Response Record

### 3.21 Report (Query Response, Report Change)

The Report record is returned as part of the Query Response when the Data Banks contain an active report on the subject queried on.

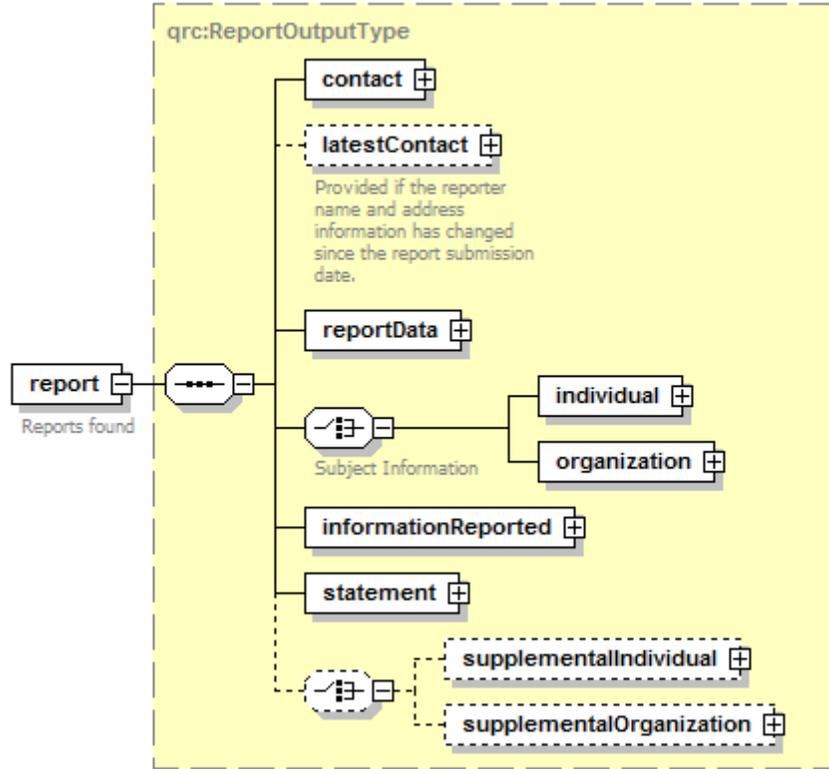


Figure 26: Report Record

### 3.22 Contact

The Contact Record contains the contact information for the reporting entity.

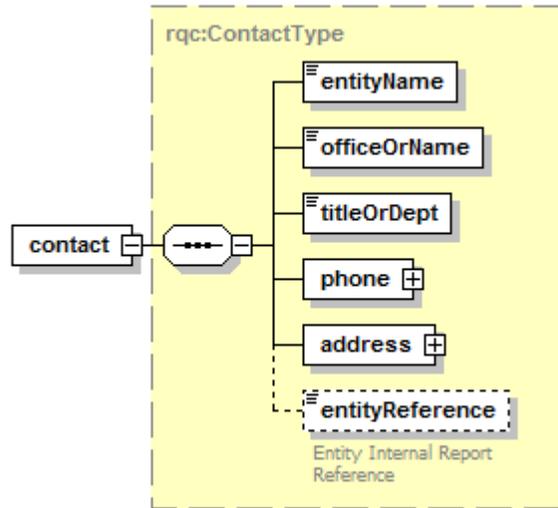


Figure 27: Contact Record

### 3.23 Latest Contact

The Latest Contact Record contains the most recent contact information on file with the Data Banks for the reporting entity. This record is provided if the reporter name and address information has changed since the report submission date. Point of contact information (officeOrName, titleOrDept, and phone) is only provided when the entity has a successor and the successor has provided that information to the Data Banks.

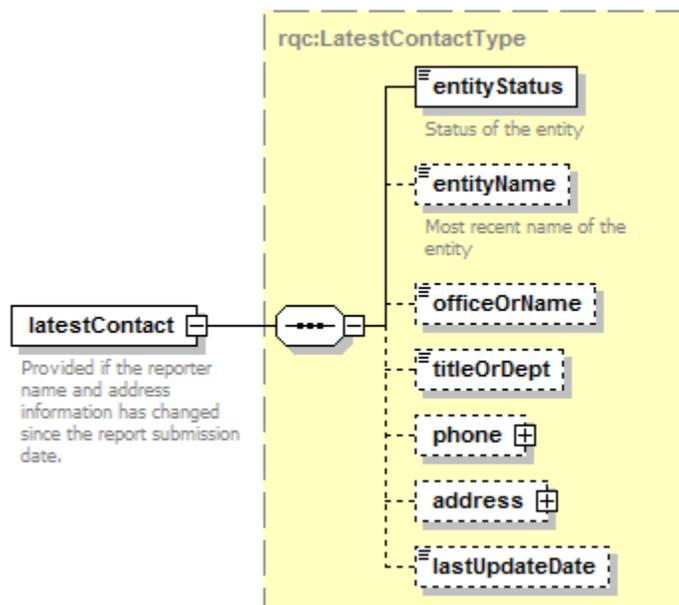


Figure 28: Latest Contact Record

### 3.24 Report Data

The Report Data Record contains the information for the report transaction type, information about the related report (Revision to Action reports), and statutory authority for maintaining the report in the Data Bank(s). For appeals, the previousDCN and previousTransaction will contain the values from the appealed report. For Revision to Action reports where the previousDCN was corrected or voided by another transaction, latestRelatedDCN, latestRelatedTransaction, and latestRelatedNote will contain information about the related report as it has been corrected or voided. For Revision to Action reports where the previousDCN was voided by another transaction, latestRelatedDCN will be omitted.

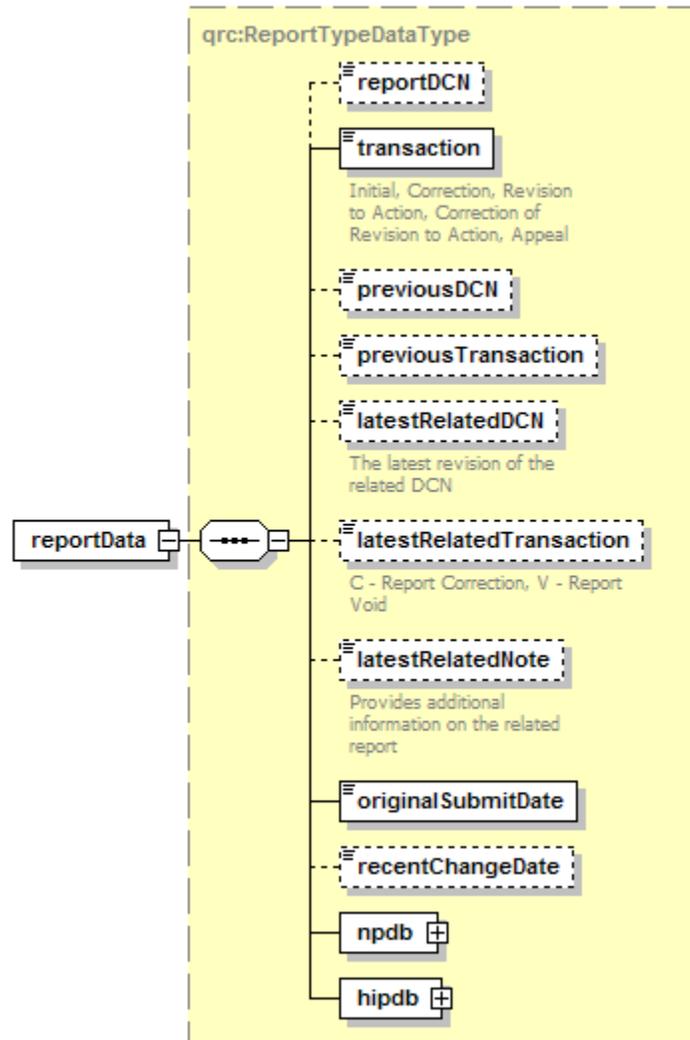
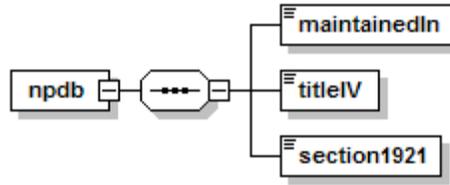


Figure 29: Report Data Record

### 3.25 NPDB

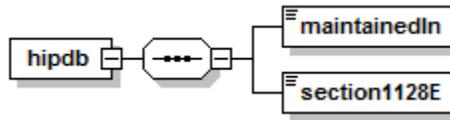
The NPDB Authority Record contains the statutory authority information for maintaining and disclosing the report.



**Figure 30: NPDB Authority Record**

### 3.26 HIPDB

The HIPDB Authority Record contains the statutory authority information for maintaining and disclosing the report.



**Figure 31: HIPDB Authority Record**

### 3.27 Query Report Individual

The Query Report Individual Record contains the subject information for a reported individual.

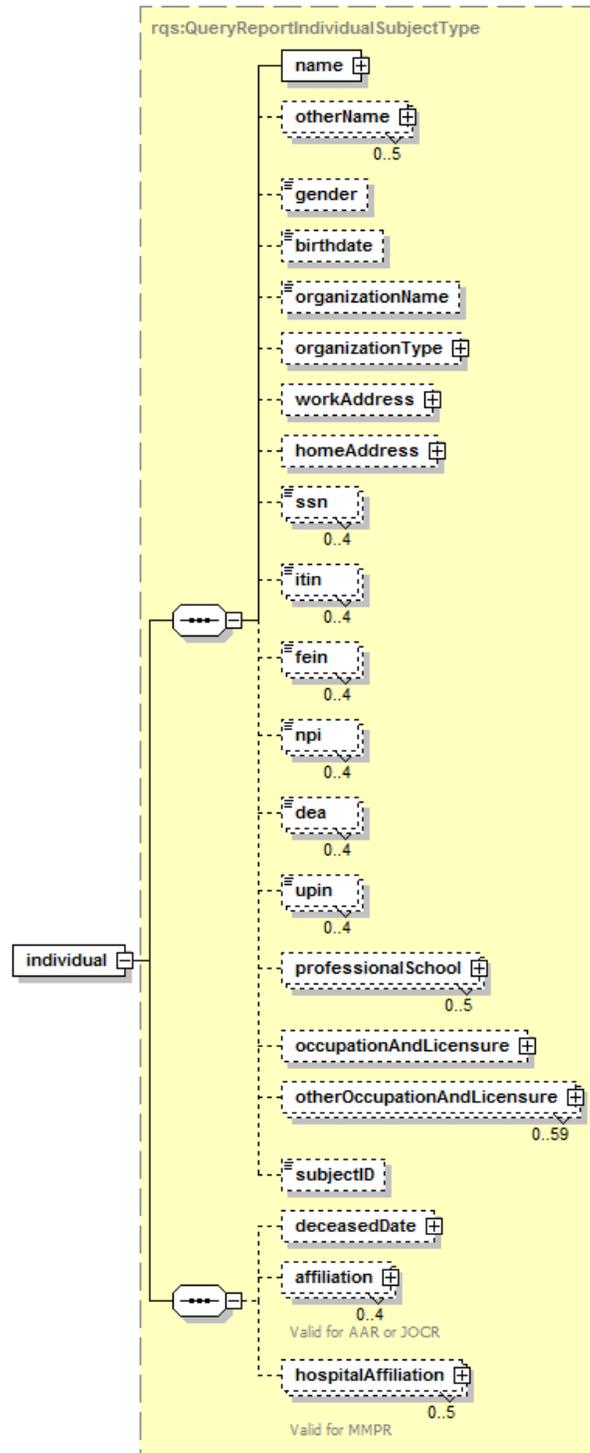


Figure 32: Query Report Individual Record

### 3.28 Deceased Date

The Deceased Date Record contains the deceased status of an individual subject.

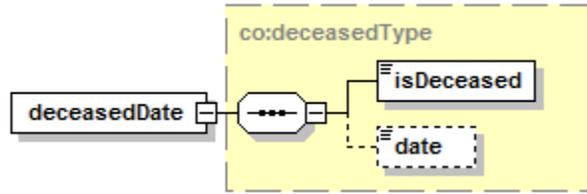


Figure 33: Deceased Date Record

### 3.29 Affiliation

The Affiliation Record contains the professional affiliation for a subject.

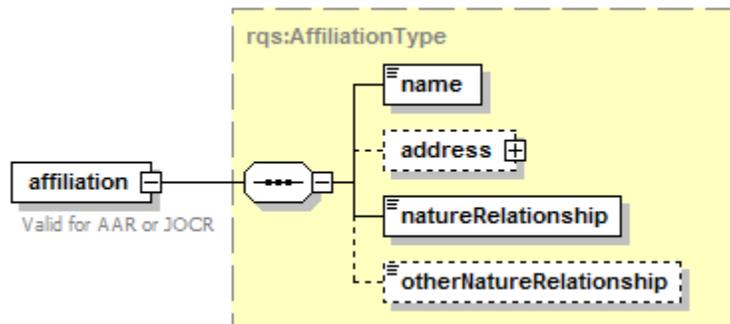


Figure 34: Affiliation Record

### 3.30 Hospital Affiliation

The Hospital Affiliation Record contains the hospital affiliation for a subject.

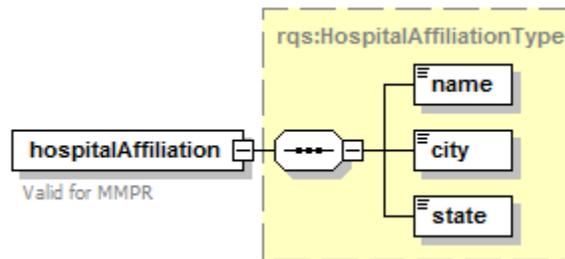


Figure 35: Hospital Affiliation Record

### 3.31 Query Report Organization

The Query Response Organization Record contains the subject information for a reported organization.

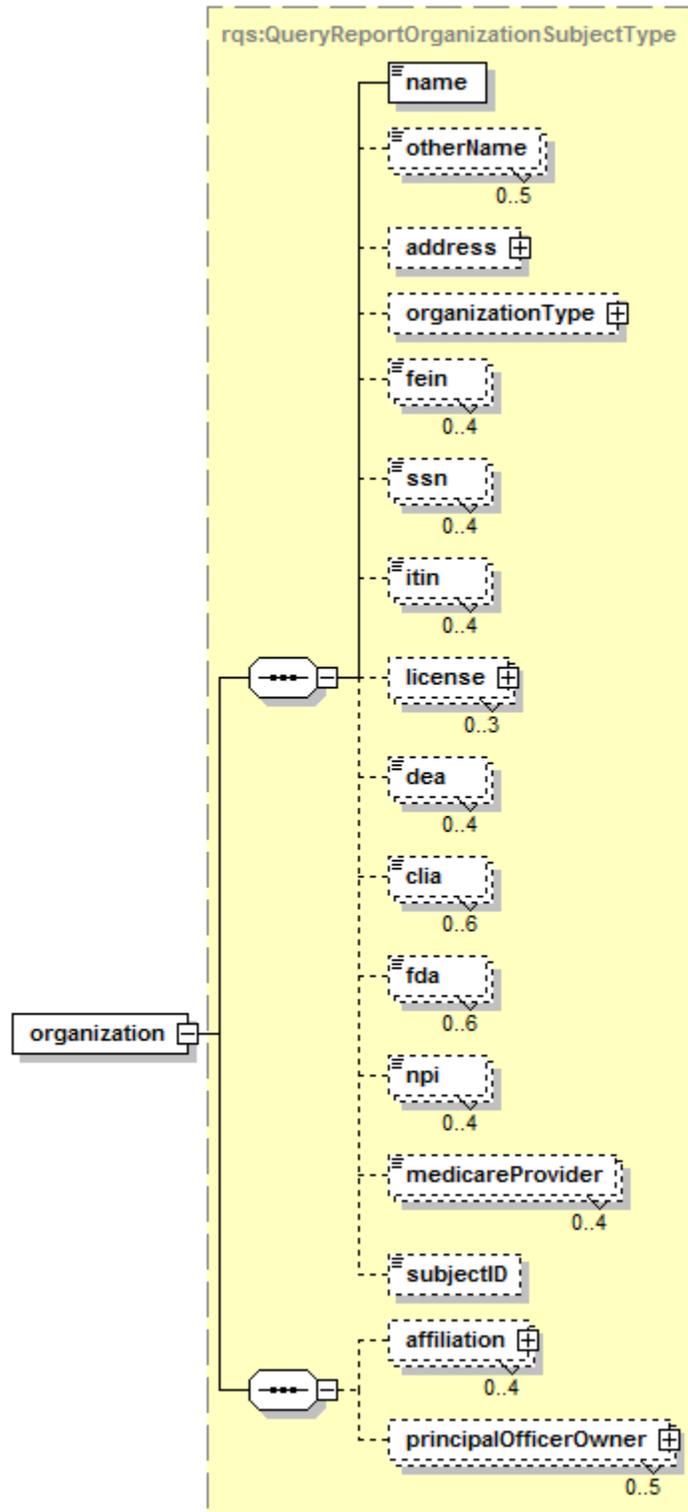


Figure 36: Query Report Organization Record

### 3.32 Principal Officer Owner

The Principal Officer Owner Record contains the officer and owner information for an organization subject.

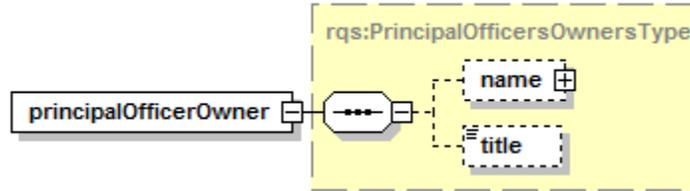


Figure 37: Principal Officer Owner Record

### 3.33 Information Reported (Query Response, Report Change)

The Information Reported Record contains the report information.

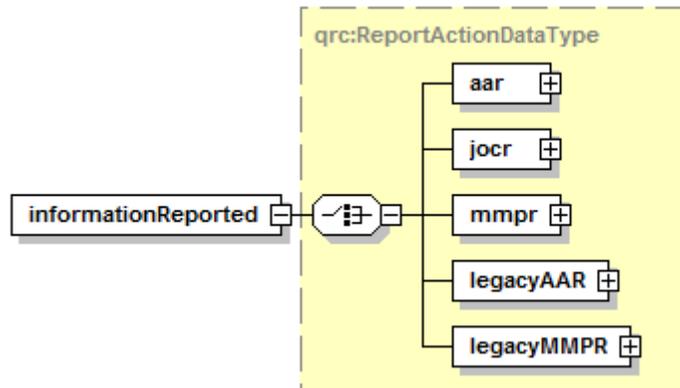


Figure 38: Information Reported Record (Query Response, Report Change)

### 3.34 AAR

The AAR Information Reported Record contains the report data for an AAR. Refer to Section 4-1, Data Dictionary - AAR Report Elements.

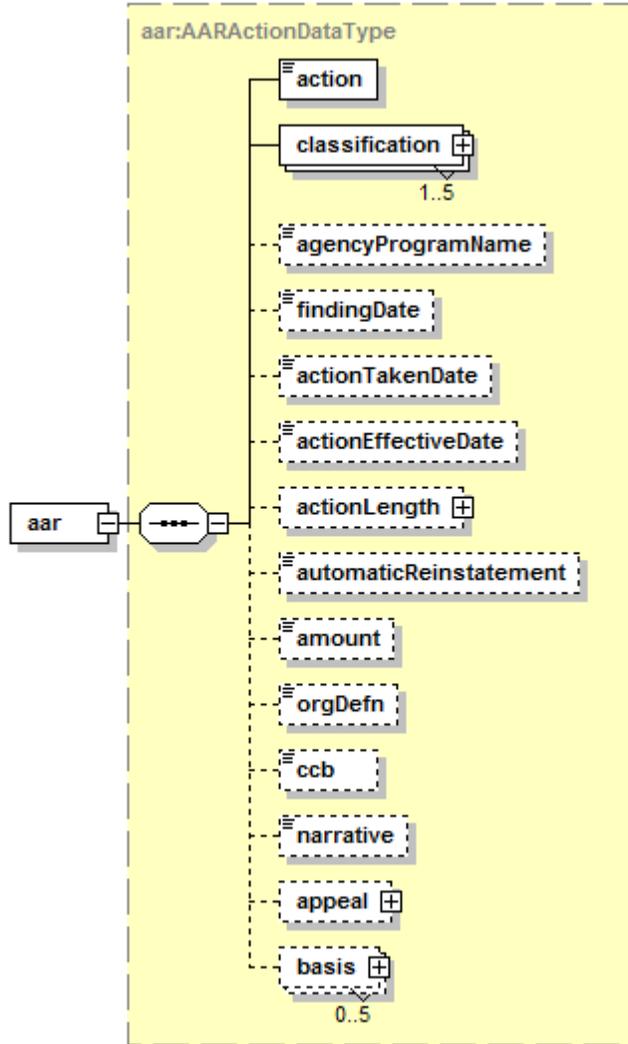


Figure 39: AAR Record

### 3.35 Classification

The Classification Record contains the Adverse Action Classification Code for the report.

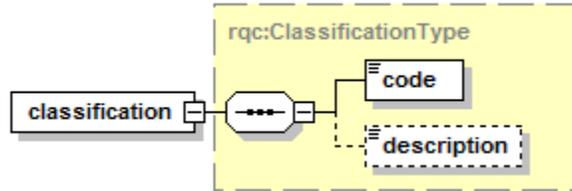


Figure 40: Classification Record

### 3.36 Action Length

The Action Length Record contains the length of action information for the report.

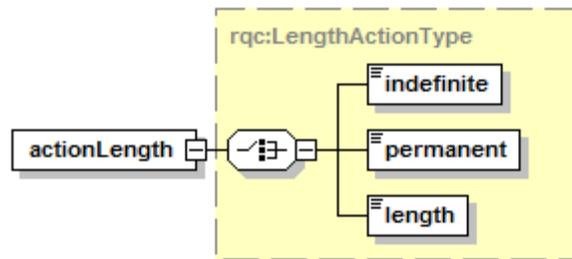


Figure 41: Action Length Record

### 3.37 Appeal

The Appeal Record shows whether the action has been appealed and if so, the date of the appeal.

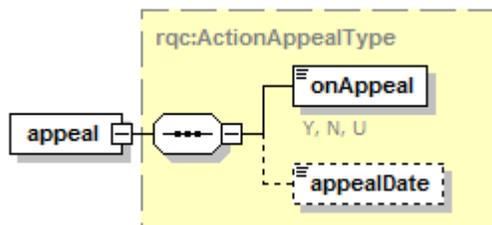


Figure 42: Appeal Record

### 3.38 Basis

The Basis Record contains the Basis for Action code for the report.

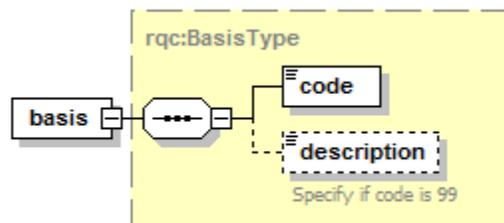


Figure 43: Basis Record

### 3.39 JOCR

The JOCR Information Reported Record contains the report data for a JOCR. Refer to Section 4-1, Data Dictionary - JOCR Report Elements.

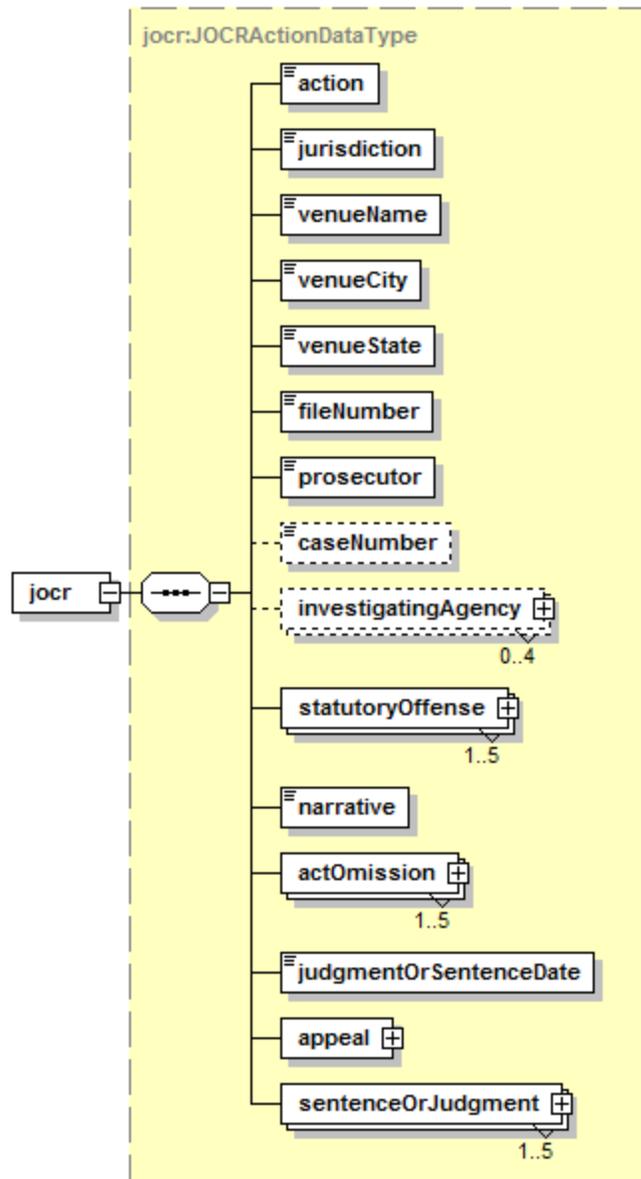
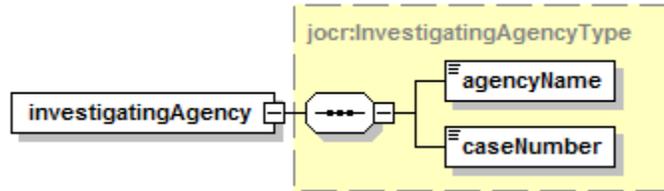


Figure 44: JOCR Record

### 3.40 Investigating Agency

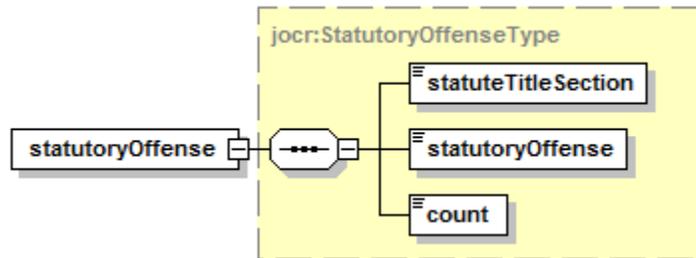
The Investigating Agency Record contains the agency name and case number for the report.



**Figure 45: Investigating Agency Record**

### 3.41 Statutory Offense

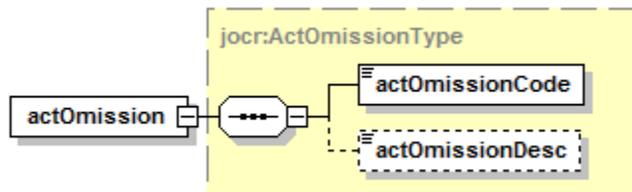
The Statutory Offense Record contains the statute title, code section, offense description and the violation count.



**Figure 46: Statutory Offense Record**

### 3.42 Act/Omission

The Act or Omission Record contains the act or omission codes for the report.



**Figure 47: Act/Omission Record**

### 3.43 Sentence/Judgment

The Sentence or Judgment Record contains information about the sentence or judgment of the report.

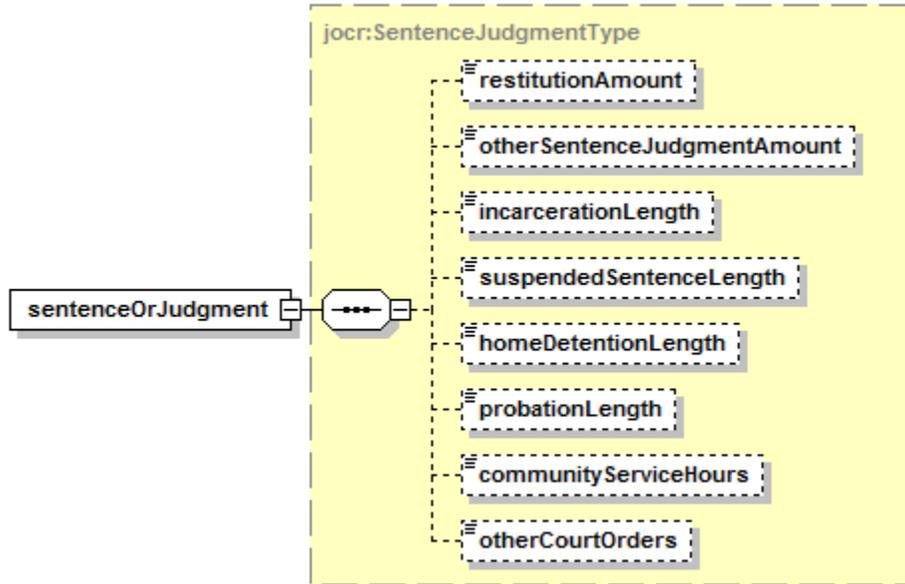


Figure 48: Sentence/Judgment Record

### 3.44 MMPR

The MMPR Information Reported Record contains the report data for a MMPR. Refer to Section 4.1, Data Dictionary - MMPR Report Elements.

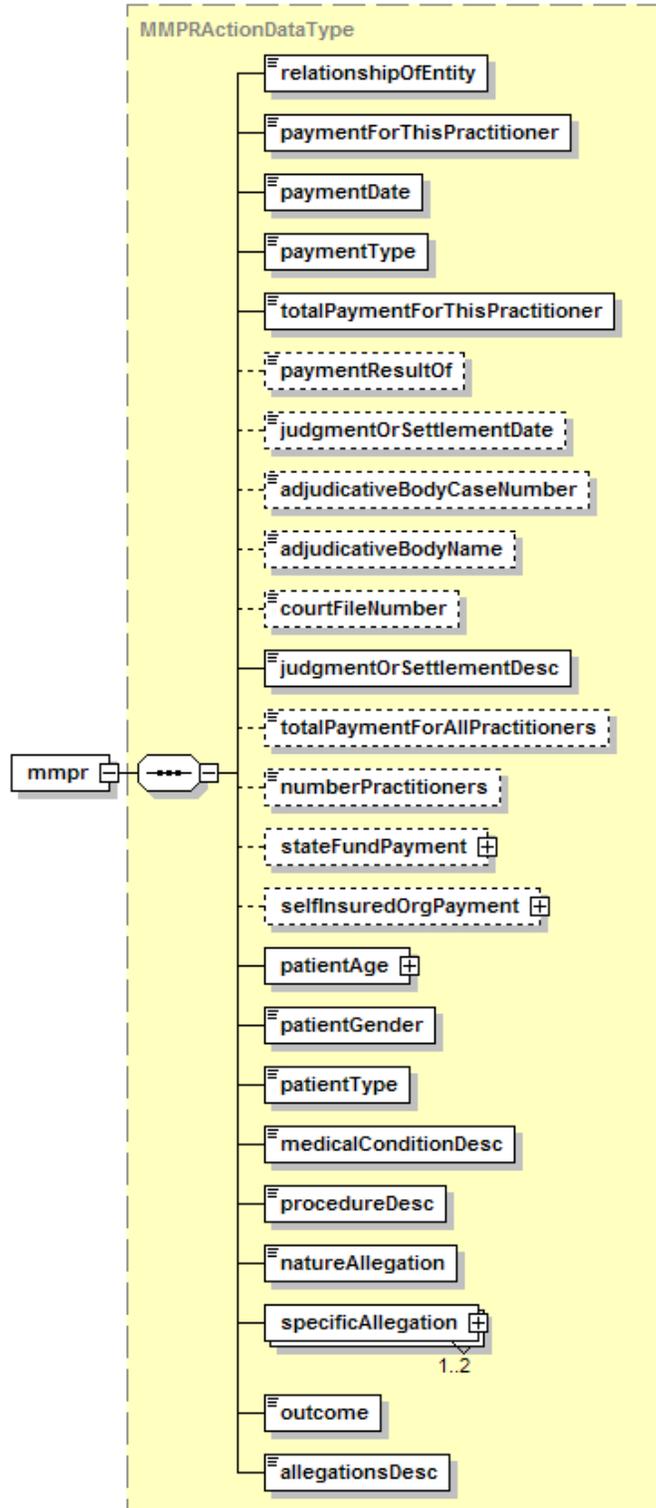


Figure 49: MMPR Record

### 3.45 State Fund Payment

The State Fund Payment Record contains payment information made by a state guaranty fund or state excess judgment fund. This payment is made by a state guaranty fund or state excess judgment fund in addition to the payment made by the reporting entity.

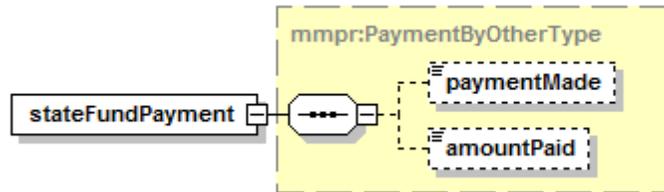


Figure 50: State Fund Payment Record

### 3.46 Self-Insured Organization Payment

The Self-Insured Organization Payment Record contains payment information made by a self-insured organization and/or other insurance company/companies. This payment is made by a self-insured organization and/or other insurance company/companies in addition to the payment made by the reporting entity.

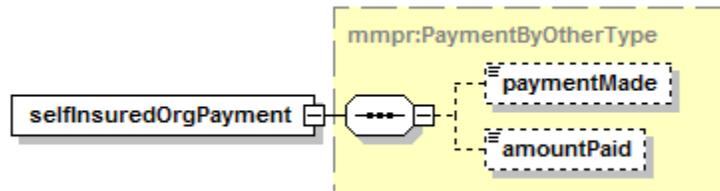


Figure 51: Self-Insured Organization Payment Record

### 3.47 Patient Age Record

The Patient Age Record contains the age of the patient at the time of the initial event.

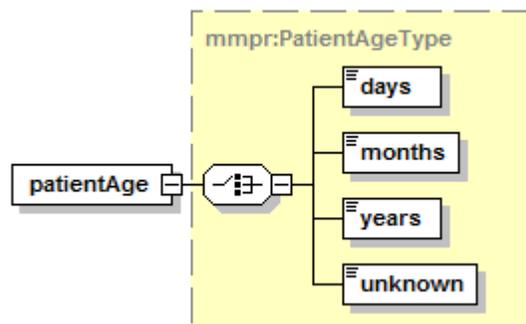


Figure 52: Patient Age Record

### 3.48 Specific Allegation Record

The Specific Allegation Record contains the subject’s alleged acts or omissions.

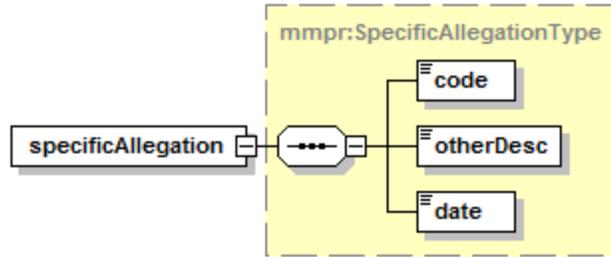


Figure 53: Specific Allegation Record

### 3.49 Legacy AAR

The Legacy AAR Record contains the information reported for a Legacy AAR report. Refer to Section 4.1 Data Dictionary - Legacy AAR Report Elements.

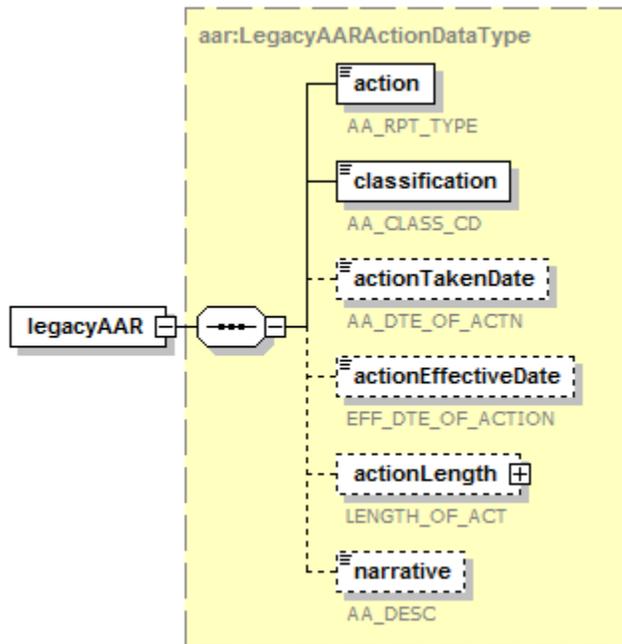


Figure 54: Legacy AAR Record

### 3.50 Legacy MMPR

The Legacy MMPR Record contains the information reported for a Legacy MMPR report. Refer to Section 4.1 Data Dictionary - Legacy MMPR Report Elements.

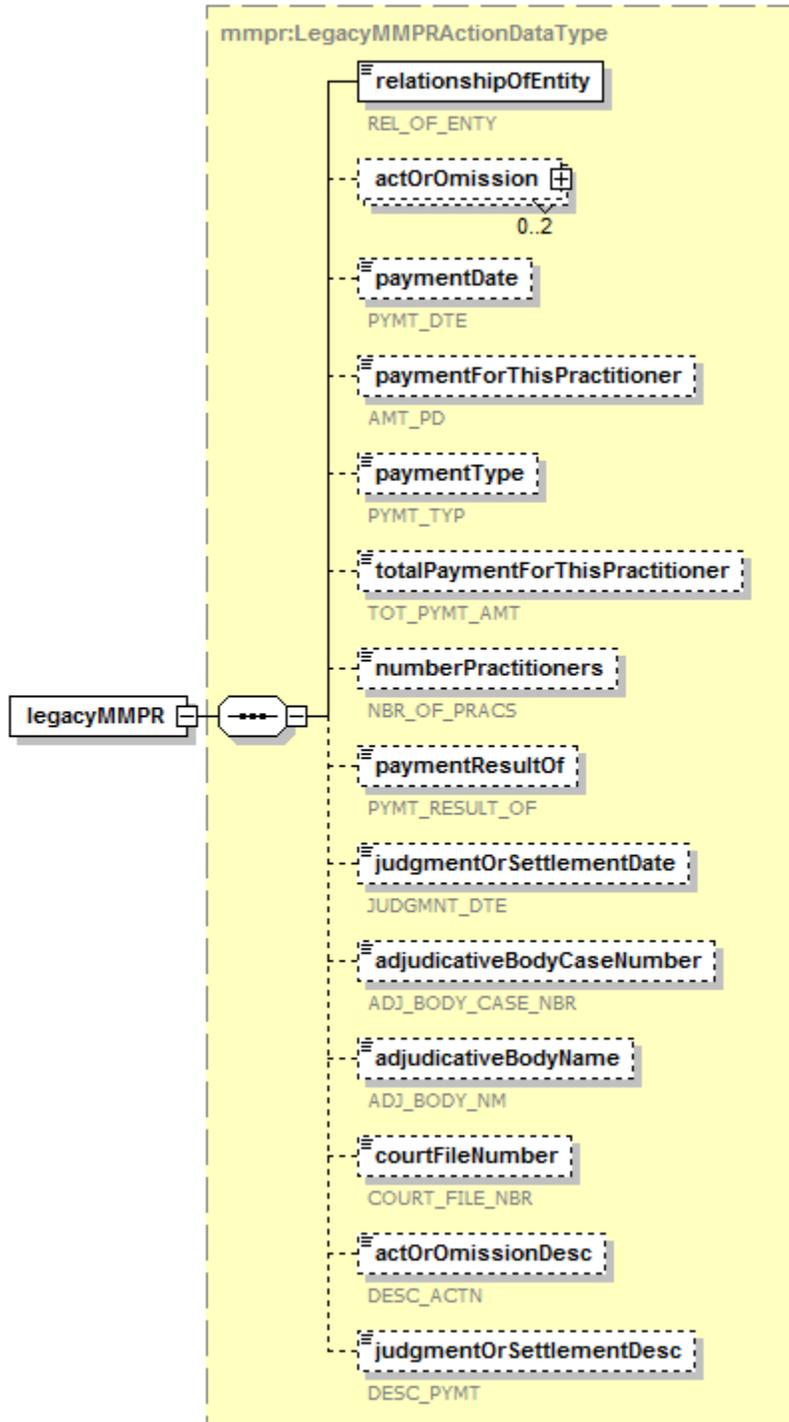


Figure 55: Legacy MMPR Record

### 3.51 Legacy Act/Omission

The Act or Omission Record contains the act or omission reported for a Legacy MMRP report. See Section 4.2, Table 4-25 for a list of codes.

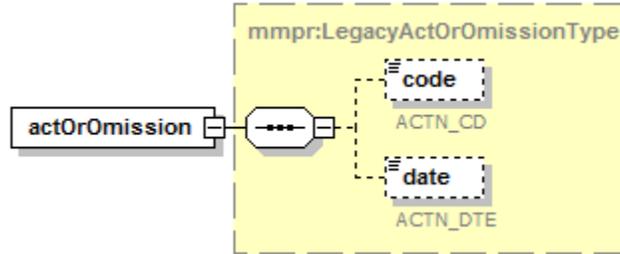


Figure 56: Legacy Act/Omission Record

### 3.52 Statement

The Statement Record contains the statements associated with the report and the dispute status.

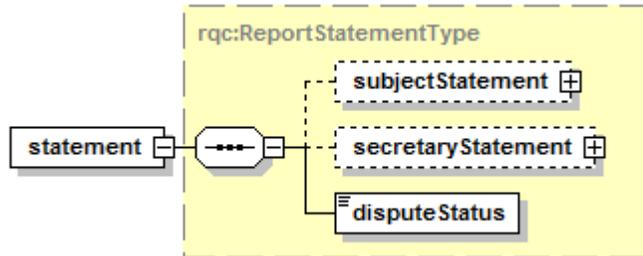


Figure 57: Statement Record

### 3.53 Subject Statement, Secretary Statement

The Subject Statement Record contains the statement information for the report’s subject. The Secretary Statement contains the statement information from the Secretary of the U.S. Department of Health and Human Services.

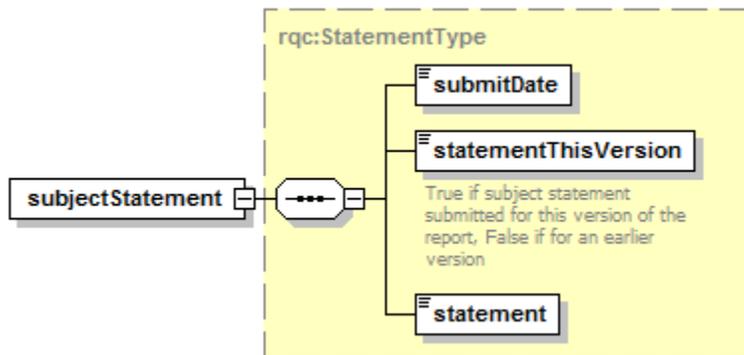


Figure 58: Subject Statement Record

### 3.54 Supplemental Individual

The Supplemental Individual Record contains the supplemental information associated with an individual subject. Information in this data record was not provided by the reporting entity. This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report. This disclaimer should be clearly identified on generated reports.

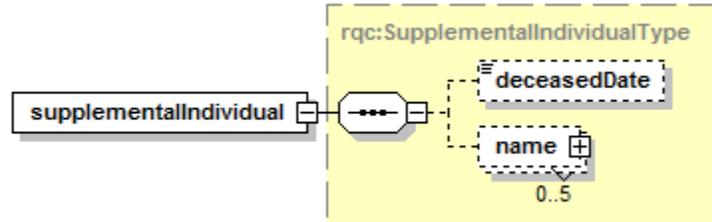


Figure 59: Supplemental Individual Record

### 3.55 Supplemental Organization

The Supplemental Organization Record contains the supplemental information associated with an organization subject. Information in this data record was not provided by the reporting entity. This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report. This disclaimer should be clearly identified on generated reports.

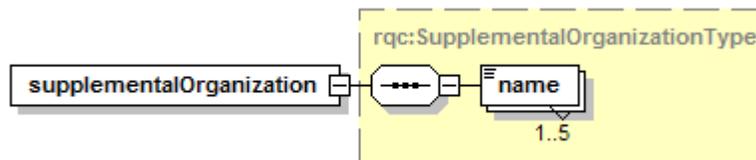


Figure 60: Supplemental Organization Record

### 3.56 Report Change Information

The Report Change Information Record contains general report change information.

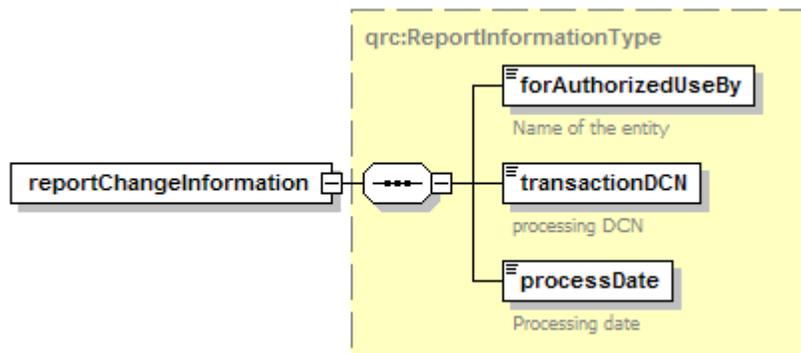
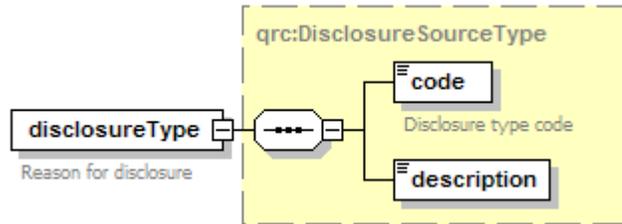


Figure 61: Report Change Information Record

### 3.57 Disclosure Type

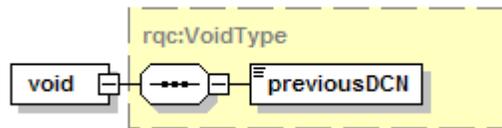
The Disclosure Type Record contains the description of the change to the report.



**Figure 62: Disclosure Type Record**

### 3.58 Void

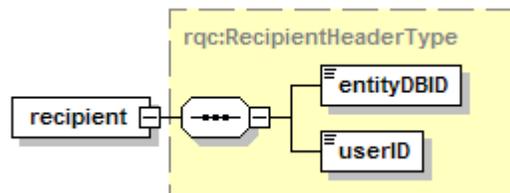
The Void record in a Report Change Notification response indicates that the report identified by the previous DCN has been voided and should be destroyed.



**Figure 63: Void Record**

### 3.59 Recipient

The Recipient Record is included in every Data Bank Correspondence response and identifies for whom the message is intended.



**Figure 64: Recipient Record**

### 3.60 Correspondence Response

The Correspondence Response Record contains the message information.

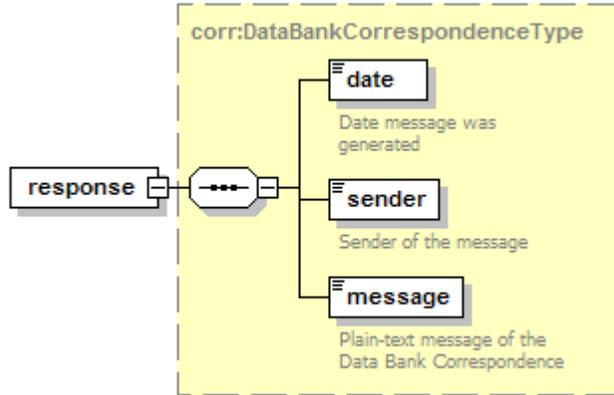


Figure 65: Correspondence Response Record

## 4. Data Definitions

### 4.1 Data Dictionary – Elements

The data dictionary defines each element that appears in the Query schemas (Submission, Confirmation, Response, Report Change Notification, and Correspondence). Data must follow the specified type according to the following codes:

A = Alphanumeric

C = Code (refer to the appropriate code list in Section 4.2, Data Dictionary - Common List of Values, or the data description)

D = Date (YYYY-MM-DD). Dates are specified using the XML Schema date type unless noted otherwise. In responses from the Data Bank(s), date fields will be 16 characters and include a time value (YYYY-MM-DD-HH:MI). For submissions, if the time is included in a date element, it will be ignored.

N = Numeric

B = Boolean (true, false, 1, 0). Boolean values are specified using the XML Schema boolean type unless noted otherwise.

R = Duration (PnYnMnD). Durations are specified using the XML Schema duration type unless noted otherwise. Duration is defined as a three dimensional space where the coordinates designate the Gregorian year, month, and day, respectively, and will be of the form “PnYnMnD”. For example one year, 8 months, 16 days would be written as “P1Y8M16D”. One year, 6 months would be written as “P1Y6M”. No more than two digits may be used to specify the number of years and the number of months. No more than three digits may be used to specify the number of days.

M = Monetary (NNNN.NN). Specify dollars and cents (do not include dollar sign; include decimal point; max value 99999999.99; must be greater than 0.00 if a required field).

Unless otherwise noted, the specified field width represents the maximum number of characters allowed for the field. **All fields larger than the specified field width will be truncated.** Data values that are shorter than the specified field width should **not** be padded with additional characters. **Reports submitted using an incorrect format or code(s) will be rejected.**

**Table 4-1: Data Dictionary Elements**

Data Element	Description	Field Type	Field Width
<b>Query Submission</b>			
entityDBID	Data Bank Identification Number (DBID) of Querying Entity assigned by the Data Bank(s).	N	15
agentDBID	Agent DBID (if registered agent is submitting report). Complete only if a registered agent is querying on behalf of the entity identified (entityDBID) above. If an agent is not submitting the query, omit this field.	N	15
vendorID	Self-defined value identifying the vendor of the software that was used to generate the submission file.	A	40
EFT	Flag indicating that payment is/was made by Electronic Funds Transfer.	B	N/A
creditCard/number	Credit card number.	A	12-16
creditCard/expirationDate	Date of credit card expiration.	D	10
creditCard/cardholderName	The name of the credit card holder.	A	40
address/address	First line of street address.	A	40
address/address2	Second line of address.	A	40
address/city	City. Refer to Section 4.2, Table 4-2 if Military.	A	28

Data Element	Description	Field Type	Field Width
address/state	If State or territory is inside U.S. Refer to Section 4.2, Table 4-2 for State codes.	C	2
address/zip	ZIP code. Refer to Section 4.2, Table 4-3 for APO/FPO Codes.	A	5
address/zip4	4-digit ZIP code extension.	A	4
address/country	Required if country is not U.S. Omit if country is U.S.	A	20
purpose	Code indicating purpose of query submission. Refer to Section 4.2, Table 4-19.	C	1
certification/name	Name of individual certifying transaction. (The individual certifying a transaction must be authorized to submit information to the Data Bank(s) on behalf of the eligible entity. This individual certifies that all transaction information is true and correct to the best of his or her knowledge).	A	40
certification/title	Title of individual certifying transaction.	A	40
phone/number	Telephone number. Area code must be included. For international phone numbers, include country code. Do not use delimiters. Format: NNNNNNNNNNNNNNNN.	N	15
phone/extension	Telephone extension.	N	5
certification/date	Certification date. The certification date must not be in the future.	D	10
name/last	Last name. When specifying other names used information (otherName), both first name and last name must be provided.	A	25
name/first	First name.	A	15
name/middle	Middle name.	A	15
name/suffix	Suffix (e.g., JR, SR, III).	A	4
gender	“M” = Male, “F” = Female, “U” = Unknown	C	1
birthdate	Individual subject’s birth date.	D	10
organizationName organization/name organization/otherName	Name of organization or name of organization where subject works when subject is an individual.	A	50
organizationType/typeCode	Type of organization when subject is an organization. Type of organization where subject works when subject is an individual. Refer to Section 4.2, Table 4-8 for codes.	C	3
organizationType/description	Organization type description. Complete only if Type of Organization code “999” is specified above. Otherwise, omit this field.	A	100
ssn	Social Security Number (SSN) of subject. Cannot be all zeros. Must be all numbers or include optional hyphens (NNN-NN-NNNN).	N	9 or 11
itin	Individual Taxpayer Identification Number (ITIN). Must begin with 9. Must be all numbers or include optional hyphens (NNN-NN-NNNN).	N	9 or 11
fein	Federal Employer Identification Number (FEIN).	N	9
npi	National Provider Identifier (NPI).	N	10
dea	Drug Enforcement Administration (DEA) Number.	A	12
upin	Unique Physician Identification Number (UPIN).	A	6

Data Element	Description	Field Type	Field Width
professionalSchool/school	Name of professional school attended by a subject. Enter name of professional school or certificate program. NOTE: You may only provide up to 40 characters. Submission data beyond 40 characters will be truncated.  When specifying professional school information, both professional school and year of graduation must be provided. If the report subject did not graduate (but completed a certificate program), provide the school name in the Professional School field and the last year of attendance. If the subject did not attend a school, provide the name of the certificate program and the year that it was completed. In the event that the subject neither attended a school nor completed a certificate program, enter "None" in the Professional School field and enter the year that the subject was authorized by the state to provide health care services in the Year of Graduation field.	A	4000
professionalSchool/graduationYear	Year of graduation in YYYY format. Enter year of graduation from professional school or year of completion of certificate program. The graduation year must be at least 15 years beyond the date of birth, and between 1900 and the current year (inclusive).	N	4
licensure/number	State license number. If State law does not require a license, or if the subject has a temporary or foreign license, is operating without a required license, or is operating with an unauthorized license, this will be omitted. Must contain at least one digit.	A	16
licensure/noLicense	Select when State law does not require a license or the subject has a temporary or foreign license, is operating without a required license, or is operating with an unauthorized license. Omit when a number is provided for this license.	B	N/A
licensure/state	State of license. Refer to Section 4.2, Table 4-2 for State codes.	C	2
licensure/field	Occupation/Field of Licensure. (Refer to Section 4.2, Table 4-4 for codes. Also, refer to Section 4.2, Table 4-11 for retired field of licensure codes).	C	3
licensure/description	Other Occupation/Field of Licensure. Complete only if Occupation/Field of Licensure code of "699" or "899" is selected. Describe the Occupation/Field of Licensure. Otherwise, omit this field.	A	60
licensure/specialty	Specialty of subject when the subject is a physician or dentist (i.e., Occupation/Field of Licensure code is "010", "015", "020", "025", "030", or "035"). Refer to Section 4.2, Table 4-5 for Specialty codes.	C	2
subjectID	Reserved. Do not specify.	A	20
customerUse	Identification record for use by the submitting entity. This data field does not appear on report output and will be returned without modification in the response file. This field may be used by the submitter to identify this transaction.	A	20
clia	Clinical Laboratory Improvement Act (CLIA) Number.	A	10
fda	Food and Drug Administration (FDA) Number.	N	7
medicareProvider	Medicare Provider and Supplier Number.	A	15
<b>Query Confirmation</b>			
submissionFilename	The name of the submission file in which this query transaction was received.	A	255
batchStatus/dcn	The Data Bank Control Number assigned to this query batch.	N	16
batchStatus/processDate	Date transaction was processed.	D	10
batchStatus/successfullyProcessed	Status indicating if the file was successfully processed.	B	N/A

Data Element	Description	Field Type	Field Width
error/code	Indicates why the transaction was rejected and could not be processed. Refer to Section 4.2, Table 4-14 for Error Codes. This field will be repeated for each error found. The field is only present when an error is present.	C	2
error/message	Error message description corresponding to the error code.	A	4000
subjectConfirmation/accepted	If true, this value means that this subject has been accepted for query processing. If false, one or more error elements will be present describing the problems with this subject.	B	N/A
subjectConfirmation/dcn	The Data Bank Control Number Assigned to this query subject.	N	16
<b>Query Response</b>			
payment/isFree	Flag indicating that the query was processed for free.	B	N/A
dateCharged	The date that the Data Bank charged fees for the associated query.	D	10
chargeReference/dataBank	An indicator whether this transaction was charged by the National Practitioner Data Bank (NPDB) or the Healthcare Integrity and Protection Data Bank (HIPDB). Valid values are "N" and "H". If the charge reference is shown as part of the query response element it means that the subjects in this output file were previously charged and charge receipt details can be found in a previous output file for this same query batch.	C	1
chargeReference/referenceNumber	Data Bank reference number associated with the charge to your entity's EFT or credit card account for this query. The Data Banks pass this information along with the charge request to your bank which will process the charge. The bank may provide this information to you for help in reconciling your entity's NPDB-HIPDB charges against your financial accounts. If the charge reference is shown as part of the query response element it means that the subjects in this output file were previously charged and charge receipt details can be found in a previous output file for this same query batch.	A	25
numberOfSubjects	The number of subjects in this query batch.	N	3
numberOfSubjectsCharged	The number of subjects in this query batch that were charged in this billing transaction.	N	3
numberOfSubjectsChargedSeparately	The number of subjects in this query batch that were charged in a previous billing transaction.	N	3
numberOfSubjectsNotProcessed	The number of subjects in this query batch that have not yet been processed and will be charged in a future billing transaction.	N	3
pricePerSubject	Fee charged per name by the associated Data Bank. Does not include dollar sign, includes decimal point followed by two digits.	M	12
numberOfCreditsUsed	The number of query credits used to process the subjects in this query batch.	N	3
amountOfCreditsUsed	The dollar amount of query credits used to process the subjects in this query batch. Does not include dollar sign, includes decimal point followed by two digits.	M	12
totalCharge	The total dollar amount charged in this billing transaction. Does not include dollar sign, includes decimal point followed by two digits.	M	12
entityName	The entity of the point of contact.	A	40
officeOrName	The current individual or office designated as the point of contact for this report.	A	40
titleOrDept	Title or department of point of contact.	A	40

Data Element	Description	Field Type	Field Width
entityReference	Entity Internal Report Reference. A file number or other reference information established by the reporting entity to help identify this report in their files. This information is not used by the Data Banks, but it will be provided on copies of the report sent to querier(s).	A	20
latestContact/entityStatus	Most recent status of the entity. Refer to Section 4.2, Table 4-17 for Entity Status Codes.	C	1
latestContact/entityName	Most recent name of the entity or its successor entity.	A	40
latestContact/lastUpdateDate	Date of most recent name or address change made by the original reporting entity. The date is only provided if the original reporting entity has no successor.	D	10
reportData/reportDCN	Data Bank Control Number. Unique number assigned to the report.	N	16
transaction previousTransaction	Identifies the type of report: Initial, Correction, Revision to Action, Correction of Revision to Action, Appeal, Void. Refer to Section 4.2, Table 4-10 for Report Type codes.	C	1
previousDCN	Data Bank Control Number of Corrected, Revised, Appealed, or Voided report.	N	16
latestRelatedDCN	DCN of the related report Correction. Only appears in Revision to Action Report when the related report has been corrected.	N	16
latestRelatedTransaction	Indicates whether the related report has been corrected or voided. "C" = Correction, "V" = Void. Only appears in Revision to Action Report when the related report is corrected or voided.	C	1
latestRelatedNote	Describes the relationship between this report and the related report. Only appears in Revision to Action Report when the related report is corrected or voided.	A	4000
originalSubmitDate	Date of original submission.	D	10
recentChangeDate	Date of most recent change.	D	10
npdb/maintainedIn hipdb/maintainedIn	The report is maintained in the specified Data Bank.	B	N/A
npdb/titleIV	The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Title IV of Public Law 99-660, as amended; and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. Disclosure or use of confidential information for other purposes is a violation of Federal law.	B	N/A
npdb/section1921	The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Section 1921 of the Social Security Act, and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. Disclosure or use of confidential information for other purposes is a violation of Federal law.	B	N/A
hipdb/section1128E	The information contained in this report is maintained by the Healthcare Integrity and Protection Data Bank for restricted use under the provisions of Section 1128E of the Social Security Act, and 45 CFR Part 61. All information is confidential and may be used only for the purpose for which it was disclosed. Disclosure or use of confidential information for other purposes is a violation of Federal law.	B	N/A
deceasedDate/isDeceased	"Y" = Yes, "N" = No, "U" = Unknown.	C	1
deceasedDate/date	Deceased Date.	D	10
affiliation/name	Name of health care entity with which subject is affiliated or associated. (Inclusion does not imply complicity in the reported action.)	A	40

Data Element	Description	Field Type	Field Width
affiliation/ natureRelationship	Nature of Subject's Relationship to Affiliate/Associate code (Refer to Section 4.2, Table 4-6 for Individual subjects or Section 4.2, Table 4-7 for Organization subjects.)	C	3
affiliation/ otherNatureRelationship	Other Nature of Subject's Relationship to Affiliate. Complete only if Nature of Subject's Relationship to Affiliate/Associate code is "999". Otherwise, omit this field.	A	40
hospitalAffiliation/name	Name of hospital with which practitioner is affiliated (Inclusion does not imply complicity in the reported action).	A	40
hospitalAffiliation/city	City where affiliated hospital is located.	A	28
hospitalAffiliation/state	State where affiliated hospital is located. Refer to Section 4.2, Table 4-2 for State codes.	C	2
principalOfficerOwner/title	Title of Principal Officer or Owner.	A	40
subjectStatement/submitDate	Date statement was submitted by the subject.	D	10
subjectStatment/ statementThisVersion	"true": The subject entered the statement in response to this version of this report. "false": The subject entered the statement submitted in response to an earlier version of this report. The reporting entity changed the report after the subject prepared the statement. As of the date this report response was processed, the subject has not changed the statement in response to the changes in the report.	B	N/A
subjectStatement/statement	Subject statement.	A	4000
secretaryStatement/ submitDate	Date statement was submitted by the Secretary of the U.S. Department of Health and Human Services.	D	10
secretaryStatement/ statementThisVersion	"true": The Secretary of the U.S. Department of Health and Human Services reviewed this version of this report and entered this statement. "false": The Secretary of the U.S. Department of Health and Human Services reviewed an earlier version of this report and entered this statement. After the Secretarial Review decision and subject statement were entered, the reporting entity changed the report. The Secretary has not reviewed the current version of the report.	B	N/A
secretaryStatement/statement	Secretary of the U.S. Department of Health and Human Services statement.	A	4000
disputeStatus	Report dispute status. "N" = not in dispute, "Y" = in dispute, "S" = elevated to Secretarial Review, "R" = reviewed by Secretary.	C	1
supplementalIndividual/ deceasedDate	Deceased date of individual subject. This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report.	D	10
supplementalIndividual/ name/last	Last name of subject. This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report.	A	25
supplementalIndividual/ name/first	First name of subject. This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report.	A	15
supplementalIndividual/ name/middle	Middle name of subject. This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report.	A	15
supplementalIndividual/ name/suffix	Suffix (e.g., JR, SR, III). This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report.	A	4
supplementalOrganization/ name	Name of organization when subject is an organization. This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report.	A	50

Data Element	Description	Field Type	Field Width
<b>AAR Report Elements</b>			
action	Describes the type of Adverse Action. Refer to Section 4.2, Table 4-9.	C	2
classification/code	Adverse Action Classification Code. Refer to Section 4.2, Table 4-26 for descriptions of Adverse Action Classification Codes. Also refer to Section 4.2, Table 4-12 for retired codes.	C	4
classification/description	Description of the adverse action taken; included if the reporter selected one of the following codes: "1645", "1989", "1189", "1199", "1389", "1399", "1589", "1745", "3989", "3239", and "3589".	A	40
agencyProgramName	Name of Agency or Program that took the Adverse Action.	A	40
findingDate	Reserved.	D	10
actionTakenDate	Date action was taken.	D	10
actionEffectiveDate	Date action became effective.	D	10
actionLength/indefinite *	Is the action indefinite?	B	N/A
actionLength/permanent *	Is the action permanent?	B	N/A
actionLength/length *	Number of years, months and days that action is effective. (Not applicable to actions with a permanent or indefinite duration or actions with no duration.)	R	3-11
<b>* Only one of these three types of actionLength type elements shall be accepted in the actionLength.</b>			
automaticReinstatement	Is reinstatement automatic at completion of adverse action period? "Y" = Yes, "N" = No, "C" = Yes, with conditions (requires a Revision to Action report when status changes).	C	1
amount	Total amount of monetary penalty, fine, or restitution in dollars and cents.	M	12
orgDefn	Is the subject a health care entity that provides health care services and engages in a formal peer review process for the purpose of furthering quality health care?	B	N/A
ccb	Is the adverse action specified in this report based on the subject's professional competence or conduct, which adversely affected, or could have adversely affected, the health or welfare of the patient?	B	N/A
narrative	Narrative description of Subject's act(s) or omission(s) and relevant information related to the adverse action taken.	A	4000
appeal/onAppeal	Is the action on appeal? "Y" = Yes, "N" = No, "U" = Unknown.	C	1
appeal/appealDate	Date the action was appealed.	D	10
basis/code	Basis for the action taken. Refer to Section 4.2, Table 4-27 for descriptions of Basis For Action codes. Also, refer to Section 4.2, Table 4-13 for retired codes. This field is not applicable to Revision to Action Reports and Correction of Revision to Action Reports.	C	2
basis/description	Description of the basis for action taken.	A	75
<b>JOCR Report Elements</b>			
action	Type of action code. Refer to Section 4.2, Table 4-23 for codes.	C	2
jurisdiction	Jurisdiction of court or venue in which the action was taken. "S" = State/Local Court, "F" = Federal Court.	C	1
venueName	Venue (court) name.	A	40
venueCity	City of court.	A	28
venueState	State of court. Refer to Section 4.2, Table 4-2 for state codes.	C	2
fileNumber	Docket/Court File Number.	A	15
prosecutor	Prosecuting agency or civil plaintiff.	A	40
caseNumber	Case number used by prosecuting agency or plaintiff.	A	15

Data Element	Description	Field Type	Field Width
investigatingAgency/ agencyName	Investigating agency name.	A	40
investigatingAgency/ caseNumber	Case number used by investigating agency.	A	15
statutoryOffense/ statuteTitleSection	Statute title and code section.	A	80
statutoryOffense/ statutoryOffense	Statutory offense description.	A	80
statutoryOffense/count	Number of counts of violations.	N	3
narrative	Narrative description of subject's act(s) or omission(s).	A	4000
actOmission/ actOmissionCode	Code that describes the subject's Act(s) or Omission(s). Refer to Section 4.2, Table 4-24 for codes.	C	3
actOmission/ actOmissionDesc	Other Act(s) or Omission(s) Description.	A	40
judgmentOrSentenceDate	Date of Judgment/Sentence.	D	10
appeal/onAppeal	Is the action on appeal? "Y" = Yes, "N" = No, "U" = Unknown.	C	1
appeal/appealDate	Date the action was appealed.	D	10
sentenceOrJudgment/ restitutionAmount	Restitution amount in dollars and cents.	M	12
sentenceOrJudgment/ otherSentenceJudgmentAmount	Other sentence/judgment amount ordered in dollars and cents.	M	12
sentenceOrJudgment/ incarcerationLength	Duration of incarceration of subject.	R	3-11
sentenceOrJudgment/ suspendedSentenceLength	Duration of suspended sentence of subject.	R	3-11
sentenceOrJudgment/ homeDetentionLength	Duration of home detention of subject.	R	3-11
sentenceOrJudgment/ probationLength	Duration of probation of subject.	R	3-11
sentenceOrJudgment/ communityServiceHours	Number of hours of community service.	D	5
sentenceOrJudgment/ otherCourtOrders	Other court orders.	A	160
<b>MMPR Report Elements</b>			
relationshipOfEntity	Relationship of entity to this practitioner "P" = Insurance Company – Primary Insurer, "E" = Insurance Company – Excess Insurer, "S" = Self-Insured Organization, "G" = Insurance Guaranty Fund, "M" = State Medical Malpractice Payment Fund as the Primary Payer for This Practitioner, "O" = State Medical Malpractice Payment Fund as a Secondary Payer for This Practitioner.	C	1
paymentForThisPractitioner	Amount of the single total payment or the first of multiple payments for this practitioner in dollars and cents.	M	12
paymentDate	Date on the payment check of the single or initial payment.	D	10
paymentType	This payment represents: "S" = Single Final Payment, "M" = One of Multiple Payments.	C	1
totalPaymentForThisPractitioner	Total dollar amount paid or to be paid by this payer for this practitioner in this case.	M	12
paymentResultOf	Action from which payment resulted. "J" = Judgment, "S" = Settlement, "B" = Payment Prior to Settlement	C	1
judgmentOrSettlementDate	Date of the judgment or settlement.	D	10
adjudicativeBodyCaseNumber	Case or docket number of adjudicative body with which the claim was filed.	A	20

Data Element	Description	Field Type	Field Width
adjudicativeBodyName	Name of the adjudicative body with which the claim was filed.	A	60
courtFileNumber	File number assigned by the court with which the claim was filed.	A	10
judgmentOrSettlementDesc	Description of judgment or settlement and any conditions, including terms of payment.	A	4000
totalPaymentForAllPractitioners	Total amount paid or to be paid by this payer for all practitioners.	M	12
numberPractitioners	Number of practitioners for whom this payer has paid or will pay in this case.	N	3
stateFundPayment/paymentMade	Has a State Guaranty Fund or State Excess Judgment Fund made a payment for this practitioner in this case, or is such a payment expected to be made? "Y" = Yes, "N" = No, "U" = Unknown.	C	1
stateFundPayment/amountPaid	Amount paid or expected to be paid by State Guaranty Fund or State Excess Judgment Fund.	M	12
selfInsuredOrgPayment/paymentMade	Has a self-insured organization(s) and/or other insurance company/companies made payment for this practitioner in this case or is such payment expected to be made? "Y" = Yes, "N" = No, "U" = Unknown.	C	1
selfInsuredOrgPayment/amountPaid	Amount paid or expected to be paid by self-insured organization(s) and/or other insurance company/companies.	M	12
patientAge/days	Patient's age at time of initial event in days.	N	2
patientAge/months	Patient's age at time of initial event in months.	N	2
patientAge/years	Patient's age at time of initial event in years.	N	3
patientAge/unknown	True if the patient's age is unknown.	B	N/A
patientGender	Gender of the patient. "M" = Male, "F" = Female, "U" = Unknown.	C	1
patientType	Type of patient. "I" = Inpatient, "O" = Outpatient, "B" = Both, "U" = Unknown.	C	1
medicalConditionDesc	Description of the medical condition with which the patient presented for treatment (prior to the event that led to the malpractice allegation).	A	4000
procedureDesc	Description of the procedure performed or treatment rendered by the insured to the patient.	A	4000
natureAllegation	Nature of the allegation. Refer to Section 4.2, Table 4-20 for codes.	C	3
specificAllegation/code	Specific allegation describing the alleged acts or omissions. Refer to Section 4.2, Table 4-21 for codes.	C	3
specificAllegation/otherDesc	Other allegation description.	A	60
specificAllegation/date	Date of the event associated with allegation or incident.	D	10
outcome	Code that describes the outcome of the specific allegation(s). Refer to Section 4.2, Table 4-22.	C	2
allegationDesc	Description of the allegations and injuries or illnesses upon which the action or claim was based.	A	4000
<b>Legacy AAR Report Elements</b>			
action	Type of adverse action – "L" = licensure, "C" = clinical privileges, "S" = society membership.	C	1
classification	Adverse Action Classification Code. (Refer to Section 4, Table 4-18, for codes.)	C	5
actionTakenDate	Date of action.	D	10
actionEffectiveDate	Date action became effective.	D	10
actionLength/indefinite *	Is the action indefinite?	B	N/A
actionLength/permanent *	Is the action permanent?	B	N/A
actionLength/length *	Number of years, months and days that action is effective. (Not applicable to actions with a permanent or indefinite duration or actions with no duration.)	R	3-11
<b>* Only one of these three types of actionLength type elements shall be populated in the actionLength.</b>			

Data Element	Description	Field Type	Field Width
narrative	Narrative description of Subject's act(s) or omission(s) and relevant information related to the adverse action taken.	A	4000
<b>Legacy MPR Report Elements</b>			
relationshipOfEntity	Entity's relationship to practitioner. "I" = Insurance Company, "S" = Self-Insured Organization, "O" = Other - Guaranty Fund.	C	1
actOrOmission/code	Code for act or omission allegedly committed. (Refer to Section 4.2, Table 4-25, for Medical Malpractice Acts or Omissions codes.)	C	3
actOrOmission/date	Date act or omission occurred.	D	10
paymentDate	Date on which payment was made.	D	10
paymentForThisPractitioner	Dollar amount of this payment in dollars and cents.	M	12
paymentType	Type of payment. "S" = Single Payment, "M" = Multiple Payments.	C	1
totalPaymentForThisPractitioner	Total dollar amount of settlement.	M	12
numberPractitioners	Number of practitioners for whose benefit payment was made.	D	3
paymentResultOf	Action from which payment resulted. "J" = Judgment, "S" = Settlement, "B" = Payment Prior to Settlement, "U" = Unknown, "O" = Other.	C	1
judgmentOrSettlementDate	Date of the judgment or settlement.	D	10
adjudicativeBodyCaseNumber	Case or docket number of adjudicative body with which the claim was filed.	A	20
adjudicativeBodyName	Name of the adjudicative body with which the claim was filed.	A	60
courtFileNumber	File number assigned by the court.	A	10
actOrOmissionDesc	Description of the alleged act(s) or omission(s) that led to the claim.	A	4000
judgmentOrSettlementDesc	Description of payment made and any terms or conditions.	A	4000
<b>Report Change Notification Elements</b>			
reportChangeInformation/forAuthorizedUseBy	Name of the entity for which the Report Change Notification response is generated.	A	40
reportChangeInformation/transactionDCN	Data Bank Control Number. Unique number assigned to the transaction that generated the Report Change Notification response.	N	16
reportChangeInformation/processDate	Date transaction change was processed.	D	10
disclosureType/code	Indicates why the changed report is being disclosed. Refer to Section 4.2, Table 4-15.	C	2
disclosureType/description	Description corresponding to the disclosure type code.	A	4000
subjectSource	Indicates why the entity is receiving the report change notification. Refer to Section 4.2, Table 4-16.	C	1
void/previousDCN	The Data Bank Control Number of the report to be voided. The voided report should be destroyed.	N	16
<b>Data Bank Correspondence Elements</b>			
correspondence/recipient/entityDBID	Data Bank Identification Number (DBID) for whom the Data Bank Correspondence is intended.	N	15
correspondence/recipient/userID	The user ID for whom the Data Bank Correspondence is intended.	A	14
correspondence/response/date	The date the Data Bank Correspondence was generated.	D	10
correspondence/response/sender	The sender of the Data Bank Correspondence.	A	40
correspondence/response/message	The plain-text message of the Data Bank Correspondence.	A	4000

## 4.2 Data Dictionary – Common List of Values

**Table 4-2: State Abbreviations and U.S. Territories**

State Abbreviations and U.S. Territories					
AL	Alabama	KY	Kentucky	ND	North Dakota
AK	Alaska	LA	Louisiana	OH	Ohio
AZ	Arizona	ME	Maine	OK	Oklahoma
AR	Arkansas	MD	Maryland	OR	Oregon
CA	California	MA	Massachusetts	PA	Pennsylvania
CO	Colorado	MI	Michigan	RI	Rhode Island
CT	Connecticut	MN	Minnesota	SC	South Carolina
DE	Delaware	MS	Mississippi	SD	South Dakota
DC	District of Columbia	MO	Missouri	TN	Tennessee
FL	Florida	MT	Montana	TX	Texas
GA	Georgia	NE	Nebraska	UT	Utah
HI	Hawaii	NV	Nevada	VT	Vermont
ID	Idaho	NH	New Hampshire	VA	Virginia
IL	Illinois	NJ	New Jersey	WA	Washington
IN	Indiana	NM	New Mexico	WV	West Virginia
IA	Iowa	NY	New York	WI	Wisconsin
KS	Kansas	NC	North Carolina	WY	Wyoming
AS	American Samoa	GU	Guam	PR	Puerto Rico
FM	Federated States of Micronesia	MP	Northern Marianas	VI	Virgin Islands
PW		PW	Palau		
AA	Central and South America (Armed Forces)	AE	Europe (Armed Forces)	AP	Pacific (Armed Forces)
<p>Please adhere to the following guidelines when entering foreign or military addresses:</p> <p>Addresses for United States Territories:</p> <ul style="list-style-type: none"> <li>• Enter Territory abbreviation in state field.</li> </ul> <p>Addresses outside the United States or its territories:</p> <ul style="list-style-type: none"> <li>• Leave the state field blank.</li> <li>• Enter the city and/or province in the city field.</li> <li>• Enter the Country Code in the zip fields—maximum five characters in first field, maximum four characters in the second field.</li> <li>• Enter the country in the country field.</li> </ul> <p>Military Addresses:</p> <ul style="list-style-type: none"> <li>• Enter APO in the city field.</li> <li>• Enter AE, AA in the state field.</li> <li>• Enter the ZIP code in the zip field.</li> </ul> <p>The following State Codes are not valid for State of Licensure:</p> <ul style="list-style-type: none"> <li>• AA Central and South America (Armed Forces)</li> <li>• AE Europe (Armed Forces)</li> <li>• AP Pacific (Armed Forces)</li> </ul>					

**Table 4-3: APO/FPO Postal Codes\***

<b>APO/FPO Code</b>	<b>First 3 Digits of ZIP Code</b>	<b>Geographic Area</b>	<b>APO/FPO Code</b>	<b>First 3 Digits of ZIP Code</b>	<b>Geographic Area</b>
<b>AE - Europe</b>	090-092	Germany	<b>AA - Americas</b>	340	Central, South Americas
	094	United Kingdom		<b>AP - Pacific</b>	962
	095	Atlantic Ocean/ Mediterranean Sea Ships	963		Japan
	096	Italy, Spain	964		Philippines
	097	Other Europe	965		Other Pacific and Alaska
	098	Middle East, Africa	966		Pacific and Indian Ocean Ships

\* APO/FPO Codes (State Codes) are not valid for State of Licensure. Refer to Table 4-2.

**Table 4-4: Occupation/Field of Licensure Codes**

<b>Occupation/Field of Licensure Codes</b>		
<p><b>603 Chiropractor</b></p> <p><b>Counselor</b> 621 Counselor, Mental Health 651 Professional Counselor 654 Professional Counselor, Alcohol 657 Professional Counselor, Family/Marriage 660 Professional Counselor, Substance Abuse 661 Marriage and Family Therapist</p> <p><b>Dental Service Provider</b> 030 Dentist 035 Dental Resident 606 Dental Assistant 609 Dental Hygienist 612 Denturist</p> <p><b>Dietician/Nutritionist</b> 200 Dietician 210 Nutritionist</p> <p><b>Emergency Medical Technician (EMT)</b> 250 EMT, Basic 260 EMT, Cardiac/Critical Care 270 EMT, Intermediate 280 EMT, Paramedic</p> <p><b>Eye and Vision Service Provider</b> 630 Ocularist 633 Optician 636 Optometrist</p> <p><b>Nurse/Advanced Practice Registered Nurse</b> 100 Registered (Professional) Nurse 110 Nurse Anesthetist 120 Nurse Midwife 130 Nurse Practitioner 140 Licensed Practical or Vocational Nurse 141 Clinical Nurse Specialist</p>	<p><b>Nurses Aide, Home Health Aide and Other Aide</b> 148 Certified Nurse Aide/Certified Nursing Assistant 150 Nurses Aide 160 Home Health Aide (Homemaker) 165 Health Care Aide/Direct Care Worker 175 Certified or Qualified Medication Aide</p> <p><b>Pharmacy Service Provider</b> 050 Pharmacist 055 Pharmacy Intern 060 Pharmacist, Nuclear 070 Pharmacy Assistant 075 Pharmacy Technician</p> <p><b>Physician</b> 010 Physician (MD) 015 Physician Intern/Resident (MD) 020 Osteopathic Physician (DO) 025 Osteopathic Physician Intern/Resident (DO)</p> <p><b>Physician Assistant</b> 642 Physician Assistant, Allopathic 645 Physician Assistant, Osteopathic</p> <p><b>Podiatric Service Provider</b> 350 Podiatrist 648 Podiatric Assistant</p> <p><b>Psychologist/Psychological Assistant</b> 371 Psychologist 372 School Psychologist 373 Psychological Assistant, Associate, Examiner</p>	<p><b>Rehabilitative, Respiratory, and Restorative Service Provider</b> 402 Art/Recreation Therapist 405 Massage Therapist 410 Occupational Therapist 420 Occupational Therapy Assistant 430 Physical Therapist 440 Physical Therapy Assistant 450 Rehabilitation Therapist 663 Respiratory Therapist 666 Respiratory Therapy Technician</p> <p><b>300 Social Worker</b></p> <p><b>Speech, Language, and Hearing Service Provider</b> 400 Audiologist 460 Speech/Language Pathologist 470 Hearing Aid/Hearing Instrument Specialist</p> <p><b>Technologist</b> 500 Medical Technologist 505 Cytotechnologist 510 Nuclear Medicine Technologist 520 Radiation Therapy Technologist 530 Radiologic Technologist</p> <p><b>Other Health Care Practitioner</b> 600 Acupuncturist 601 Athletic Trainer 615 Homeopath 618 Medical Assistant 624 Midwife, Lay (Non-Nurse) 627 Naturopath 639 Orthotics/Prosthetics Fitter 647 Perfusionist 170 Psychiatric Technician 699 Other Health Care Practitioner—Not Classified, Specify</p>

**Table 4-4: Occupation/Field of Licensure Codes (Continued)**

<b>Occupation/Field of Licensure Codes</b>		
<b>Health Care Facility Administrator<sup>1</sup></b>	<b>Other Occupation<sup>1</sup></b>	
752 Adult Care Facility Administrator	850 Accountant	
755 Hospital Administrator	853 Bookkeeper	
758 Long-Term Care Administrator	822 Business Manager	
	830 Business Owner	
	820 Corporate Officer	
	810 Insurance Agent	
	812 Insurance Broker	
	800 Researcher, Clinical	
	840 Salesperson	
	899 Other Occupation—Not Classified, Specify	

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<sup>1</sup> Health Care Facility Administrator and Other Occupation codes are not available for Clinical Privilege and Professional Society actions.

**Table 4-5: Specialty Codes**

<b>Specialty Codes</b>		
<b>Physician Specialties</b>	55 Ophthalmology	<b>Dental Specialties</b>
01 Allergy and Immunology	59 Otolaryngology	D1 General Dentistry (No Specialty)
03 Aerospace Medicine	60 Pediatrics	D2 Dental: Public Health
05 Anesthesiology	63 Psychiatry	D3 Endodontics
10 Cardiovascular Diseases	65 Public Health	D4 Oral and Maxillofacial Surgery
13 Child Psychiatry	67 Clinical Pharmacology	D5 Oral and Maxillofacial Pathology
20 Dermatology	69 Physical Medicine & Rehabilitation	D6 Orthodontics and Dentofacial Orthopedics
23 Diagnostic Radiology	70 Pulmonary Diseases	D7 Pediatric Dentistry
25 Emergency Medicine	73 Anatomic/Clinical Pathology	D8 Periodontics
29 Forensic Pathology	75 Radiology	D9 Prosthodontics
30 Gastroenterology	76 Radiation Oncology	DA Oral and Maxillofacial Radiology
33 General Practice/Family Practice	80 Colon and Rectal Surgery	DB Unknown
35 General Preventive Medicine	81 General Surgery	
37 Hospitalist	82 Neurological Surgery	
39 Internal Medicine	83 Orthopedic Surgery	
40 Neurology	84 Plastic Surgery	
43 Neurology, Clinical Neurophysiology	85 Thoracic Surgery	
45 Nuclear Medicine	86 Urological Surgery	
50 Obstetrics & Gynecology	98 Other Specialty—Not Classified	
53 Occupational Medicine	99 Unspecified	

**Table 4-6: Nature of Relationship – Individual Subjects**

<b>Nature of Relationship – Individual Subjects</b>	
100	Subject is Owner/Partner of Affiliate or Associate
150	Subject is Manager/Supervisor/Director of Affiliate or Associate
200	Subject is Employee of Affiliate or Associate
250	Subject is Contractor to Affiliate or Associate
300	Subject is Member of Affiliate or Associate’s Network
350	Subject has Clinical Privileges With Affiliate or Associate
400	Subject is Supplier to Affiliate or Associate
450	Subject is Customer of Affiliate or Associate
700	Subject is in Joint Venture With Affiliate or Associate
999	Other Relationship - Not Classified, Specify

**Table 4-7: Nature of Relationship – Organization Subjects**

<b>Nature of Relationship – Organization Subjects</b>	
250	Subject is Contractor to Affiliate or Associate
300	Subject is Member of Affiliate or Associate’s Network
400	Subject is Supplier to Affiliate or Associate
450	Subject is Customer of Affiliate or Associate
500	Subject is Parent Organization of Affiliate or Associate
600	Subject is Subsidiary of Affiliate or Associate
700	Subject is in Joint Venture With Affiliate or Associate
999	Other Relationship - Not Classified, Specify

**Table 4-8: Type of Organization Codes**

<b>Type of Organization Codes</b>		
<p><b>Group or Practice</b>                      361 Chiropractic Group/Practice                      362 Dental Group/Practice                      365 Medical Group/Practice                      366 Mental Health/Substance Abuse Group/Practice                      363 Optician/Optometric Group/Practice                      367 Physical/Occupational Therapy Group/Practice                      364 Podiatric Group/Practice</p> <p><b>393 Home Health Agency/Organization</b></p> <p><b>382 Hospice/Hospice Care Provider</b></p> <p><b>Hospital</b>                      304 Federal Hospital                      301 General/Acute Care Hospital                      302 Psychiatric Hospital                      303 Rehabilitation Hospital</p> <p><b>Hospital Unit</b>                      307 Psychiatric Unit                      308 Rehabilitation Unit</p> <p><b>310 Laboratory/CLIA Laboratory</b></p> <p><b>389 Nursing Facility/Skilled Nursing Facility</b></p>	<p><b>370 Research Center/Facility</b></p> <p><b>Other Health Care Facility</b>                      381 Adult Day Care Facility                      392 Ambulatory Clinic/Center                      391 Ambulatory Surgical Center                      398 End Stage Renal Disease Facility                      394 Health Center/Federally Qualified Health Center/Community Health Center                      383 Intermediate Care Facility for Mentally Retarded/Substance Abuse                      397 Mammography Service Provider                      395 Mental Health Center/Community Mental Health Center                      388 Outpatient Rehabilitation Facility/Comprehensive Outpatient Rehabilitation Facility                      399 Radiology/Imaging Center                      386 Residential Treatment Facility/Program                      396 Rural Health Clinic</p> <p><b>Managed Care Organization</b>                      331 Health Maintenance Organization                      335 Preferred Provider Organization</p>	<p>336 Provider Sponsored Organization                      338 Religious, Fraternal Benefit Society Plan</p> <p><b>320 Health Insurance Company/Provider</b></p> <p><b>Health Care Supplier/Manufacturer</b>                      347 Biological Products Manufacturer                      342 Blood Bank                      343 Durable Medical Equipment Supplier                      344 Eyewear Equipment Supplier                      351 Fiscal/Billing/Management Agent                      353 Nursing/Health Care Staffing Service                      348 Organ Procurement Organization                      345 Pharmacy                      346 Pharmaceutical Manufacturer                      349 Portable X-Ray Supplier                      352 Purchasing Service</p> <p><b>390 Ambulance Service/Transportation Company</b></p> <p><b>999 Other Type – Not Classified, Specify</b></p>

**Table 4-9: Type of Action**

Code	Type	Description
SL	Licensure (State Licensure)	State licensure actions are adverse actions taken by a State licensing authority related to the license, certification or registration of a health care provider, practitioner, or supplier. State licensing actions include State professional and health care facility licensing sanctions. State licensing actions against physicians and dentists are reportable to the NPDB under provisions of Title IV of the <i>Health Care Quality Improvement Act of 1986</i> , as amended, and 45 CFR Part 60. State licensing actions against health care practitioners, providers, and suppliers are reportable to the HIPDB under Section 1128E of the <i>Social Security Act</i> and 45 CFR Part 61.
FL	Licensure (Federal Licensure)	Federal licensure actions are adverse actions taken by a Federal licensing authority related to the license, certification or registration of a health care provider, practitioner, or supplier. Federal licensure actions include Federal CLIA certification actions, Federal DEA registration actions, and Federal FDA licensing/certification/registration actions. These actions are reportable to the HIPDB under Section 1128E of the <i>Social Security Act</i> and 45 CFR Part 61. DEA registration actions against health care practitioners also are reportable to the NPDB under Title IV of the <i>Health Care Quality Improvement Act of 1986</i> , as amended, and 45 CFR Part 60.
CP	Clinical Privilege (Includes Panel Membership)	Clinical privilege actions are adverse actions taken by a hospital or other health care entity related to its authorization of a health care practitioner to provide health care services, including actions related to a practitioner's membership on the medical staff or panel. These actions are reportable to the NPDB under Title IV of the <i>Health Care Quality Improvement Act of 1986</i> , as amended, and 45 CFR Part 60.
HP	Health Plan	Health plan actions are adverse actions that are taken by a health plan against a health care practitioner, provider or supplier and that are reportable to the HIPDB under Section 1128E of the <i>Social Security Act</i> and 45 CFR part 61. These actions must meet the regulatory definition of "other adjudicated actions or decisions," which requires that they: 1) be formal or official actions; 2) include the availability of a due process mechanism; and 3) be based on acts or omissions that affect or could affect the payment, provision or delivery of a health care item or service. The definition specifically excludes clinical privileging actions or paneling decisions (which normally are the result of a formal peer review process). However, quality actions that include the availability of due process are reportable. An example of a reportable health plan action would be the termination of a practitioner's contract to provide health care services, as long as it meets the three specified criteria.
ED	Exclusion or Debarment	Exclusion or debarment of a practitioner, provider, or supplier from participating in and/or contracting with a Federal or State health care program is an adverse action that is reportable to the HIPDB under Section 1128E of the <i>Social Security Act</i> and 45 CFR Part 61. Exclusion of a practitioner from the Medicare and Medicaid programs is reportable to the NPDB under a Memorandum of Understanding with the Office of Inspector General, and the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services.
PS	Professional Society	Professional Society actions are adverse actions taken by an association of health care practitioners that follows a formal peer review process for the purpose of furthering quality health care. These actions are reportable to the NPDB under provisions of Title IV of the <i>Health Care Quality Improvement Act of 1986</i> , as amended and 45 CFR Part 60.

Code	Type	Description
GA	Government Administrative	Government administrative actions are reportable to the HIPDB under Section 1128E of the <i>Social Security Act</i> and 45 CFR Part 61. They encompass adverse actions reportable to HIPDB that are not elsewhere classified. This category includes any publicly available negative action or finding by a Federal or State agency that certifies health care practitioners, providers, or suppliers for participation in a government health care program. In addition, other government administrative actions include any other adjudicated action or decision by an authorized Federal or State agency against a health care practitioner, provider, or supplier. Other adjudicated actions or decisions must meet the regulatory definition for that term as described in the Health Plan action definition above. These adjudicated actions or decisions may include, for example, personnel actions and employment disqualifications, and contract terminations.

**Table 4-10: Report Type Codes**

Code	Description
I	<b>Initial:</b> The first record of an adverse action that is submitted to and processed by the Data Bank(s). An Initial Report is the current version of the report until a Revision to Action, Correction, Void, or Notice of Appeal is submitted.
C	<b>Correction:</b> A report that corrects an error or omission in an existing report. The Correction will supersede the contents of the current version of a report in the Data Bank(s). It should be submitted as soon as possible after a reporting error or omission is discovered. Corrections may be submitted as often as necessary.
V	<b>Void:</b> The retraction of a report in its entirety from the Data Bank(s). The report is removed from the subject's disclosable record.
R	<b>Revision to Action:</b> A new action that relates to and modifies a previously reported adverse action, (e.g., reinstatement of a license, extension of an exclusion from a Government program, restrictions of clinical privileges lifted, previously stayed license revocation imposed).
O	<b>Correction of Revision to Action:</b> A report that corrects a previously submitted Revision to Action Report. This correction will supersede the contents of the current version of the Revision to Action Report in the Data Bank(s). It should be submitted as soon as possible after a reporting error or omission is discovered. Corrections may be submitted as often as necessary.
A	<b>Notice of Appeal:</b> A report notifying the HIPDB that a subject has formally appealed a previously reported adverse action. Reporting entities must submit a Notice of Appeal whenever a previously reported adverse action is on appeal. A Notice of Appeal is separate and distinct from a subject's dispute of a Data Bank report. There is no legal requirement for this type of report to be submitted to the NPDB.

**Table 4-11: Occupation/Field of Licensure Codes – Retired**

<b>Occupation/Field of Licensure Codes – Retired</b>	
135	Advanced Practice Nurse
370	Psychologist, Clinical
<b>Note(s):</b> Retired Codes are not available for submitting on new reports but may appear on Notice of Appeal responses.	

**Table 4-12: Adverse Action Classification Codes – Retired**

<b>Adverse Action Classification Codes – Retired</b>	
1172	Administrative Fine/Monetary Penalty
1636	Voluntary Acceptance of Restrictions on Privileges
1699	Reversal of Previous Action Due to Appeal or Review
1799	Reversal of Previous Action Due to Appeal or Review
<b>Note(s):</b> Retired Codes are not available for submitting on new reports but may appear on Notice of Appeal responses.	

**Table 4-13: Basis for Action Codes – Retired**

<b>Basis for Action Codes – Retired</b>	
01	Alcohol and/or Other Substance Abuse
03	Narcotics Violations
06	Insurance Fraud – Medicare or Other Federal Government Program
07	Insurance Fraud – Medicaid or Other State Government Program
08	Insurance Fraud – Non-Government or Private Insurance
09	Fraud in Obtaining License or Credentials
20	Mental Disorder
22	Advertising or Marketing Services or Products That Are Discriminatory, Misleading, False, or Deceptive
30	Allowing Unlicensed Person to Practice
74	Violation of Federal or State Antitrust Statute
75	Violation of Drug-Free Workplace Act
76	Violation of Immigration and Nationality Act Employment Provisions
77	Violation of Americans With Disabilities Act or Applicable Federal and State Laws
78	Violation of Civil Rights Act or Applicable Federal and State Laws
80	Physical Impairment
83	Hospital Privileges Restricted, Suspended or Revoked
AD	Surrendered Clinical Privileges for Clinical Privilege Reports
<b>Note(s):</b> Retired Codes are not available for submitting on new reports but may appear on Notice of Appeal responses.	

**Table 4-14: Error Codes**

<b>Error Code</b>	<b>Description</b>
01	Format of information in subject record(s) was in error.
02	Virus found.
03	File is not compliant with the current format version.
04	Check sum failed.
05	SQL error.
06	Invalid transaction code entered.
07	Invalid Data Bank ID.
08	Invalid password.
09	This entity does not have the privilege to perform this transaction.
11	Entity registration has expired.
12	Agent registration has expired.
13	This agent does not have the authority to act for entity.
14	All or part of agent information is missing or illegible.
15	Entity name or Data Bank ID is missing or illegible.
16	All or part of the entity address is missing or invalid.
18	Invalid entity type code.
19	Invalid governmental designation code.
20	All or part of a subject's name is missing or invalid. Subject First Name and Last Name are required.
21	All or part of the subject's address is missing or illegible.
22	Invalid subject type.
23	Incomplete subject Occupation/Field of Licensure information. For each license number you provide, you must also provide a valid, two-letter abbreviation for the U.S. State from where the license was issued, and a valid, three-digit Occupation/Field of Licensure code.
24	Invalid Occupation/Field of Licensure code.
25	All or part of school information is missing or illegible: professional school information must include both the name of the professional health care school attended and the year the subject graduated. If the subject did not graduate, provide the last year he or she attended the school-this will be presented on the response as the subject year of graduation.
26	Invalid Drug Enforcement Administration number.
27	Invalid Social Security Number.
28	Missing, invalid, or illegible date of birth. Date of birth must be at least 15 years before today's date and after 1900.
29	Invalid gender code.
30	Adverse Action Report data is missing or illegible: required information is missing in section C of the Adverse Action Report you submitted. Each of the fields in this section must be completed legibly. Please submit a new, fully completed adverse action report to the Data Bank(s). Do not reference Data Bank Control Number of this rejection notice on your new report. If this rejected report was an initial report, you must submit a new initial report; if a correction or void was rejected, you must resubmit your correction or void as if this rejected report was never submitted to the Data Bank(s).
31	Invalid Adverse Action Classification code.
32	Invalid Adverse Action type code: the type of Adverse Action taken (licensure, clinical privileges, or professional society membership) was not indicated in field 3 of your Adverse Action Report form, or more than one type was marked. Please submit a new, fully completed Adverse Action Report to the Data Bank(s), indicating the type of adverse action your organization is reporting. Do not reference the document control number of this rejection notice on your new report. If this rejected report was an initial report, you must submit a new initial report; if a correction or void was rejected, you must resubmit your correction or void as if this rejected report was never submitted to the Data Bank(s).
33	Invalid Omission code.

Error Code	Description
34	Medical Malpractice Payment Report data is missing or illegible: required information is missing or illegible in section C of the Medical Malpractice Payment Report you submitted. Each of the unshaded fields in this section must be completed legibly. Please submit a new, fully completed Medical Malpractice Payment Report to the Data Bank(s). Do not reference the Data Bank Control Number of this rejection notice on your new report. If this rejected report was an initial report, you must submit a new initial report; if a correction or void was rejected, you must resubmit your correction or void as if this rejected report was never submitted to the Data Bank(s).
35	Invalid Hospital data. A valid Name, City, and State is required for each hospital provided.
36	Missing or invalid relation of entity to subject.
37	Invalid payment type.
38	Invalid payment result.
39	All or part of certification is missing: you must provide your printed name, your title (except for individual subject self-queries), your daytime telephone number, your signature, and the date you signed the form. Please submit a new, fully completed form to the Data Bank(s).
40	All or part of notarization is missing: to be legal and valid, a notarized form must include the notary public's signature; the date that the practitioner appeared before the notary; the date the notary's commission expires; and the notary's stamp, seal, or notary number. Please submit a new, fully completed and notarized form to the Data Bank(s).
41	Missing or invalid credit card information. The Data Banks accept VISA, MasterCard, Discover or American Express. The Data Banks do not accept cash, checks or money orders.
42	Your registered entity does not have a valid EFT account on file.
43	Expired credit card: please contact your credit card company for further information.
44	Rejected credit card: the bank that issued your credit card has denied these charges. No further information was made available to the Data Bank(s) regarding the reason for this rejection. Please contact your credit card company for further information.
45	Duplicate report.
46	Data Bank Control Number of report to be voided or corrected is missing or invalid.
47	Query data is missing.
48	Invalid Query Purpose code.
49	Time to dispute a report has expired.
50	Valid Data Bank Control Number of report to be corrected or voided was not provided.
51	Cannot dispute a changed/voided report.
52	Attempted to correct or void a report that has been previously voided or replaced by a corrected version.
53	Report is already in dispute.
54	Report is already in Secretarial Review.
55	Report is not in dispute: cannot withdraw dispute.
56	Report is not in Secretarial Review: cannot withdraw dispute.
57	Control character (non-alphanumeric) found in file.
58	Possible data entry error found.
59	Credit card bill authorization error.
60	File is not in the appropriate format. Check to ensure that the file is not zipped or in binary format (e.g., MS Word or Corel WordPerfect) prior to resubmission.
61	Query file with this name has already been processed.
62	Cannot access drive.
63	Damaged diskette.
64	Bad sector(s) on disk.
65	Warning detection error.
66	No files found on disk.
67	I/O error.
68	Missing, invalid, or illegible date of omission. Date of omission must not be later than today's date and not earlier than 1900.
69	Graduation year is inconsistent with year of birth: the subject's date of birth and year of graduation must be at least 15 years apart.
70	Length of action is missing or contains more than two digits.
71	Invalid Agent Identification Number.
72	Entity does not have active status.

<b>Error Code</b>	<b>Description</b>
73	Agent does not have active status.
74	Possible @ sign in data.
75	Invalid entity phone number.
76	Invalid entity phone extension.
77	Invalid certification phone number.
78	Invalid certification phone extension.
79	Invalid subject deceased flag.
80	Invalid subject identification number.
81	Invalid subject address.
82	Invalid payment on Medical Malpractice Payment Report.
83	Invalid Medical Malpractice Payment Report data.
84	Invalid report category code.
85	Credit card authorization unavailable: the NPDB-HIPDB experienced communications problems with our credit card authorization service when we attempted to bill your account for the enclosed query. As a result, the charges were not fully authorized and we are unable to process the query. Your credit card account may show a temporary hold for these charges that will expire within 10 days of the process date shown above. If, for any reason, you are billed for the enclosed query file, please contact the NPDB-HIPDB Customer Service Center immediately at 1-800-767-6732. Please create a new query file for the subject names you need to have processed and transmit it to the Data Bank(s). We regret any inconvenience that this may cause.
86	Unknown record tag was found in input file. Valid tags are PRCT, DEA, FQSL, and GRAD.
87	Unable to read certification data record.
88	Unable to read query data record.
89	Unable to read password data record.
90	Missing last name from name record. Must enter both Last Name and First Name.
91	Missing first name from name record. Must enter both Last Name and First Name.
92	Missing password.
94	Invalid date of judgment or sentence. The date must be a valid date and must not occur in the future.
95	Invalid Taxpayer Identification Number.
96	Self-queries are no longer supported in this version of QPRAC. Upgrade to QPRAC 4.01 or higher.
97	The NPDB-HIPDB no longer accepts payment by check or money order. Entities who wish to query the NPDB-HIPDB must either include valid credit card information in their query files or pre-authorize payment through Electronic Funds Transfer (EFT).
98	As of October 1, 1998, the NPDB no longer accepts 5-1/4" diskettes.
99	Billing problem - transaction on hold.
A0	The date the action became effective cannot be before the date action was taken.
A1	Invalid type of adverse action.
A2	The Name of Agency or Program That Took the Adverse Action is missing or invalid.
A3	Invalid or duplicate Adverse Action Classification code.
A4	Invalid entry for total amount of monetary penalty, assessment, restitution and/or fine.
A5	Invalid entry for date of action, date of finding, or date action became effective.
A6	Invalid length of action.
A7	Invalid entry in automatic reinstatement field.
A8	Missing narrative description.
A9	Invalid entries in the publicly available or professional competence or conduct field.
AA	Invalid combination of Adverse Action Classification codes. State Licensure actions taken against physicians, dentists, or medical or dental residents may not contain multiple codes when one of the following codes is reported: 1138, 1139, 1149, or 1189. Federal Licensure actions taken by the DEA against health care practitioners may not contain multiple codes when one of the following codes is reported: 1149, 1173, or 1189. Exclusion/Debarment actions taken by the HHS Office of Inspector General may not contain multiple codes when one of the following codes is reported: 1508, 1509, 3508, or 3509. Additional actions should be submitted in separate reports.
AB	Duplicate Type of Negative Finding code.
AC	Length of action information should not be included in the report for the selected Adverse Action Classification codes.
AD	Name of Agency or Program that took the Adverse Action is not allowed for this report type.

<b>Error Code</b>	<b>Description</b>
AE	The QRXS does not accept transactions related to Adverse Action Reports in legacy format.
AF	This agent does not have authority to perform this action for this entity.
AG	Invalid date of action or date of finding. For a Revision to Action report, the date of action or date of finding must be the same as or later than the date of action or date of finding on the initial report.
AH	Invalid combination of Adverse Action Classification codes. State Licensure actions taken against registered nurses or licensed practical or vocational nurses may not contain multiple codes when one of the following codes is reported: 1338 or 1339. Additional actions should be submitted in separate reports.
AI	Status codes in Licensure Actions and Nurse Multi-State Licensure Privilege Actions cannot be selected together.
AJ	At most five adverse action codes are allowable.
AK	At least one Adverse Action Code must be selected.
AL	Classification Code with Other Description is selected but not specified or Other Description field filled in but Other not selected for the Classification Code.
AM	Invalid combination of Adverse Action Classification codes. State Licensure actions taken against organizations may not contain multiple codes when code 3238 is reported. Additional actions should be submitted in separate reports.
B1	Incomplete individual subject Occupation/Field of Licensure.
B2	Incomplete or invalid subject Occupation/Field of Licensure information. For each License provided, a valid, two-letter abbreviation for the U.S. State from where the license was issued and a valid, three-digit Occupation/Field of Licensure code must be provided. License Numbers must contain at least one digit. If the subject does not have a license, specify No License and do not provide a License Number. An Occupation/Field of Licensure Description is required if the Occupation/Field of Licensure code is "Other", and not allowed otherwise.
B3	The specialty code selected is either invalid or incompatible with the occupation/field of licensure code selected. Physician specialty codes should only be used for physicians (occupation/field of licensure codes 010, 015, 020 and 025). Dental specialty codes should only be used for dentists (occupation/field of licensure codes 030 and 035).
B4	Invalid organization subject license number.
B5	Incomplete or invalid subject Occupation/Field of Licensure information. For each License provided, a valid, two-letter abbreviation for the U.S. State from where the license was issued must be provided. License numbers must contain at least one digit. If the subject does not have a license, specify No License and do not provide a License Number.
B6	Invalid organization subject license number State field.
B7	Incomplete short organization subject data record.
B8	Act or Omission code missing or invalid.
B9	Missing Judgment or Conviction Report information.
BA	Specialty code is a required field for this occupation/field of licensure selection.
BB	The specialty code must not be specified for Clinical Privilege or Professional Society actions.
C0	Incomplete or invalid Organization Name or Type information. For each organization, you must provide a valid Organization Name and Organization Type. An Other Description is required if the Organization Type is 999, and not allowed otherwise.
C1	Missing or invalid sentence/judgment information.
C3	Invalid Judgment or Conviction Report type record.
C4	Invalid Food and Drug Administration number(s).
C5	Invalid National Provider Identifier(s).
C6	Invalid Federal Employer Identification Number(s).
C7	Invalid affiliation data. For each provided affiliate, a valid name is required. If an affiliate address is provided, the city and state (or city and country) are required. An Other Description is required if the Nature of Relationship code is 999, and not allowed otherwise.
C8	Invalid appeal information. Specify if the report is on appeal, and only provide an appeal date if the report is on appeal.
C9	Incomplete information for statutory offenses and counts.
CC	orgDefn not allowed for this report type.
CD	CCB not allowed for this report type.
CE	At least one SSN or FEIN must be provided for Organization Subject.
CF	Negative Finding Date not allowed for this report type.

Error Code	Description
CG	Invalid date of judgment or sentence. For a Revision to Action report, the date of judgment or sentence must be the same as or later than the date of judgment or sentence on the initial report.
D0	Invalid deceased date.
D1	Invalid deceased flag.
D2	Invalid health care entity definition entry.
D3	Invalid type of organization.
D4	Missing organization name.
D5	Missing or invalid Basis for Action code.
D6	Report is not valid under any NPDB-HIPDB statutory authority.
D7	This type of report does not accept notices of appeal.
D8	You do not have the statutory authority to submit a notice of appeal for this report.
D9	Professional school and year of graduation should not be present for non-practitioners.
DA	Missing or invalid basis for action description.
DF	Data cleanup for the disk credit card rejects.
E0	Missing basis code.
E1	No basis code should be present for revision to actions.
E4	Publicly available field should not be filled in.
E5	Missing competence or conduct basis entry.
E6	Competence or conduct entry not applicable to your report.
E7	You selected a statutory function/service in section C that is incompatible with your selection under at least one other statutory authority. Please review once more the statutory information regarding the eligibility requirements for Title IV, Section 1921, and Section 1128E; then complete and submit a new Entity Registration form.
E8	Entities that indicate that they are a Federal Government agency in field 8 of the Entity Registration form must also indicate the appropriate Federal department or agency. The receipt of financial support or reimbursement from a Federal Government agency for providing health care services does not qualify an entity as a Federal Government agency. Entities that are not Federal Government agencies may not select a federal department or agency in field 8 of the Entity Registration form.
F1	The NPDB-HIPDB no longer accepts reports submitted via QPRAC or paper forms. All reports submitted to the NPDB-HIPDB must be submitted through the Integrated Querying and Reporting Service found on the World Wide Web at <a href="http://www.npdb-hipdb.hrsa.gov">www.npdb-hipdb.hrsa.gov</a> .
F2	The NPDB-HIPDB no longer accepts Adverse Action Reports submitted via disk. All Adverse Action Reports submitted to the NPDB-HIPDB must be submitted through the Integrated Querying and Reporting Service found on the World Wide Web at <a href="http://www.npdb-hipdb.hrsa.gov">www.npdb-hipdb.hrsa.gov</a> .
F3	The NPDB-HIPDB no longer accepts any transactions submitted via QPRAC. All transactions submitted to the NPDB-HIPDB must be submitted through the Integrated Querying and Reporting Service found on the World Wide Web at <a href="http://www.npdb-hipdb.hrsa.gov">www.npdb-hipdb.hrsa.gov</a> .
F4	A correction transaction attempted to correct a revision to action report.
F5	A revision to action transaction attempted to modify certain fields that must contain the same information as the report being revised: 'Type of Action', 'Occupation/Field of Licensure' if you are filing a report on an individual subject, as well as 'Competence/Conduct Basis' if you are filing a State licensure report on an individual subject, or 'Health Care Entity Definition' if you are filing a State licensure report on an organizational subject.
F6	The previous DCN did not match a report in the Data Bank.
F7	A transaction type was not found for the specified report.
F8	The previous DCN is not applicable for this type of report.
F9	A correction of revision to action transaction attempted to correct a non-revision to action report.
G1	Set A and set B mandatory fields not complete for individual query.
G2	Set A and set B mandatory fields not complete for organization query.
G3	Missing/invalid notary date
G4	Missing/invalid notary seal, stamp, or certificate.
G5	Missing/invalid notary signature.
G6	Missing/invalid subject appearance date.
G7	Missing/invalid subject signature.
G8	Invalid number of subjects in query
G9	Invalid batch query. Individual and organization subjects may not be queried on in the same query batch.

<b>Error Code</b>	<b>Description</b>
H1	Missing Social Security Number for self-query transaction.
I1	Invalid Individual Taxpayer Identification Number(s).
I2	At least one ITIN or SSN must be provided for Individual Subject.
I3	At least one ITIN, SSN or FEIN must be provided for Organization Subject.
I4	Invalid Unique Physician Identification Number(s).
I5	Invalid Principal Officers and Owners Information.
I6	Invalid Medicare Provider/Supplier Number(s).
I7	Invalid Clinical Laboratory Improvement Act Number(s).
I8	Invalid Entity Internal Report Reference.
I9	Invalid report type.
IN	ITIN not allowed for this report type.
J1	Credit Card Issuer Unavailable: The Data Banks experienced communication problems in contacting your financial institution when we attempted to bill your account for the enclosed query. Since your financial institution was not contacted, your account should not have been charged for this query. If, for any reason, you are billed for the enclosed file, please contact the NPDB-HIPDB Customer Service Center immediately at 1-800-767-6732. Please create a new query file for the subject name(s) in the enclosed query file and transmit it to the Data Bank(s). Should you add additional subject names to your new query, your new charges will be higher than your original charge because fees are levied on a per-name basis. We regret any inconvenience that this may cause.
J2	Missing or invalid credit card information, the card holder name is missing or not valid.
J3	Missing or invalid credit card information, the credit card number is not a valid credit card number.
J4	Missing or invalid credit card information, the credit card expiration date is not valid.
J5	All or part of the credit card billing address is missing or invalid.
K1	Professional School information is not allowed in judgment or conviction reports.
K2	An Act or Omission Description is required if the Act or Omission Code is 999, and not allowed otherwise.
K3	Invalid Case Number.
K4	Invalid Type of Action.
K5	Missing or invalid Docket/Court File Number.
K6	Missing or invalid Jurisdiction.
K7	Missing or invalid Narrative description of act(s) or omission(s).
K8	Missing or invalid Prosecuting Agency or Civil Plaintiff.
K9	Missing or invalid Venue information. Venue name, city and state are all required.
KA	Invalid Investigating Agency Name.
KB	Invalid Investigating Agency Case Number.
KC	Invalid Other Organization Name.
KD	Hospital Affiliates are only valid for medical malpractice payment reports. Report this data in an Affiliate record instead.
KE	Type of Action on this correction or revision report must match the Type of Action of the previous report.
KF	CLIA not allowed in organization judgment or conviction reports.
KG	FDA not allowed in organization judgment or conviction reports.
M0	Specific allegation or date of event is missing or invalid, or description for an unclassified specific allegation is missing.
M1	Missing or invalid Payment date. The date must be a valid date, must not be in the future, and must occur after the date(s) of event(s) associated with the allegation(s) or incident(s).
M2	Description of judgment or settlement is missing or invalid.
M3	Number of practitioners for whom this payer has paid or will pay in this case must be a value between 1 and 999 inclusive.
M4	State fund payment flag or amount is invalid.
M5	Self-insured payment flag or amount is invalid.
M6	Patient age, gender or type is missing or invalid.
M7	Description of the medical condition with which the patient presented for treatment is missing or invalid.
M8	Description of the procedure performed is missing or invalid.
M9	Nature of allegation code is missing or invalid.
MA	Outcome is missing or invalid.

<b>Error Code</b>	<b>Description</b>
MB	Description of allegations and injuries or illnesses is missing or invalid.
MC	Total amount paid or to be paid by this payer for this practitioner must be greater than or equal to the amount of this payment by this payer for this practitioner.
MD	Total amount paid or to be paid by this payer for all practitioners must be greater than or equal to total amount paid or to be paid by this payer for this practitioner.
ME	The NPDB no longer accepts initial Medical Malpractice Payment Reports in legacy format.
MF	State fund payment flag and/or amount is invalid. Your entity's relationship to this practitioner (as specified in this submission) does not allow the completion of the state fund payment fields.
MG	Self-insured payment flag or amount is invalid. Your entity's relationship to this practitioner (as specified in this submission) does not allow the completion of the self-insured organization and/or other insurance company payment fields.
MH	Judgment or Settlement Date is invalid.
MJ	Invalid Adjudicative Body Case Number.
MK	Invalid Adjudicative Body Name.
ML	Invalid Court File Number.
MM	Missing or invalid Amount of This Payment for This Practitioner.
MN	Missing or invalid Total Amount Paid or to Be Paid by This Payer for This Practitioner.
MO	Total amount paid or to be paid by this payer for this practitioner must be greater than or equal to the state fund payment amount.
MP	Missing or invalid Total Amount Paid or to Be Paid by This Payer for All Practitioners.
MQ	Total amount paid or to be paid by this payer for this practitioner must be greater than or equal to the self-insured payment amount.
MR	ITIN not allowed in medical malpractice payment reports.
MS	Licensure Specialty not allowed in medical malpractice payment reports.
MT	Organization Type not allowed in medical malpractice payment reports.
MU	NPI not allowed in medical malpractice payment reports.
MV	FEIN not allowed in medical malpractice payment reports.
MW	UPIN not allowed in medical malpractice payment reports.
MX	Only information regarding hospital affiliations may be reported for medical malpractice payment reports.
P1	Missing or invalid customer subject ID number.
P2	Too many data elements have been changed in this enrollment update which may change the identity of the subject and cause erroneous matching results.
P3	Missing or invalid enrollment purpose code.
P4	Missing or invalid cancellation purpose code.
P5	A cancellation purpose description must be provided if the cancellation purpose is "Other" and is not allowed otherwise.
P6	Purpose code only allowed for enrollment and cancellation transactions.
P7	Invalid number of subjects: Number of subjects does not match the number of subjects in the file.
P8	Data Bank subject ID number is not allowed for enrollment transactions.
P9	Data Bank subject ID number does not correspond to the same enrolled subject as the customer subject ID number.
PA	Data Bank subject ID number does not correspond to an active enrolled subject.
PB	Data Bank subject ID number or customer subject ID number must be provided.
PC	Customer subject ID number does not correspond to an active enrolled subject.
PD	Subject is currently being enrolled or updated. Retry your PDS update after receiving output from the enrollment or most recent update.
PE	Enrolled subject can only be renewed within two months before or one month after its renewal date.
PF	The entity on whose behalf you are submitting this transaction has not enabled use of the PDS.
PG	Missing or invalid Data Bank subject ID number.
PH	Only one PDS update, cancellation or status request is allowed per submission file.
PI	A maximum of 999 subjects may be submitted in a batch transaction.
PJ	This PDS renewal batch contains enrolled subjects with different expiration dates.
Q1	Missing or invalid basis for finding.
Q4	Action taken date not allowed for this report type.
Q5	Action effective date not allowed for this report type.

Error Code	Description
Q6	Action length indefinite not allowed for this report type.
Q7	Action length permanent not allowed for this report type.
Q8	Action length not allowed for this report type.
Q9	Automatic reinstatement not allowed for this report type.
QA	Amount not allowed for this report type.
QB	Missing or invalid Type of Negative Finding code.
QC	Missing or invalid negative finding description.
QD	Missing or invalid negative finding date.
QE	Missing or invalid basis for finding description.
QF	Missing or invalid description of finding.
R1	All or part of certification information is missing.
R2	Invalid affiliate address.
R4	Invalid Organization Name.
R6	Invalid Customer Use data.
R9	You do not have the correct statutory authority to submit this report.
RB	Due to the publication of final regulations implementing Section 1921 of the Social Security Act, the DBID for your organization must be renewed before the submission file can be processed by the Data Banks. The certifying official for your organization must review the new Section 1921 regulations, available at <a href="http://www.npdb-hipdb.hrsa.gov/legislation.html">http://www.npdb-hipdb.hrsa.gov/legislation.html</a> , as part of the renewal process. Once the regulations have been reviewed, complete the on-line registration renewal form by logging in to the IQRS and selecting Renew Registration on the registration confirmation screen. The completed form must be signed and mailed to the NPDB-HIPDB for processing. If your organization has already mailed your registration renewal to the Data Banks, it will be processed within one business day of its receipt by the NPDB-HIPDB. You will receive Data Bank Correspondence once the Data Banks have successfully processed your registration renewal form. If necessary, you may complete a new form by selecting Renew Registration on the registration confirmation screen within the IQRS. If you need further assistance, please contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732.
RC	Due to the publication of final regulations implementing Section 1921 of the Social Security Act, the DBID for your organization must be renewed before the submission file can be processed by the Data Banks. The certifying official for your organization must review the new Section 1921 regulations, available at <a href="http://www.npdb-hipdb.hrsa.gov/legislation.html">http://www.npdb-hipdb.hrsa.gov/legislation.html</a> , as part of the renewal process. Contact the administrator of your organization so they can renew the registration. If you need further assistance, please contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732.
RD	Due to the publication of final regulations implementing Section 1921 of the Social Security Act, the DBID for the entity on whose behalf you are submitting the file must be renewed before the submission file can be processed by the Data Banks. As part of the renewal process, the certifying official of the entity on whose behalf you are submitting the file must review the new Section 1921 regulations, available at <a href="http://www.npdb-hipdb.hrsa.gov/legislation.html">http://www.npdb-hipdb.hrsa.gov/legislation.html</a> . Once the certifying official has reviewed these regulations, the entity administrator can complete the on-line registration renewal form by logging in to the IQRS and selecting Renew Registration on the registration confirmation screen. If you need further assistance, please contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732.
RE	The DBID for your organization must be renewed before you can access the Data Banks services. The NPDB-HIPDB requires all registered entities to periodically renew their registration information. Re-registration enables the NPDB-HIPDB to maintain accurate entity contact information and provides the entity with the opportunity to review the legal requirements and verify their compliance for participation with NPDB-HIPDB. The certifying official for your organization must review the NPDB-HIPDB regulations, available at <a href="http://www.npdb-hipdb.hrsa.gov/legislation.html">http://www.npdb-hipdb.hrsa.gov/legislation.html</a> , as part of the renewal process. Once the regulations have been reviewed, complete the on-line registration renewal form by logging in to the IQRS and selecting Renew Registration on the registration confirmation screen. The completed form must be signed and mailed to the NPDB-HIPDB for processing. If your organization has already mailed the registration renewal to the Data Banks, it will be processed within one business day of its receipt by the NPDB-HIPDB. Data Bank Correspondence will be sent once the Data Banks have successfully processed your registration renewal form. If necessary, you may complete a new form by selecting Renew Registration below. If you need further assistance, please contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732.

Error Code	Description
RF	The DBID for your organization must be renewed before you can access the Data Banks services. The NPDB-HIPDB requires all registered entities to periodically renew their registration information. Re-registration enables the NPDB-HIPDB to maintain accurate entity contact information and provides the entity with the opportunity to review the legal requirements and verify their compliance for participation with NPDB-HIPDB. The certifying official for your organization must review the NPDB-HIPDB regulations, available at <a href="http://www.npdb-hipdb.hrsa.gov/legislation.html">http://www.npdb-hipdb.hrsa.gov/legislation.html</a> , as part of the renewal process. Contact the administrator of your organization so they can renew the registration. If you need further assistance, please contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732.
RG	The DBID for the entity on whose behalf you are submitting the file must be renewed before the submission file can be processed by the Data Banks. The NPDB-HIPDB requires all registered entities to periodically renew their registration information. Re-registration enables the NPDB-HIPDB to maintain accurate entity contact information and provides the entity with the opportunity to review the legal requirements and verify their compliance for participation with NPDB-HIPDB. As part of the renewal process, the certifying official of the entity on whose behalf you are submitting the file must review the NPDB-HIPDB regulations, available at <a href="http://www.npdb-hipdb.hrsa.gov/legislation.html">http://www.npdb-hipdb.hrsa.gov/legislation.html</a> . Once the certifying official has reviewed these regulations, the entity administrator can complete the on-line registration renewal form by logging in to the IQRS and selecting Renew Registration on the registration confirmation screen. If you need further assistance, please contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732.
RH	File is not compliant with the current format version of the latest Interface Control Document (ICD). Please review the appropriate ICD specification for the type of transaction you wish to submit and update your ICD transaction files.
RI	The administrator account can not be used to submit report or query transactions. These transactions must be submitted using a user account.
RJ	The administrator account can not be used to submit query, report, or PDS transactions. These transactions must be submitted using a user account.
S0	The new password was based on a commonly used keyboard sequence. Passwords may not be a simplistic or systematic sequence (e.g., abcd1234).
S1	The new password must be different from the old password.
S2	The new password must be between 8 and 14 characters long.
S3	The new password contains only alphabetic characters.
S4	The new password contains only numeric characters.
S5	The new password contains an illegal character.
S6	The new password was similar to your account user ID.
S7	The new password was similar to your account user ID with the characters reversed.
S8	The new password was the same as one you used previously. Passwords may not be the same as any of the last four passwords.
S9	The new password did not contain enough different characters.
SA	The new password was similar to a word in the dictionary.
SB	The new password was similar to a word in the dictionary with the characters reversed.
SC	Missing or invalid user account in the password change or reset request.
SD	Only the administrator may reset a user's account password.
SE	You may not change another user's account password.
SF	The administrator password cannot be reset. A password change request may be submitted instead.
SG	The new password must be provided in the password change request.
SH	The password must be omitted in the password reset request. The Data Banks will generate a new password.
SI	The DBID specified in the initialization file for the ITP client program did not match the agent or entity DBID contained in the submitted ICD file.
SJ	Reserved for future use.
SK	No more than one password change transaction can submitted at any time.
SL	Your password must be changed before other transactions can be submitted.

**Table 4-15: Disclosure Type Codes**

Code	Description
IR	The reporting entity identified in this disclosure has submitted Initial Report {1}.
RR	The reporting entity identified in this disclosure has submitted Revision to Action Report {1}.
CR	The reporting entity identified in this disclosure has submitted correction(s) to report {1}.
CA	The reporting entity identified in this disclosure has submitted correction(s) to report {1}.
DA	The subject of report {1} has filed a dispute with the Data Bank(s) concerning information contained in the report. The reporting entity identified in this disclosure and the subject of the report are responsible for settling the dispute.
DW	The subject of report {1} has withdrawn the dispute originally associated with this report.
SA	The subject of report {1} has added a statement to the report to explain or comment on the action reported.
SW	The subject of report {1} has withdrawn the statement previously associated with this report.
NA	The reporting entity identified in this disclosure has indicated that the action described in report {1} is being appealed.
RE	The subject of report {1} has requested that this dispute be reviewed by the Secretary of the U.S. Department of Health and Human Services.
RW	The subject of report {1} has withdrawn the request for review of this dispute by the Secretary of the U.S. Department of Health and Human Services.
RD	The Secretary of the U.S. Department of Health and Human Services has reviewed the facts of the dispute and has made a determination regarding report {1}.
VR	Report {1} and all information in it have been expunged from the Data Bank(s) and should not be used. Please destroy all copies of this report.
OC	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) corrected report {1}. The following data fields have been modified: {2}.
OA	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) corrected report {1}. The following data fields have been modified: {2}.
RC	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) corrected report {1} as directed by the Secretary of the U.S. Department of Health and Human Services. For further information, see the Secretary's comments included in this disclosure.
RA	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) corrected report {1} as directed by the Secretary of the U.S. Department of Health and Human Services. For further information, see the Secretary's comments included in this disclosure.
OV	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) voided report {1} because it was determined to be a duplicate report. Please destroy all copies of report {1}. The original report remains in the Data Bank(s).
RV	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) voided report {1} as directed by the Secretary of the U.S. Department of Health and Human Services. The referenced report and all information in it have been expunged from the Data Bank(s) and should not be used. Please destroy all copies of this report.
BI	Correction Report {1} should have been submitted as a Revision to Action since it modifies a previously reported action. To correct this, the Data Bank(s), on behalf of the reporting entity identified in this disclosure, have resubmitted the original or previous Initial Report as {2}. Additionally, the Correction Report {1} has been voided and resubmitted as Revision to Action {3}. Please destroy all copies of report {1}.
BV	Correction Report {1} should have been submitted as a Revision to Action since it modifies a previously reported action. To correct this, the Data Bank(s), on behalf of the reporting entity identified in this disclosure, have resubmitted the original or previous Initial Report as {2}. Additionally, the Correction Report {1} has been voided and resubmitted as Revision to Action {3}. Please destroy all copies of report {1}.
BR	Correction Report {1} should have been submitted as a Revision to Action since it modifies a previously reported action. To correct this, the Data Bank(s), on behalf of the reporting entity identified in this disclosure, have resubmitted the original or previous Initial Report as {2}. Additionally, the Correction Report {1} has been voided and resubmitted as Revision to Action {3}. Please destroy all copies of report {1}.

Code	Description
AV	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) converted report {1} to Revision to Action Report {2}. This action should have been reported as a Revision to Action since it modifies the previously reported action {3}. Please destroy all copies of report {1}.
AR	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) converted report {1} to Revision to Action Report {2}. This action should have been reported as a Revision to Action since it modifies the previously reported action {3}. Please destroy all copies of report {1}.
<b>Note(s):</b> The descriptions listed herein contain placeholder references ({1}, {2}, and {3}) and each will be replaced with an actual report DCN when a notification is generated by the Data Bank(s).	

**Table 4-16: Subject Source Codes**

Code	Description
Q	You received the previous version of this report via a query.
R	Your entity submitted the previous version of this report.
P	You received the previous version of this report via a PDS enrollment that has since been canceled.

**Table 4-17: Entity Status Codes**

Code	Type	Description
A	Original Reporting Entity is Active	The entity that filed the report may have changed its name or address on file with the Data Banks. The most recent entity contact information reported to the Data Banks and the date on which it was reported is provided.
S	Original Reporting Entity is Inactive but has a Successor	The entity that filed the report is no longer an active registrant with the Data Banks. The most recent information for the registered successor entity is provided.
D	Original Reporting Entity is Inactive with no Successor	The entity that filed the report is no longer an active registrant with the Data Banks. The most recent entity contact information reported to the Data Banks and the date on which it was reported is provided. The Data Banks have no additional information regarding this entity.
N	Original Reporting Entity is Inactive and its Successor is Inactive	The entity that filed the report is no longer an active registrant with the Data Banks. The most recent information for the registered successor entity is provided, but that entity is also no longer an active registrant with the Data Banks. The Data Banks have no additional information regarding this entity.

**Table 4-18: Adverse Action Classification Codes – Legacy AAR**

<p>1000 License Revoked                  10100 License Revoked: Alcohol and Other Substance Abuse                  10200 License Revoked: Incompetence/Malpractice/Negligence                  10300 License Revoked: Narcotics Violations                  10400 License Revoked: Felony                  10500 License Revoked: Fraud                  11000 License Revoked: Unprofessional Conduct                  12000 License Revoked: Mental Disorder                  13000 License Revoked: Allowing Unlicensed Person to Practice                  15000 License Revoked: Disciplinary Action in Another State                  18000 License Revoked: Other Reason - Not Classified</p> <p>20000 License Probation                  20100 License Probation: Alcohol and Other Substance Abuse                  20200 License Probation: Incompetence/Malpractice/Negligence                  20300 License Probation: Narcotics Violations                  20400 License Probation: Felony                  20500 License Probation: Fraud                  21000 License Probation: Unprofessional Conduct                  22000 License Probation: Mental Disorder                  23000 License Probation: Allowing Unlicensed Person to Practice                  25000 License Probation: Disciplinary Action in Another State                  28000 License Probation: Other Reason - Not Classified</p> <p>30000 License Suspended                  30100 License Suspended: Alcohol and Other Substance Abuse                  30200 License Suspended: Incompetence/Malpractice/Negligence                  30300 License Suspended: Narcotics Violations                  30400 License Suspended: Felony                  30500 License Suspended: Fraud                  31000 License Suspended: Unprofessional Conduct                  32000 License Suspended: Mental Disorder                  33000 License Suspended: Allowing Unlicensed Person to Practice                  35000 License Suspended: Disciplinary Action in Another State                  38000 License Suspended: Other Reason - Not Classified</p> <p>40000 License-Miscellaneous                  40100 License-Misc.: License Restored or Reinstated                  40200 License-Misc.: Reinstatement Denied                  40600 License-Misc.: Reprimand                  41000 License-Misc.: Other Misc. Action (Inc. Censure &amp; Surrender)                  41200 License-Misc.: License Denied (Renewal Only)</p> <p>60000 Code/Clinical Privileges</p> <p>61000 Clinic Privileges Revoked                  61001 Clinic Priv Revoked: Alcohol and Other Substance Abuse                  61002 Clinic Priv Revoked: Incompetence/Malpractice/Negligence                  61003 Clinic Priv Revoked: Narcotics Violations                  61004 Clinic Priv Revoked: Felony                  61005 Clinic Priv Revoked: Fraud                  61010 Clinic Priv Revoked: Unprofessional Conduct                  61020 Clinic Priv Revoked: Mental Disorder                  61030 Clinic Priv Revoked: Allowing Unlicensed Person to Practice                  61050 Clinic Priv Revoked: Disciplinary Action in Another State                  61080 Clinic Priv Revoked: Physical Impairment                  61090 Clinic Priv Revoked: Other</p> <p>63000 Clinic Privileges Suspended                  63001 Privs Suspended: Alcohol and Other Substance Abuse                  63002 Privs Suspended: Incompetence/Malpractice/Negligence                  63003 Privs Suspended: Narcotics Violations                  63004 Privs Suspended: Felony                  63005 Privs Suspended: Fraud                  63010 Privs Suspended: Unprofessional Conduct                  63020 Privs Suspended: Mental Disorder                  63030 Privs Suspended: Allowing Unlicensed Person to Practice                  63050 Privs Suspended: Disciplinary Action in Another State                  63080 Privs Suspended: Physical Impairment                  63090 Privs Suspended: Other</p>	<p>63500 Voluntary Surrender of Privileges                  63501 Vol Surr of Priv: Alcohol and Other Substance Abuse                  63502 Vol Surr of Priv: Incompetence/Malpractice/Negligence                  63503 Vol Surr of Priv: Narcotics Violations                  63504 Vol Surr of Priv: Felony                  63505 Vol Surr of Priv: Fraud                  63510 Vol Surr of Priv: Unprofessional Conduct                  63520 Vol Surr of Priv: Mental Disorder                  63530 Vol Surr of Priv: Allowing Unlicensed Person to Practice                  63550 Vol Surr of Priv: Disciplinary Action in Another State                  63580 Vol Surr of Priv: Physical Impairment                  63590 Vol Surr of Priv: Other</p> <p>64000 Clinical Privileges Reduced                  64001 Clinic Priv Reduced: Alcohol and Other Substance Abuse                  64002 Clinic Priv Reduced: Incompetence/Malpractice/Negligence                  64003 Clinic Priv Reduced: Narcotics Violations                  64005 Clinic Priv Reduced: Fraud                  64010 Clinic Priv Reduced: Unprofessional Conduct                  64020 Clinic Priv Reduced: Mental Disorder                  64030 Clinic Priv Reduced: Allowing Unlicensed Person to Practice                  64050 Clinic Priv Reduced: Disciplinary Action in Another State                  64080 Clinic Priv Reduced: Physical Impairment                  64090 Clinic Priv Reduced: Other</p> <p>64500 Other Clinical Privileges Restriction                  64501 Other Priv Restrict: Alcohol and Other Substance Abuse                  64502 Other Priv Restrict: Incompetence/Malpractice/Negligence                  64503 Other Priv Restrict: Narcotics Violations                  64504 Other Priv Restrict: Felony                  64505 Other Priv Restrict: Fraud                  64510 Other Priv Restrict: Unprofessional Conduct                  64520 Other Priv Restrict: Mental Disorder                  64530 Other Priv Restrict: Allowing Unlicensed Person to Practice                  64550 Other Priv Restrict: Disciplinary Action in Another State                  64580 Other Priv Restrict: Physical Impairment                  64590 Other Priv Restrict: Other (Inc. Probation Restricting Priv)</p> <p>65000 Clinical Privileges Denial                  65001 Denial-Privs: Alcohol and Other Substance Abuse                  65002 Denial-Privs: Incompetence/Malpractice/Negligence                  65003 Denial-Privs: Narcotics Violations                  65004 Denial-Privs: Felony                  65005 Denial-Privs: Fraud                  65010 Denial-Privs: Unprofessional Conduct                  65020 Denial-Privs: Mental Disorder                  65030 Denial-Privs: Allowing Unlicensed Person to Practice                  65050 Denial-Privs: Disciplinary Action Taken in Another State                  65080 Denial-Privs: Physical Impairment                  65090 Denial-Privs: Other</p> <p>68000 Revision-Privs: Reinstatement, Complete                  68100 Revision-Privs: Reinstatement, Conditional                  68900 Revision-Privs: Reinstatement Denied                  69000 Revision-Privs: Reduction of Previous Action                  69500 Revision-Privs: Extension of Previous Action                  69900 Revision-Privs: Reversal of Action Due to Appeal or Review</p> <p>71000 Professional Society Membership Revoked                  71001 Prof Society Revoked: Alcohol and Other Substance Abuse                  71002 Prof Society Revoked: Incompetence/Malpractice/Negligence                  71003 Prof Society Revoked: Narcotics Violations                  71004 Prof Society Revoked: Felony                  71005 Prof Society Revoked: Fraud                  71010 Prof Society Revoked: Unprofessional Conduct                  71020 Prof Society Revoked: Mental Disorder                  71030 Prof Society Revoked: Allowing Unlicensed Person to Practice                  71050 Prof Society Revoked: Disciplinary Action in Another State                  71080 Prof Society Revoked: Physical Impairment                  71090 Prof Society Revoked: Other</p>
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**Adverse Action Classification Codes - Legacy AAR (continued)**

<p>73000 Professional Society Membership Suspended                  73001 Prof Soc. Suspended: Alcohol and Other Substance Abuse                  73002 Prof Soc. Suspended: Incompetence/Malpractice/Negligence                  73003 Prof Soc. Suspended: Narcotics Violations                  73004 Prof Soc. Suspended: Felony                  73005 Prof Soc. Suspended: Fraud                  73010 Prof Soc. Suspended: Unprofessional Conduct                  73020 Prof Soc. Suspended: Mental Disorder                  73030 Prof Soc. Suspended: Allowing Unlicensed Person to Practice                  73050 Prof Soc. Suspended: Disciplinary Action in Another State                  73080 Prof Soc. Suspended: Physical Impairment                  73090 Prof Soc. Suspended: Other</p> <p>74500 Other Restrictions - Professional Society Membership                  74501 Prof Soc Other Rest: Alcohol and Other Substance Abuse                  74502 Prof Soc Other Rest: Incompetence/Malpractice/Negligence                  74503 Prof Soc Other Rest: Narcotics Violations                  74504 Prof Soc Other Rest: Felony                  74505 Prof Soc Other Rest: Fraud                  74510 Prof Soc Other Rest: Unprofessional Conduct                  74520 Prof Soc Other Rest: Mental Disorder                  74530 Prof Soc Other Rest: Allowing Unlicensed Person to Practice                  74550 Prof Soc Other Rest: Disciplinary Action in Another State                  74580 Prof Soc Other Rest: Physical Impairment                  74590 Prof Soc Other Rest: Other (Inc Probation Restricting Privs)</p>	<p>75000 Denial-Professional Society Membership                  75001 Denial-Prof Society: Alcohol and Other Substance Abuse                  75002 Denial-Prof Society: Incompetence/Malpractice/Negligence                  75003 Denial-Prof Society: Narcotics Violations                  75004 Denial-Prof Society: Felony                  75005 Denial-Prof Society: Fraud                  75010 Denial-Prof Society: Unprofessional Conduct                  75020 Denial-Prof Society: Mental Disorder                  75030 Denial-Prof Society: Allowing Unlicensed Person to Practice                  75050 Denial-Prof Society: Disciplinary Action in Another State                  75080 Denial-Prof Society: Physical Impairment                  75090 Denial-Prof Society: Other</p> <p>78000 Revision-Prof Society: Reinstatement, Complete                  78100 Revision-Prof Society: Reinstatement, Conditional                  78900 Revision-Prof Society: Reinstatement Denied                  79000 Revision-Prof Society: Reduction of Previous Action                  79500 Revision-Prof Society: Extension of Previous Action                  79900 Revision-Prof Society: Reversal of Previous Action</p>
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**Table 4-19: Query Purpose Codes**

Code	Query Purpose
P	Privileging or Employment
R	Professional Review
M	Mandatory Two-Year Review (For Use by Hospitals)
S	Licensing
F	Fraud and Abuse Investigation
G	Certification to Participate in a Government Program
I	Claims Processing

**Table 4-20: Nature of Allegation Codes**

001 Diagnosis Related	060 Treatment Related
010 Anesthesia Related	070 Monitoring Related
020 Surgery Related	080 Equipment/Product Related
030 Medication Related	090 Other Miscellaneous
040 IV & Blood Products Related	100 Behavioral Health Related
050 Obstetrics Related	

**Table 4-21: Specific Allegation Codes**

<b>Failure to Take Appropriate Action</b>	328 Wrong Medication Dispensed
100 Failure to Use Aseptic Technique	329 Wrong Medication Ordered
101 Failure to Diagnose	330 Wrong Body Part
102 Failure to Delay a Case When Indicated	331 Wrong Blood Type
103 Failure to Identify Fetal Distress	332 Wrong Equipment
104 Failure to Treat Fetal Distress	333 Wrong Patient
105 Failure to Medicate	334 Wrong Procedure or Treatment
106 Failure to Monitor	<b>Unnecessary/Contraindicated Procedure</b>
107 Failure to Order Appropriate Medication	400 Contraindicated Procedure
108 Failure to Order Appropriate Test	401 Surgical or Procedural Clearance Contraindicated
109 Failure to Perform Preoperative Evaluation	402 Unnecessary Procedure
110 Failure to Perform Procedure	403 Unnecessary Test
111 Failure to Perform Resuscitation	404 Unnecessary Treatment
112 Failure to Recognize a Complication	<b>Communication/Supervision</b>
113 Failure to Treat	500 Communication Problem Between Practitioners
<b>Delay In Performance</b>	501 Failure to Instruct or Communicate with Patient or Family
200 Delay in Diagnosis	502 Failure to Report on Patient Condition
201 Delay in Performance	503 Failure to Respond to Patient
202 Delay in Treatment	504 Failure to Supervise
203 Delay in Treatment of Identified Fetal Distress	505 Improper Supervision
<b>Error/Improper Performance</b>	<b>Continuity of Care/Care Management</b>
300 Administration of Blood or Fluids Problem	600 Failure/Delay in Admission to Hospital or Institution
301 Agent Use or Selection Error	601 Failure/Delay in Referral or Consultation
302 Complementary or Alternative Medication Problem	602 Premature Discharge from Institution
303 Equipment Utilization Problem	603 Altered, Misplaced or Prematurely Destroyed Records
304 Improper Choice of Delivery Method	<b>Behavior/Legal</b>
305 Improper Management	700 Abandonment
306 Improper Performance	701 Assault and Battery
307 Improperly Performed C-Section	702 Breach of Contract or Warranty
308 Improperly Performed Vaginal Delivery	703 Breach of Patient Confidentiality
309 Improperly Performed Resuscitation	704 Equipment Malfunction
310 Improperly Performed Test	705 Failure to Conform with Regulation, Statute, or Rule
311 Improper Technique	706 Failure to Ensure Patient Safety
312 Intubation Problem	707 Failure to Obtain Consent or Lack of Informed Consent
313 Laboratory Error	708 Failure to Protect a Third Party
314 Pathology Error	709 Failure to Test Equipment
315 Medication Administered via Wrong Route	710 False Imprisonment
316 Patient History, Exam, or Workup Problem	711 Improper Conduct
317 Problems With Patient Monitoring in Recovery	712 Inadequate Utilization Review
318 Patient Monitoring Problem	713 Negligent Credentialing
319 Patient Positioning Problem	714 Practitioner with Communicable Disease
320 Problem with Appliance, Prostheses, Orthotic, Restorative, Splint, Device, etc.	715 Product Liability
321 Radiology or Imaging Error	716 Religious Issues
322 Surgical or Other Foreign Body Retained	717 Sexual Misconduct
323 Wrong Diagnosis or Misdiagnosis	718 Third Party Claimant
324 Wrong Dosage Administered	719 Vicarious Liability
325 Wrong Dosage Dispensed	720 Wrongful Life/Birth
326 Wrong Dosage Ordered of Correct Medication	<b>899 Cannot Be Determined from Available Records</b>
327 Wrong Medication Administered	<b>999 Allegation – Not Otherwise Classified, Specify _____</b>

\* These codes were adapted from code lists developed by The Risk Management Foundation of the Harvard Medical Institutions and the Physician Insurers Association of America.

**Table 4-22: Outcome Codes**

Code	Description
01	Emotional injury only
02	Insignificant injury
03	Minor temporary injury
04	Major temporary injury
05	Minor permanent injury
06	Significant permanent injury
07	Major permanent injury
08	Grave Permanent Injury, such as quadriplegic or brain damage, requiring lifelong dependent care
09	Death
10	Cannot be determined from available records

**Table 4-23: JOCR Type of Action Codes**

Code	Type	Description
10	Criminal Conviction (Guilty Plea or Trial)	Federal or State criminal convictions against health care practitioners, providers and suppliers. Convictions must be related to the delivery of a health care item or service. Convictions include guilty pleas, and findings of guilt by either a judge or a jury. These actions are reportable to the Healthcare Integrity and Protection Data Bank under Section 1128E of the <i>Social Security Act</i> and 45 CFR Part 61.
20	Deferred Conviction/ Pre-Trial Diversion	Actions in which a health care practitioner, provider, or supplier has entered into participation in a first offender, or other program or arrangement where the Federal or State conviction has been deferred or held in abeyance. These actions must be related to the delivery of a health care item or service. These actions are reportable to the Healthcare Integrity and Protection Data Bank under Section 1128E of the <i>Social Security Act</i> and 45 CFR Part 61.
30	Nolo Contendere (No Contest) Plea	Acceptance by a Federal or State court of a nolo contendere or no contest plea by a health care practitioner, provider or supplier in a matter related to the delivery of a health care item or service. These actions are reportable to the Healthcare Integrity and Protection Data Bank under Section 1128E of the <i>Social Security Act</i> and 45 CFR Part 61.
40	Civil Judgment	Civil judgments against a health care practitioner, provider, or supplier in Federal or State court. Judgments must be related to the delivery of a health care item or service. This reporting requirement does not include consent judgments or settlements in which no findings of liability have been made. These actions are reportable to the Healthcare Integrity and Protection Data Bank under Section 1128E of the <i>Social Security Act</i> and 45 CFR Part 61.
50	Injunction	Civil actions taken against a health care practitioner, provider or supplier that seek to stop a specific activity, such as the continued production or distribution of a violative product or provision of a service. The action must be related to the delivery of a health care item or service. These actions are reportable to the Healthcare Integrity and Protection Data Bank under Section 1128E of the <i>Social Security Act</i> and 45 CFR Part 61.

**Table 4-24: Act or Omission Codes - JOCR**

<b>200</b>	<b>Fraudulent Billing/Cost Reporting</b>	<b>525</b>	<b>Research Fraud</b>
205	Billing for Services Not Rendered/Supplies Not Provided	<b>550</b>	<b>Medical Record Falsification</b>
207	Misrepresentation of Services / Supplies Provided	551	Creating Medical Record for Patient Who Does Not Exist
210	Duplicate Billing	552	Alteration/Misrepresentation of Medical Record
220	Unbundling of Services	<b>600</b>	<b>Anti-Competition Violation/Deceptive Advertising</b>
222	Upcoding of Services	<b>700</b>	<b>Controlled Substances Violation</b>
230	Fraudulent Cost Reporting	710	Mislabeled Drugs
240	Medicare/Medicaid Secondary Payor Fraud	720	Generic Substitutions
250	Submitting Claims After Sanctions	730	Prescription Splitting
260	Overcharging	735	Prescription Shorting
270	Failure to Pay Non-Assigned Claim	740	Drug Diversion
<b>300</b>	<b>Patient Abuse</b>	750	Forged/Altered Prescription Drugs
<b>305</b>	<b>Theft or Misappropriation of Patient Property</b>	760	Illegal Prescription of Controlled Substance
<b>310</b>	<b>Billing for Medically Unnecessary Services</b>	770	Counterfeiting Drugs
<b>320</b>	<b>Poor Quality of Care</b>	780	Illegal Drug Use/Possession
<b>350</b>	<b>Failure to Provide Medically Necessary Care</b>	790	Illegal Drug Trafficking
<b>400</b>	<b>Licensed Practitioner Impersonation/ Allowing Unlicensed Persons to Practice</b>	<b>810</b>	<b>Kickbacks</b>
<b>500</b>	<b>Procurement Fraud</b>	<b>820</b>	<b>Self-Referral Violations</b>
		<b>999</b>	<b>Other Act/Omission - Not Classified, Specify</b>

**Table 4-25: Medical Malpractice Act or Omission Codes - Legacy MMPR**

<p><b>Diagnosis</b></p> <p>010 Failure to Diagnose (i.e., Concluding That Patient Has No Disease or Condition Worthy of Follow-Up or Observation)</p> <p>020 Wrong Diagnosis or Misdiagnosis (i.e., Original Diagnosis is Incorrect)</p> <p>030 Improper Performance of Test</p> <p>040 Unnecessary Diagnostic Test</p> <p>050 Delay in Diagnosis</p> <p>060 Failure to Obtain Consent/Lack of Informed Consent</p> <p>090 Diagnosis Related—Not Otherwise Classified</p> <p><b>Anesthesia</b></p> <p>110 Failure to Complete Patient Assessment</p> <p>120 Failure to Monitor</p> <p>130 Failure to Test Equipment</p> <p>140 Improper Choice of Anesthesia Agent or Equipment</p> <p>150 Improper Technique/Induction</p> <p>160 Improper Equipment Use</p> <p>170 Improper Intubation</p> <p>180 Improper Positioning</p> <p>185 Failure to Obtain Consent/Lack of Informed Consent</p> <p>190 Anesthesia Related—Not Otherwise Classified</p> <p><b>Surgery</b></p> <p>210 Failure to Perform Surgery</p> <p>220 Improper Positioning</p> <p>230 Retained Foreign Body</p> <p>240 Wrong Body Part</p> <p>250 Improper Performance of Surgery</p> <p>260 Unnecessary Surgery</p> <p>270 Delay in Surgery</p> <p>280 Improper Management of Surgical Patient</p> <p>285 Failure to Obtain Consent/Lack of Informed Consent</p> <p>290 Surgery Related—Not Otherwise Classified</p> <p><b>Medication</b></p> <p>305 Failure to Order Appropriate Medication</p> <p>310 Wrong Medication Ordered</p> <p>315 Wrong Dosage Ordered of Correct Medication</p>	<p><b>Medication (contd.)</b></p> <p>320 Failure to Instruct on Medication</p> <p>325 Improper Management of Medication Regimen</p> <p>330 Failure to Obtain Consent/Lack of Informed Consent</p> <p>340 Medication Error—Not Otherwise Classified</p> <p>350 Failure to Medicate</p> <p>355 Wrong Medication Administered</p> <p>360 Wrong Dosage Administered</p> <p>365 Wrong Patient</p> <p>370 Wrong Route</p> <p>380 Improper Technique</p> <p>390 Medication Administration Related—Not Otherwise Classified</p> <p><b>Intravenous and Blood Products</b></p> <p>410 Failure to Monitor</p> <p>420 Wrong Solution</p> <p>430 Improper Performance</p> <p>440 IV Related—Not Otherwise Classified</p> <p>450 Failure to Ensure Contamination Free</p> <p>460 Wrong Type</p> <p>470 Improper Administration</p> <p>480 Failure to Obtain Consent/Lack of Informed Consent</p> <p>490 Blood Product Related—Not Otherwise Classified</p> <p><b>Obstetrics</b></p> <p>505 Failure to Manage Pregnancy</p> <p>510 Improper Choice of Delivery Method</p> <p>520 Improperly Performed Vaginal Delivery</p> <p>525 Improperly Performed C-Section</p> <p>530 Delay in Delivery (Induction or Surgery)</p> <p>540 Failure to Obtain Consent/Lack of Informed Consent</p> <p>550 Improperly Managed Labor—Not Otherwise Classified</p> <p>555 Failure to Identify/Treat Fetal Distress</p> <p>560 Delay in Treatment of Fetal Distress (i.e., Identified but Treated in Untimely Manner)</p> <p>570 Retained Foreign Body/Vaginal/Uterine Abandonment</p> <p>575 Abandonment</p> <p>580 Wrongful Life/Birth</p> <p>590 Obstetrics Related—Not Otherwise Classified</p>	<p><b>Treatment</b></p> <p>610 Failure to Treat</p> <p>620 Wrong Treatment/Procedure Performed</p> <p>630 Failure to Instruct Patient on Self-Care</p> <p>640 Improper Performance of Treatment/Procedure</p> <p>650 Improper Management of Course of Treatment</p> <p>660 Unnecessary Treatment</p> <p>665 Delay in Treatment</p> <p>670 Premature End of Treatment (Also Abandonment)</p> <p>675 Failure to Supervise Treatment/Procedure</p> <p>680 Failure to Obtain Consent/Lack of Informed Consent</p> <p>685 Failure to Refer or Seek Consultation</p> <p>690 Treatment Related—Not Otherwise Classified</p> <p><b>Monitoring</b></p> <p>710 Failure to Monitor</p> <p>720 Failure to Respond to Patient</p> <p>730 Failure to Report on Patient Condition</p> <p>790 Monitoring Related—Not Otherwise Classified</p> <p><b>Biomedical Equipment/Product</b></p> <p>810 Failure to Inspect/Monitor</p> <p>820 Improper Maintenance</p> <p>830 Improper Use</p> <p>840 Failure to Respond to Warning</p> <p>850 Failure to Instruct Patient on Use of Equipment/Product</p> <p>860 Malfunction/Failure</p> <p>890 Biomedical Equipment/Product Related—Not Otherwise Classified</p> <p><b>Miscellaneous</b></p> <p>910 Inappropriate Behavior of Clinician (e.g., Sexual Misconduct Allegation, Assault)</p> <p>920 Failure to Protect Third Parties (e.g., Failure to Warn/Protect From Violent Patient Behavior)</p> <p>930 Breach of Confidentiality/Privacy</p> <p>940 Failure to Maintain Appropriate Infection Control</p> <p>950 Failure to Follow Institutional Policy or Procedure</p> <p>960 Other (Provide Detailed Description)</p> <p>990 Failure to Review Provider Performance</p>
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\* Codes other than those listed above may be returned to the user. These additional codes are no longer accepted by the Data Banks and should be interpreted as 'UNKNOWN'.

**Table 4-26: Adverse Action Classification Codes**

<b>Code</b>	<b>Description</b>
<b>Individual Codes</b>	
1110	Revocation of License
1125	Probation of License
1135	Suspension of License
1138	Summary or Emergency Limitation or Restriction on License (NPDB Only)
1139	Summary or Emergency Suspension of License (NPDB Only)
1140	Reprimand or Censure
1145	Voluntary Surrender of License
1146	Voluntary Limitation or Restriction on License
1147	Limitation or Restriction on License
1148	Denial of License Renewal
1149	Denial of Initial License
1173	Publicly Available Fine/Monetary Penalty
1189	Publicly Available Negative Action or Finding, Specify
1199	Other Licensure Action - Not Classified, Specify
1280	License Restored or Reinstated, Complete
1282	License Restored or Reinstated, Conditional
1285	License Restoration or Reinstatement Denied
1295	Reduction of Previous Licensure Action
1296	Extension of Previous Licensure Action
1310	Revocation of Nurse Multi-State Licensure Privilege
1325	Probation of Nurse Multi-State Licensure Privilege
1335	Suspension of Nurse Multi-State Licensure Privilege
1338	Summary or Emergency Limitation or Restriction of Nurse Multi-State Licensure Privilege (NPDB Only)
1339	Summary or Emergency Suspension of Nurse Multi-State Licensure Privilege (NPDB Only)
1340	Reprimand or Censure of Nurse Multi-State Licensure Privilege
1345	Voluntary Surrender of Nurse Multi-State Licensure Privilege
1346	Voluntary Limitation or Restriction on Practice Authorized by Nurse Multi-State Licensure Privilege
1347	Limitation or Restriction on Nurse Multi-State Licensure Privilege
1348	Denial of Renewal of Nurse Multi-State Licensure Privilege
1349	Denial of Initial Nurse Multi-State Licensure Privilege
1373	Publicly Available Fine/Monetary Penalty to Nurse Practicing under Multi-State Licensure Privilege
1389	Publicly Available Negative Action or Finding Concerning Nurse Practicing under Multi-State Licensure Privilege, Specify
1399	Other Action Against Nurse Practicing Under Multi-State Licensure Privilege - Not Classified, Specify
1480	Nurse Multi-State Licensure Privilege Restored or Reinstated, Complete
1482	Nurse Multi-State Licensure Privilege Restored or Reinstated, Conditional
1485	Nurse Multi-State Licensure Privilege Restoration or Reinstatement Denied
1495	Reduction of Previous Nurse Multi-State Licensure Privilege Action
1496	Extension of Previous Nurse Multi-State Licensure Privilege Action
1500	Debarment From Federal Programs
1505	Exclusion From a Federal Health Care Program
1507	Exclusion From a State Health Care Program
1508	Exclusion From Medicare, Medicaid and All Other Federal Health Care Programs
1509	Exclusion From Medicare and State Health Care Programs
1510	Termination of Medicare or Other Federal Health Care Program Participation
1512	Voluntary Termination of Medicare or Other Federal Health Care Program Participation After Notification of Investigation or Disciplinary Action
1513	Nonrenewal of Medicare or Other Federal Health Care Program Participation Agreement for Cause

<b>Code</b>	<b>Description</b>
1515	Reinstatement
1516	Reinstatement Denied
1517	Voluntary Termination of Medicaid or Other State Health Care Program Participation After Notification of Investigation or Disciplinary Action
1518	Nonrenewal of Medicaid or Other State Health Care Program Participation Agreement for Cause
1520	Contract Termination
1530	Civil Money Penalty
1532	Administrative Fine/Monetary Penalty
1550	Disqualification of Clinical Investigator From Receiving Investigational Products
1551	Termination of Medicaid or Other State Health Care Program Participation
1555	Employment Disqualification Based on Finding in State Nurse Aide Registry
1560	Personnel Action - Employee Termination
1562	Personnel Action - Employee Suspension
1565	Personnel Action - Not Classified
1589	Other Action - Not Classified, Specify
1590	Reinstatement
1592	Reinstatement Denied
1595	Reduction of Previous Action
1596	Extension of Previous Action
1610	Revocation of Clinical Privileges
1630	Suspension of Clinical Privileges
1632	Summary or Emergency Suspension of Clinical Privileges
1634	Voluntary Limitation, Restriction, or Reduction of Clinical Privilege(s), While Under, or to Avoid, Investigation Relating to Professional Competence or Conduct
1635	Voluntary Surrender of Clinical Privilege(s), While Under, or to Avoid, Investigation Relating to Professional Competence or Conduct
1639	Summary or Emergency Limitation, Restriction, or Reduction of Clinical Privileges
1640	Reduction of Clinical Privileges
1645	Other Restriction/Limitation of Clinical Privileges, Specify
1650	Denial of Clinical Privileges
1680	Clinical Privileges Restored or Reinstated, Complete
1681	Clinical Privileges Restored or Reinstated, Conditional
1689	Clinical Privileges Restoration or Reinstatement Denied
1690	Reduction of Previous Action
1695	Extension of Previous Action
1710	Revocation of Professional Society Membership
1730	Suspension of Professional Society Membership
1745	Other Restriction/Limitation on Professional Society Membership, Specify
1750	Denial of Professional Society Membership (Subsequent)
1780	Membership Reinstated, Complete
1781	Membership Reinstated, Conditional
1789	Membership Reinstatement Denied
1790	Reduction of Previous Action
1795	Extension of Previous Action
1830	Recommendation to Sanction
1840	Withdrawal of Recommendation to Sanction
1841	Withdrawal of Recommendation to Exclude from Participating in Medicare, Medicaid
1889	Other Finding - Not Classified, Specify
1920	Contract Termination
1930	Suspension of Contract
1932	Administrative Fine/Monetary Penalty
1941	Employment Termination
1942	Employment Suspension
1950	Denial of Contract Application or Renewal
1989	Other Health Plan Action, Specify

<b>Code</b>	<b>Description</b>
1990	Reinstatement
1992	Reinstatement Denied
1995	Reduction of Previous Action
1996	Extension of Previous Action
<b>Organization Codes</b>	
3111	Revocation of License or Certificate
3136	Suspension of License or Certificate
3141	Voluntary Surrender of License or Certificate
3143	Conditional or Probationary License or Certificate
3144	Denial of License or Certificate Renewal
3145	Denial of Initial License or Certificate
3202	Directed Plan of Correction
3203	On-Site Monitoring
3205	Directed In-Service Training
3206	Appointment of Temporary Management
3207	Restrictions on Admissions or Services
3210	Closure of Facility
3212	Transfer of Residents to Other Facilities Without Closure of the Facility
3220	Receivership
3225	Liquidation
3230	Civil Money Penalty
3232	Administrative Fine/Monetary Penalty
3233	Publicly Available Fine/Monetary Penalty
3238	Summary or Emergency Action, Specify
3239	Other Licensure Action - Not Classified, Specify
3281	License or Certificate Restored or Reinstated, Complete
3283	License or Certificate Restored or Reinstated, Conditional
3286	License or Certificate Restoration or Reinstatement Denied
3295	Reduction of Previous Licensure Action
3296	Extension of Previous Licensure Action
3500	Debarment From Federal Programs
3505	Exclusion From a Federal Health Care Program
3507	Exclusion From a State Health Care Program
3508	Exclusion From Medicare, Medicaid and All Other Federal Health Care Programs
3509	Exclusion From Medicare and State Health Care Programs
3510	Termination of Medicare or Other Federal Health Care Program Participation
3512	Voluntary Termination of Medicare or Other Federal Health Care Program Participation After Notification of Investigation or Disciplinary Action
3513	Nonrenewal of Medicare or Other Federal Health Care Program Participation Agreement for Cause
3515	Reinstatement
3516	Reinstatement Denied
3517	Voluntary Termination of Medicaid or Other State Health Care Program Participation After Notification of Investigation or Disciplinary Action
3518	Nonrenewal of Medicaid or Other State Health Care Program Participation Agreement for Cause
3520	Contract Termination
3540	Marketing Activities Suspended or Restricted
3542	Beneficiary Enrollment Suspended
3551	Termination of Medicaid or Other State Health Care Program Participation
3589	Other Action - Not Classified, Specify
3590	Reinstatement
3592	Reinstatement Denied
3595	Reduction of Previous Action
3596	Extension of Previous Action
3830	Recommendation to Sanction from Participating in Medicare, Medicaid

Code	Description
3831	Recommendation to Exclude from Participating in Medicare, Medicaid
3840	Withdrawal of Recommendation to Sanction from Participating in Medicare, Medicaid
3841	Withdrawal of Recommendation to Exclude from Participating in Medicare, Medicaid
3850	Accreditation Terminated
3855	Non-Accreditation/Denial of Accreditation
3859	Other Private Accreditation Action - Not Classified, Specify
3860	Accreditation
3862	Accreditation Restored or Reinstated, Conditional
3864	Accreditation Restoration or Reinstatement Denied
3889	Other Finding - Not Classified, Specify
3920	Contract Termination
3930	Suspension of Contract
3932	Administrative Fine/Monetary Penalty
3950	Denial of Contract Application or Renewal
3989	Other Health Plan Action, Specify
3990	Reinstatement
3992	Reinstatement Denied
3995	Reduction of Previous Action
3996	Extension of Previous Action

**Table 4-27: Basis for Action Codes**

Code	Description
<b>Individual Codes</b>	
05	Fraud - Unspecified
10	Unprofessional Conduct
11	Incompetence
12	Malpractice
13	Negligence
14	Patient Abuse
15	Patient Neglect
16	Misappropriation of Patient Property or Other Property
19	Criminal Conviction
29	Practicing Beyond the Scope of Practice
31	Failure to Comply With Health and Safety Requirements
39	License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licensing Authority
40	Exclusion or Suspension From a Federal or State Health Care Program
44	Default on Health Education Loan or Scholarship Obligations
45	Failure to Maintain Records or Provide Medical, Financial or Other Required Information
47	Failure to Take Corrective Action
51	Failure to Perform Contractual Obligations
53	Failure to Provide Medically Reasonable and/or Necessary Items or Services
55	Improper or Abusive Billing Practices
56	Submitting False Claims
71	Conflict of Interest
72	Corporate Integrity Agreement Breach
73	Settlement Agreement Breach
81	Misrepresentation of Credentials
99	Other - Not Classified, Specify
A2	Failure to Comply With Continuing Education or Competency Requirements
A4	Practicing Without a Valid License
A5	Violation of or Failure to Comply With Licensing Board Order
A6	Violation of Federal or State Statutes, Regulations or Rules
A7	Surrendered License to Practice

<b>Code</b>	<b>Description</b>
A8	Clinical Privileges Restricted, Suspended or Revoked by Another Hospital or Health Care Facility
A9	Failure to Meet or Comply With Contractual Obligations or Participation Requirements
AA	Failure to Comply With Corrective Action Plan
AB	Practicing Beyond the Scope of Privileges
B1	Nolo Contendere Plea
C1	Failure to Obtain Informed Consent
C2	Failure to Comply With Patient Consultation Requirements
C3	Breach of Confidentiality
D1	Sexual Misconduct
D2	Non-Sexual Dual Relationship or Boundary Violation
D3	Exploiting a Patient for Financial Gain
E1	Insurance Fraud (Medicare, Medicaid or Other Insurance)
E3	Filing False Reports or Falsifying Records
E4	Fraud, Deceit or Material Omission in Obtaining License or Credentials
F1	Immediate Threat to Health or Safety
F2	Unable to Practice Safely by Reason of Alcohol or Other Substance Abuse
F3	Unable to Practice Safely by Reason of Psychological Impairment or Mental Disorder
F4	Unable to Practice Safely by Reason of Physical Illness or Impairment
F5	Unable to Practice Safely
F6	Substandard or Inadequate Care
F7	Substandard or Inadequate Skill Level
F8	Failure to Consult or Delay in Seeking Consultation With Supervisor/Proctor
F9	Patient Abandonment
FA	Inappropriate Refusal to Treat
FB	Excessive Malpractice Cases/Extensive Malpractice History
G1	Improper or Inadequate Supervision or Delegation
G2	Allowing or Aiding Unlicensed Practice
H1	Narcotics Violation or Other Violation of Drug Statutes
H2	Unauthorized Prescribing of Medication
H3	Unauthorized Dispensing of Medication
H4	Unauthorized Administration of Medication
H5	Error in Prescribing, Dispensing or Administering Medication
H6	Diversion of Controlled Substance
<b>Organization Codes</b>	
05	Fraud - Unspecified
14	Patient Abuse
15	Patient Neglect
16	Misappropriation of Patient Property or Other Property
19	Criminal Conviction
31	Failure to Comply With Health and Safety Requirements
32	Lack of Appropriately Qualified Professionals
34	Financial Insolvency
39	License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licensing Authority
40	Exclusion or Suspension From a Federal or State Health Care Program
44	Default on Health Education Loan or Scholarship Obligations
45	Failure to Maintain Records or Provide Medical, Financial or Other Required Information
47	Failure to Take Corrective Action
48	Failure to Obtain a Surety Bond
49	Failure to Comply With the Composition of Enrollment Requirements
51	Failure to Perform Contractual Obligations
53	Failure to Provide Medically Reasonable and/or Necessary Items or Services
55	Improper or Abusive Billing Practices
56	Submitting False Claims
71	Conflict of Interest

<b>Code</b>	<b>Description</b>
72	Corporate Integrity Agreement Breach
73	Settlement Agreement Breach
91	Noncompliance With Private Accreditation Standards
92	Noncompliance with Private Accreditation Standards That Indicate a Risk to the Safety of Patient(s) or Quality of Health Care Services
99	Other - Not Classified, Specify
A6	Violation of Federal or State Statutes, Regulations or Rules
A7	Surrendered License to Practice
AC	Failure to Maintain Equipment/Missing or Inadequate Equipment
B1	Nolo Contendere Plea
C1	Failure to Obtain Informed Consent
C2	Failure to Comply With Patient Consultation Requirements
C3	Breach of Confidentiality
E1	Insurance Fraud (Medicare, Medicaid or Other Insurance)
E3	Filing False Reports or Falsifying Records
E4	Fraud, Deceit or Material Omission in Obtaining License or Credentials
F6	Substandard or Inadequate Care
F9	Patient Abandonment
FA	Inappropriate Refusal to Treat
FC	Negligent Credentialing
H1	Narcotics Violation or Other Violation of Drug Statutes
H2	Unauthorized Prescribing of Medication
H3	Unauthorized Dispensing of Medication
H4	Unauthorized Administration of Medication
H5	Error in Prescribing, Dispensing or Administering Medication

## APPENDIX A: DISCLAIMER

Terms and Conditions: The National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) make this ICD available as a courtesy to assist authorized clients who have unique operating requirements.

No warranty or guarantee of any type is implied or intended for the use of ICDs by the QRXS user or its customers. Should there remain any latent faults in the ICD, or for any other reason, the QRXS user will not hold or attempt to hold the Data Bank(s) or individuals associated with them responsible for damages of any type resulting from its use.

The Data Bank(s) make no commitment, and none shall be inferred by the QRXS user or its customers, for providing any technical support or other assistance or consultation whatsoever regarding the modification, installation, use, maintenance, or operation of software produced by the QRXS user to produce transaction files as described in the ICD.

Any QRXS user is prohibited from identifying its product as sanctioned or authorized by the Data Bank(s). The QRXS user is required to inform its customers that the Data Bank(s) do not sanction or authorize any software, other than software produced by the NPDB or the HIPDB, that produces transaction files as described in the ICD.

The QRXS user agrees to indemnify and hold harmless the Data Bank(s) in the event that one of its customers obtains a judgment as a result of any use of the QRXS user's software.

Definitions:

**Customer** – Any NPDB or HIPDB entity to whom the QRXS user provides application software and support for electronic querying and/or reporting to the NPDB-HIPDB.

**HIPDB entity** – Any entity that is authorized to query or report to the HIPDB, pursuant to 42 U.S.C. §1301, *et seq.*, as amended by Sections 201 and 205, the *Health Insurance Portability and Accountability Act of 1996*.

**ICD** – The Interface Control Document that provides information about the format, structure, and content of electronic transaction files for processing by the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank (NPDB-HIPDB).

**NPDB entity** – Any entity that is authorized to query or report to the NPDB, pursuant to 42 U.S.C. §11101, *et seq.*, the *Health Care Quality Improvement Act of 1986*.

**QRXS user** – Any individual or organization that implements software to produce transaction files as described in the ICD, either for its own use or to provide to NPDB or HIPDB entities.

## **APPENDIX B: RULES OF BEHAVIOR**

All individuals that have access to obtain information from and report information to the NPDB-HIPDB system must comply with the following conditions:

### **B.1 Ownership**

This system is the property of the U.S. Department of Health and Human Services, Health Resources and Services Administration and is for authorized users only. The system is for official NPDB-HIPDB business only. Unauthorized access or use of this system may subject violators to criminal, civil and/or administrative penalties.

### **B.2 Responsibilities**

Individual users are provided with a unique user ID and initial password to access this system. You are responsible for maintaining the integrity of and are held accountable for everything done using your user ID and password. No other person, including those at the NPDB-HIPDB Customer Service Center has access to your password. Passwords shall not be shared with others. If password security is suspected to be compromised you agree to change the password immediately, and notify the NPDB-HIPDB Customer Service Center.

Information and activities associated with the NPDB-HIPDB system shall not be false, inaccurate or misleading; violate any law, statute, ordinance or regulation; and contain any viruses or any malicious code that may damage, detrimentally interfere with, surreptitiously intercept, or expropriate any system, data, or personal information. "Information" is defined as any information you provide to the NPDB-HIPDB System in the course of using this system. "Activities" is defined as any process of interacting with the NPDB-HIPDB system.

### **B.3 Confidentiality**

The system contains personal information protected under the provisions of the Privacy Act of 1974, 5 USC Section 552a. Violations of the provisions of the Privacy Act may subject the offender to criminal penalties.

Information reported to the NPDB and the HIPDB is confidential and shall not be disclosed except as specified in the NPDB and HIPDB regulations. The HHS OIG has the authority to impose civil money penalties on those who violate the confidentiality provisions of NPDB and/or HIPDB information. Persons or entities that receive information either directly or indirectly are subject to the confidentiality provisions specified in the NPDB regulations at 45 CFR Part 60 and the imposition of a civil money penalty of up to \$11,000 for each offense if they violate those provisions. When an authorized agent is designated to handle NPDB-HIPDB queries, both the entity and the agent are required to maintain confidentiality in accordance with the federal statutory requirements.

### **B.4 Intrusion Detection**

The system is maintained for the U.S. Government. It is protected by various provisions of Title 18, U.S. Code. Violations of Title 18 are subject to criminal prosecution in federal court.

Individuals using this system are subject to monitoring of those activities. Anyone using this system expressly consents to such monitoring and is advised that if such monitoring reveals possible evidence of criminal activity, system personnel may provide the evidence obtained by such monitoring to law enforcement officials. Moreover, for system security purposes and to ensure that the system is used for legitimate purposes by authorized, registered users, we collect information concerning the use of this system e.g. data you view and alter. We employ software programs to monitor traffic, and to identify unauthorized attempts to view and/or change information, or otherwise cause damage to the system.

Information from these sources may be used to help identify an individual(s) in the event of authorized law enforcement investigation, and pursuant to any required legal process.

## **B.5 Violation of Rules of Behavior**

In the event it is suspected that you have not complied with these rules of behavior your account will be frozen, resulting in denial of all access to the system; and criminal, civil and/or administrative action may be taken.

Use of the NPDB-HIPDB system signifies acknowledgement and understanding of the responsibilities and agreement to comply with the Rules of Behavior for the NPDB-HIPDB system.