Overview

The NPDB acts primarily as a flagging system; its principal purpose is to facilitate a comprehensive review of professional credentials. Information on medical malpractice payments, certain adverse licensure actions, adverse clinical privilege actions, adverse professional society membership actions and Medicare/ Medicaid exclusions is collected from and disseminated to eligible entities. NPDB information should be considered with other relevant information in evaluating a practitioner's credentials.

Eligible entities are responsible for meeting specific querying and/or reporting requirements and must register with the NPDB in order to query or report to the NPDB.

The information required to be reported to the NPDB is applicable to physicians, dentists, and, in some cases, other health care practitioners who are licensed or otherwise authorized by a State to provide health care services.

Time Frame for Reporting to the NPDB

Mandated NPDB reporters must report medical malpractice payments and adverse actions taken on or after September 1, 1990. This is the date that the NPDB commenced operation. With the exception of reports on Medicare/ Medicaid Exclusions, the NPDB cannot accept any report with a date of payment or a date of action prior to September 1, 1990.

Civil Liability Protection

The immunity provisions in the *Healthcare Quality and Improvement Act of 1986* protect individuals, entities, and their authorized agents from being held liable in civil actions for reports made to the NPDB unless they have actual knowledge of falsity of the information. The statute provides the same immunity to HHS in maintaining the NPDB. For more information on civil liability protection, refer to page A-2.

Official Language

The NPDB's official language is English. All reports must be submitted in English. Files submitted in any other language or containing non-alphanumeric characters (e.g., tildes, accents, umlauts) are not accepted.

Computation of Time Periods

In computing any period of time prescribed or allowed by the NPDB statute or regulations, the date of the act or event in question shall not be included. The day following the date of the act or event is Day 1 for purposes of computation. The last day of the period so computed shall be included. Saturdays, Sundays, and Federal holidays are to be included in the calculation of time periods. However, if the end date for submitting a report falls on a Saturday, Sunday, or Federal holiday, the due date is the next Federal work day. This method of computation of time periods is consistent with *Federal Rule of Civil Procedure 6*.

Table E-1. NPDB Reporting Requirements

Entity	Physicians and Dentists	Other Health Care Practitioners
Medical Malpractice Payers Payment resulting from written claim or judgment. Reports must be submitted to the NPDB and appropriate State licensing board within 30 days of a payment.	Must report	Must report
State Licensing Boards Licensure disciplinary action based on reasons related to professional competence or conduct. Reports must be submitted to the NPDB within 30 days of the action.	Must report	Currently no reporting requirements
Hospitals and Other Health Care Entities Professional review action, based on reasons related to professional competence or conduct, adversely affecting clinical privileges for a period longer than 30 days; or voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation. Reports must be submitted to the NPDB and appropriate State licensing board within 15 days of the action.	Must report	May report
Professional Societies Professional review action, based on reasons relating to professional competence or conduct, adversely affecting membership. Reports must be submitted to the NPDB and appropriate State licensing board within 15 days of the action.	Must report	May report
HHS Office of Inspector General Exclusions from Medicaid/Medicare and other Federal programs. Exclusions are reported monthly.	Must report	Must report

Submitting Reports to the NPDB

Subject Information

When submitting a report to the NPDB, the reporting entity is required to provide certain subject information. **The NPDB computer system does not allow entities to submit reports that do not include information in all mandatory fields. An entity's lack of mandatory information does not relieve the entity of reporting requirements for the purposes of Title IV.** All required fields in a subject's record must be completed before a report can be generated. Entities should provide as much information as possible, even in the fields that are not required.

When Subject Information Is Unknown

As indicated previously, the NPDB computer system does not allow reports to be submitted without all mandatory subject information. The NPDB suggests that each reporting entity review the mandatory fields information and make an effort to collect this information for each practitioner **before** there is a cause to file a report (i.e., during the application process). An incomplete report (one that is missing required information or is improperly completed) is not accepted. If you are having trouble filing your electronic report, please contact the NPDB-HIPDB Customer Service Center.

Reporting Subject Social Security Numbers

Under Title IV, a subject's Social Security Number (SSN) should be provided if known when reporting medical malpractice payments, adverse clinical privileges and professional society actions, but only if obtained in accordance with Section 7 of the *Privacy Act of 1974*, which provides that disclosure of an individual's SSN is voluntary unless otherwise provided by law. Disclosure of an individual's SSN for the purposes of the NPDB is voluntary.

The NPDB will use SSNs only to verify the identity of individuals, and SSNs are disclosed only as authorized by the *Health Care Quality Improvement Act of 1986*, as amended. The inclusion of this information, wherever possible, is encouraged because it helps to ensure the accurate identification of the subject of the report.

An SSN is required for adverse licensure actions, as these reports are also mandated for inclusion in the HIPDB under Section 1128E of the *Social Security Act*. Section 1128E requires that SSNs be provided as part of the reporting process.

Incorrectly Identified Subject

If an entity reports information for the wrong subject, the reporting entity must submit a Void of the incorrect report and submit a new Initial report for the correct subject. See page E-5 for more information on Void reports.

Submitting Reports Via the IQRS

Eligible entities may prepare and submit reports using the IQRS at *www.npdb-hipdb.com*. Once logged onto the site, the entity may enter and submit report information to the NPDB.

Medical malpractice payments are submitted using the Medical Malpractice Payment Report (MMPR) format. Clinical privileges, professional society and licensure actions, as well as Medicare/Medicaid exclusions are submitted using the Adverse Action Report (AAR) format.

Both the MMPR and the AAR formats in the IQRS capture all the necessary information for report submission. Sufficient space is provided in the fields to allow entry of multiple practitioner license numbers, Federal Drug Enforcement Administration (DEA) numbers, professional schools, and hospital affiliations. The IQRS allows for a 2,000-character description of the acts or omissions and, in the case of MMPRs, a description of the judgment or settlement statements.

Subject information does not need to be reentered into a report format if an entity maintains a subject database on the IQRS. The IQRS retrieves all pertinent information from the entity's subject database into the appropriate report screens; however, if a record in the subject database is incomplete (i.e., information is missing in required fields), the IQRS does not allow a report to be generated for that subject until the missing information is added. For more information on subject databases, see the *Fact Sheet on Creating and Maintaining a Subject Database*, available at *www.npdb-hipdb.com.*

Each data field on the report input screens is limited to a certain number of characters, including spaces and

punctuation. For example, the narrative description fields allow 2,000 characters, including spaces and punctuation. Any characters over 2,000 are truncated. Drafting your narrative in accordance with the character limits will avoid the need to correct a truncated narrative once the report is accepted by the NPDB.

Upon submitting the report to the NPDB, the entity will receive a *Temporary Record of Submission* document with a confirmation number. The confirmation number can be used to verify that the entity submitted the report. Within 4 to 6 hours of receipt, the NPDB will make available to the reporting entity an official *Report Verification Document*. The reporting entity must verify the report data on the *Report Verification Document* and correct any erroneous information on-line. The subject of the report will receive a copy of the submitted report by mail from the NPDB. Each NPDB reporter **must** mail a copy of the paper report to the appropriate State licensing board.

Draft Capability

The IQRS includes a Draft report feature for entering report data into input screens, then saving the document in draft status. The draft version of a report can be modified later. Draft reports may be saved on the IQRS server for a maximum of 30 days before they are automatically deleted. Reports saved as drafts are not considered official report submissions. Draft reports must be completed, submitted, and successfully processed by the NPDB to fulfill Title IV reporting requirements.

Submitting Reports to the NPDB Via ITP

If a reporting entity does not have access to the IQRS, or prefers to generate reports using custom software, the entity may choose to submit reports via an electronic transaction file submission (known as ICD Transfer Program [ITP]). This method of reporting requires the entity to submit data using a format specified by the NPDB. Interface Control Documents (ICDs) specify the format for ITP report submissions of MMPRs and AARs. These documents are available at *www.npdb-hipdb.com*. See page D-6 for an explanation of ITP.

Types of Reports

Initial Report

The first record of a medical malpractice payment or adverse action submitted to and processed by the NPDB is considered the Initial report. An Initial report is the current version of the report until a Correction, Void, or Revision to Action is submitted.

When the NPDB processes an Initial report, a *Temporary Record of Submission* document is available to print or save until the official *Report Verification Document* is retrieved by the reporting entity from the IQRS. A *Notification of a Report in the NPDB-HIPDB* is mailed to the subject. The reporting entity and the subject should review the report information to ensure that it is correct. The reporting entity should also print and mail a copy of the Initial report to the appropriate State licensing board.

Correction

A Correction is a change intended to supersede the contents of the current version of a report. The reporting entity must submit a Correction as soon as possible after the discovery of an error or omission in a report. A Correction may be submitted to replace the current version of a report as often as necessary.

When the NPDB processes a Correction, a *Temporary Record of Submission* document is available to print or save until the official *Report Verification Document* is retrieved from the IQRS. A *Report Revised, Voided, or Status Changed* document is mailed to the subject and all queriers who received the previous version of the report within the past 3 years. The reporting entity and the subject should review the information to ensure that it is correct, and queriers should note the changed report. The reporting entity should also print and mail a copy of the Correction to the appropriate State licensing board.

Example: A hospital submits a clinical privileges action to the NPDB. Upon receiving the Report Verification Document, the hospital identifies an error in the subject's address. The hospital submits a Correction to the Initial Report, including the correct address.

Void Previous Report

A Void is the retraction of a report in its entirety. An example of a Void is the reversal of a professional review action. The report is removed from the subject's disclosable record. A Void may be submitted by the reporting entity at any time.

When the NPDB processes a Void, a *Temporary Record of Submission* is available to print or save until the official void verification is retrieved from the IQRS. A *Report Revised, Voided, or Status Changed* document is mailed to the subject and all queriers who received the previous version of the report within the past 3 years. The reporting entity and the practitioner should review the information to ensure that the correct report was voided, and queriers should note that the report was voided. The reporting entity should also print and mail a copy of the Void to the appropriate State licensing board.

Example: A State Medical Board submits an AAR when it revokes a physician's license. Six months later, the revocation is overturned by a State court. The State Medical Board should submit a Void of the Initial Report.

Revision to Action

A Revision to Action reports an action that relates to and/or modifies an adverse action previously reported to the NPDB. It is treated as a second and separate action by the NPDB, but it does not negate the original action that was taken. The entity that reports an initial adverse action must also report any revision to that action.

A Revision to Action report should be submitted for the following reasons:

- Additional sanctions have been taken against the subject based on a previously reported incident.
- The length of action has been extended or reduced.

- The original suspension or probationary period has ended.

- Licensure, clinical privileges, professional society membership, or program participation has been reinstated.

A Revision to Action should not be reported unless the initial action was reported to the NPDB. When submitting a Revision to Action, the reporter must reference the Data Bank Control Number (DCN) on the report of the action being modified.

A Revision to Action is separate and distinct from a Correction. For example, if the hospital in the above example enters the Date of Action incorrectly, a Correction must be submitted to make the necessary change, and the Correction overwrites the Initial report. A Revision to Action is treated as an addendum to the Initial report.

When the NPDB processes a Revision to Action, a *Temporary Record of Submission* document is available to print or save until the official *Report Verification Document* is retrieved from the IQRS. A *Notification of a Report in the NPDB* is mailed to the subject practitioner. The reporting entity and the practitioner should review the information to ensure that it is correct. The reporting entity should also print and mail a copy of the Revision to Action to the appropriate State licensing board.

Example: A hospital submits an AAR when it suspends a practitioner's clinical privileges for 90 days. The suspension is later reduced to 45 days. Since this is a new action that modifies a previously reported action, the hospital must submit a new report using the Revision to Action option in the IQRS. The Initial report documents that the hospital suspended the subject's clinical privileges, and the Revision to Action documents that the hospital made a subsequent revision to the action.

Example: A hospital submits an AAR when it revokes an oral surgeon's clinical privileges. Two years later, the oral surgeon's clinical privileges are reinstated. Since this action modifies the original action, the hospital must submit a Revision to Action. The Initial report documents that the hospital revoked the oral surgeon's clinical privileges, and the Revision to Action documents that the hospital made a revision to the action.

Report Processing

When the NPDB receives a report, the information is entered into the NPDB computer system. Each version of a report processed by the NPDB computer system is assigned a unique DCN. This number is used to locate the report within the NPDB computer system. The DCN is prominently displayed in the electronic *Report Verification Document*. The DCN assigned to the most current version of the report must always be referenced in any subsequent action involving the report.

Report Responses

Each time a report is successfully submitted to the IQRS and processed by the NPDB, a *Report Verification Document* is stored for the reporting entity to retrieve through the IQRS. Reports are generally processed within 4 to 6 hours of

receipt. Once viewed, the report output is maintained on the server for 30 days before it is automatically deleted.

Entities should print or save the report output before automatic deletion occurs.

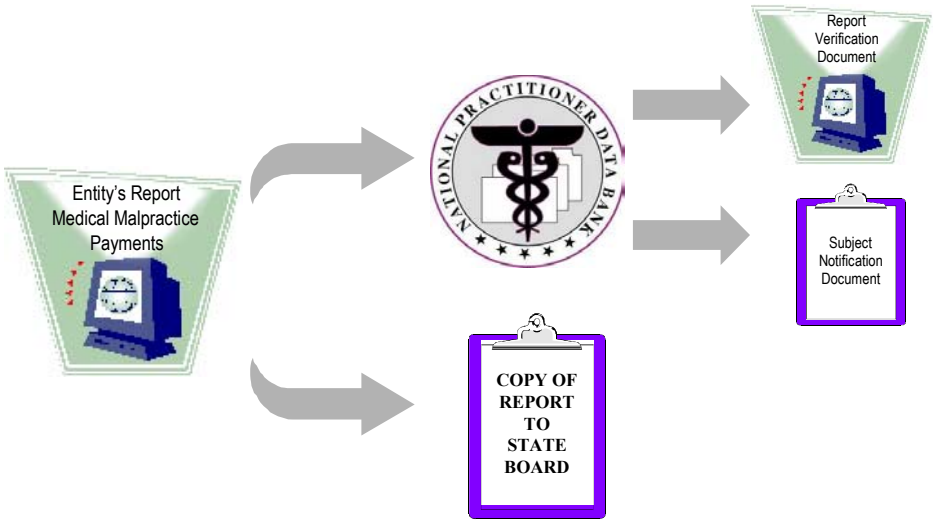
Entities that submit reports via the ITP must retrieve their report responses using the file transfer program specified in the ITP instructions. ITP responses are formatted according to the specifications of the appropriate ICD. As with responses downloaded from the IQRS, entities must review their report verifications to ensure that the information is correct and that copies of the reports are mailed to the appropriate State licensing boards.

Missing Report Verification

Reports will be available electronically within an average of 4 to 6 hours of receipt by the NPDB. Under certain circumstances, additional processing may be required. Entities should not re-submit reports on the subject in question, since this will result in duplicate reports. If you do not receive your response within 2 to 3 business days of submission, please call the NPDB-HIPDB Customer Service Center.

If your original report is not processed, the NPDB will require a new report. The NPDB will process the report and provide you with a DCN. If you need to make a change to the report, use the DCN and the appropriate procedures explained in this *Guidebook* to submit a Correction or a Void.

REPORTING MEDICAL MALPRACTICE PAYMENTS



Reporting Medical Malpractice Payments

Each entity that makes a payment for the benefit of a physician, dentist, or other health care practitioner in settlement of, or in satisfaction in whole or in part of, a claim or judgment against that practitioner must report the payment information to the NPDB. A payment made as a result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) and that does not identify an individual practitioner is not reportable under the NPDB's current regulations.

Eligible entities must report when a lump sum payment is made or when the first of multiple payments is made. Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a practitioner's provision of or failure to provide health care services. A written complaint or claim can include, but is not limited to, the filing of a cause of action based on the law of tort in any State or Federal court or other adjudicative body, such as a claims arbitration board.

Trigger Date for Reporting

Reports must be submitted to the NPDB and the appropriate State licensing boards within 30 days of the date that a payment is made (the date of the payment check). The report must be submitted regardless of how the matter was settled (for instance, court judgment, out-of-court settlement, or arbitration). The 30-day period commences on the day following the date of payment.

Interpretation of Medical Malpractice Payment Information

As stated in 427(d) of the *Health Care Quality Improvement Act of 1986*, as amended (Title IV of Public Law 99-660), and in 60.7(d) of the NPDB regulations, "[A] payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred."

The Secretary of HHS understands that some medical malpractice claims (particularly those referred to as nuisance claims) may be settled for convenience, not as a reflection on the professional competence or professional conduct of a practitioner.

Reporting entities should provide a detailed narrative to describe the acts or omissions and injuries or illnesses upon which the medical malpractice action or claim was based. This narrative may be a maximum of 2,000 characters including spaces and punctuation. Any characters over 2,000 are truncated.

Narrative descriptions should include eight general categories of information: age, sex, patient type, initial event (medical condition of the patient), procedure performed, claimant's allegation, associated legal and other issues, and outcome. Narratives cannot contain patient names or names of other health care practitioners, plaintiffs, witnesses, or any other individuals involved in the case. Guidelines for these categories follow:

- **Age** – age of claimant at the time of the initial event; age is expressed in years if the claimant is 1 year of age or older, in months from 1 month through 11 months; and in days if the claimant is less than 1 month of age. **Unknown** may be used if applicable.

- **Sex** – male, female, and disputed; disputed may be used in claims involving individuals whose sex has been physically altered or who are physically one sex but live outwardly as the other.

- **Patient Type** – generally an indication of inpatient or outpatient status; choose inpatient, outpatient, or both.

- **Initial Event (Medical Condition of the Patient)** – choose the words that best describe the diagnosis with which the claimant presented for treatment. To report the diagnosis, the reporters should use the actual condition from which the patient suffered. When the patient has more than one condition, the reporter should use the condition that is most applicable to the generation of the claim.

- **Procedure Performed** – the treatment rendered by the insured to the patient for the medical condition described under "Medical Condition of the Patient." If more than one procedure was used, the procedure that is most significant to the claim's generation should be used.

- **Claimant's Allegation** – the occurrence that precipitated the claim of medical and/or legal damages; the time sequence in relation to the initial event is relevant.

- **Associated Legal and Other Issues** – any associated issues that have an impact on the claim.

- **Outcome** – a description of the outcome resulting from the initial event and the claimant's allegation.

Sample Descriptions for Illustrative Purposes Only:

A 65-year-old male outpatient had a prostate exam by Dr. A. Six months later, the patient was diagnosed by Dr. B with

prostate cancer and underwent surgery. One year later, the patient sued Dr. A for alleged failure to diagnose. A settlement was reached in the amount of $250,000.

A 57-year-old female outpatient had a mammogram. One year later, the patient was diagnosed with breast cancer and she underwent chemotherapy and radiation. The patient sues the physician for alleged failure to diagnose and treat. A settlement was reached in the amount of $100,000.

A 45-year-old male came to the emergency department with complaints of shoulder and chest pain, and he was discharged after evaluation. Six hours later, he had a cardiac arrest and could not be resuscitated. The estate sued the treating emergency room physician for alleged failure to diagnose and treat. The case went to trial and resulted in a verdict in favor of the plaintiff for $1,000,000.

A 9-month-old girl was seen in a private office with fever and treated symptomatically. The next day she was brought to the hospital in convulsions. Her parents allege that a delay in the diagnosis of meningitis caused permanent neurological damage. A settlement was reached in the amount of $2,000,000.

A 31-year-old pregnant woman was admitted to the hospital by her physician in the early stages of labor. After four hours, the woman began to show signs of fetal distress. The hospital staff attempted to contact the physician but could not locate her for four hours. The patient sued the physician, alleging that the physician's abandonment caused permanent neurological damage to the child. A settlement was reached in the amount of $2,000,000.

(Portions adopted from the Harvard Risk Management Foundation Sample Claims Descriptions.)

Reporting of Payments by Individuals

Individual subjects are not required to report payments they make for their own benefit to the NPDB. On August 27, 1993, the Circuit Court of Appeals for the District of Columbia held that [445 (DC Cir. 3 F.3D 1993)] the NPDB regulation requiring each "person or entity" that makes a medical malpractice payment was invalid, insofar as it required individuals to report such payments. The NPDB removed reports previously filed on medical malpractice payments made by individuals for their own benefit.

A professional corporation or other business entity comprised of a sole practitioner that makes a payment for the benefit of a named practitioner must report that payment to the NPDB. However, if a practitioner or other person, rather than a professional corporation or other business entity, makes a medical malpractice payment out of personal funds, the payment is not reportable.

Payments for Corporations and Hospitals

Medical malpractice payments made solely for the benefit of a corporation such as a clinic, group practice, or hospital are currently not reportable to the NPDB. A payment made for the benefit of a professional corporation or other business entity that is comprised of a sole practitioner is reportable if the payment was made by the entity rather than by the sole practitioner out of personal funds.

Deceased Practitioners

One of the principal objectives of the NPDB is to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of their previous damaging or incompetent performance. The NPDB requires reporting medical malpractice payments made for the benefit of deceased practitioners (or for their benefit through their estates) because a fraudulent practitioner could assume the identity of a deceased practitioner.

When submitting an MMPR for a deceased practitioner, check the deceased block on the appropriate MMPR screen in the IQRS. The NPDB makes an electronic report verification available to the reporting entity via the IQRS.

Identifying Practitioners

In order for a particular physician, dentist, or other health care practitioner to be named in an MMPR submitted to the NPDB, the practitioner must be named in both the written complaint or claim demanding monetary payment for damages **and** the settlement release or final adjudication, if any. Practitioners named in the release, but not in the written demand or as defendants in the lawsuit, are not reportable to the NPDB. A practitioner named in the written complaint or claim who is subsequently dismissed from the lawsuit and not named in the settlement release is not reportable to the NPDB. In some States, the given name of the practitioner does not have to appear in the release or final adjudication as long as the practitioner is sufficiently described in the settlement or final adjudication as to be identifiable. In those States, an NPDB report on the practitioner named in the complaint, but not in the release or final adjudication, is required as long as he or she is sufficiently described as to be individually identifiable.

Insurance Policies that Cover More than One Practitioner

A medical malpractice payment made under an insurance policy that covers more than one practitioner should only be reported for the individual subject for whose benefit the payment was made, **not** for every practitioner named on the policy.

One Settlement for More than One Practitioner

In the case of a payment made for the benefit of multiple practitioners, wherein it is impossible to determine the amount paid for the benefit of each individual practitioner, the insurer must report, for each practitioner, the total (undivided) amount of the initial payment and the total number of practitioners on whose behalf the payment was made. In the case of a payment made for the benefit of multiple practitioners where it is possible to apportion payment amounts to individual practitioners, the insurer must report, for each practitioner, the actual amount paid for the benefit of that practitioner.

Residents and Interns

Reports must be submitted to the NPDB when medical malpractice payments are made for the benefit of licensed residents or interns. Medical malpractice payments made for the benefit of housestaff insured by their employers are also reportable to the NPDB.

Students

Payments made for the benefit of medical or dental students are not reportable to the NPDB. Unlicensed student providers provide health care services exclusively under the supervision of licensed health care professionals in a training environment. Students do not fall into the "other health care practitioner category;" other health care practitioners are licensed by a State and/or meet State registration or certification requirements.

Practitioner Fee Refunds

If a refund of a practitioner's fee is made by an entity (including solo incorporated practitioners), that payment is reportable to the NPDB. A refund made by an individual is not reportable to the NPDB.

For purposes of NPDB reporting, medical malpractice payments are limited to exchanges of money. A refund of a fee is reportable only if it results from a **written** complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a physician's, dentist's, or other health care practitioner's provision of, or failure to provide, health care services. A written complaint or claim may include, but is not limited to, the filing of a cause of action based on the law of tort in any State or Federal court or other adjudicative body, such as a claims arbitration board.

A waiver of a debt is not considered a payment and should not be reported to the NPDB. For example, if a patient has an adverse reaction to an injection and is willing to accept a waiver of fee as settlement, that waiver is not reportable to the NPDB.

Loss Adjustment Expenses

Loss adjustment expenses (LAEs) refer to expenses other than those in compensation of injuries, such as attorney's fees, billable hours, copying, expert witness fees, and deposition and transcript costs. If LAEs are not included in the medical malpractice payment amount, they are not required to be reported to the NPDB.

LAEs should be reported to the NPDB **only** if they are included in a medical malpractice payment. Reporting requirements specify that the total amount of a medical malpractice payment and a description and amount of the judgment or settlement and any conditions, including terms of payment should be reported to the NPDB. LAEs should be itemized in the description section of the report form.

Dismissal of a Defendant from a Lawsuit

A payment made to settle a medical malpractice claim or action is not reportable to the NPDB if the defendant health care practitioner is dismissed from the lawsuit **prior** to the settlement or judgment. However, if the dismissal results **from a condition in the settlement or release**, then the payment is reportable. In the first instance, there is no payment for the benefit of the health care practitioner because the individual has been dismissed from the action **independently** of the settlement or release. In the latter instance, if the practitioner is dismissed from the lawsuit **in consideration** of the payment being made in settlement of the lawsuit, the payment can only be construed as a payment for the benefit of the health care

practitioner and must be reported to the NPDB.

Example: A health care practitioner is named in a lawsuit. The practitioner agrees to a payment on the condition that his or her name does not appear in the settlement. The payment would be reportable to the NPDB.

High-Low Agreements

A "high-low" agreement, a contractual agreement between a plaintiff and a defendant's insurer, defines the parameters of a payment the plaintiff may receive after a trial or arbitration proceeding. If the finder of fact returns a defense verdict, the defendant's insurer agrees to pay the "low end" amount to the plaintiff. If the finder of fact returns a verdict for the plaintiff and against the defendant, the defendant's insurer agrees to pay the "high end" amount to the plaintiff.

A payment made at the low end of a high/low agreement that is in place prior to a verdict or an arbitration decision would not be reportable to the NPDB **only** if the fact-finder rules in favor of the defendant and assigns **no liability to the defendant practitioner**. In this case, the payment is not being made for the benefit of the practitioner in settlement of a medical malpractice claim. Rather, it is being made pursuant to an independent contract between the defendant's insurer and the plaintiff. The benefit to the insurer is the limitation on its liability, even if the plaintiff wins at trial and is awarded a higher amount. The benefit to the plaintiff is a guaranteed payment, even if there is no finding of liability against the practitioner. *Note: in order for the low-end payment to be exempted from the reporting requirements, the fact finder must have made a determination regarding liability at the trial or arbitration proceeding.*

A payment made at the high end of the agreement is one made for the benefit of the practitioner and, therefore, must be reported to the NPDB. **When a defendant practitioner has been found to be liable by a fact-finding authority, such as a judge, a jury, or by arbitration, any payment made pursuant to that finding must be reported, regardless of the existence of a high-low agreement.**

If a high-low agreement is in place, and the plaintiff and defendant settle the case prior to trial, the existence of the high-low agreement does not alter the reportability of the settlement payment.

Example 1: A high-low agreement is in place prior to trial. The parties agree to a low end payment of $25,000 and a high end payment of $100,000. The jury finds the defendant physician liable and awards $20,000 to the plaintiff in damages. This $20,000 payment is reportable because the jury found the defendant physician liable.

Example 2: A high-low agreement is in place prior to binding arbitration. The parties agree to a low end payment of $50,000 and a high end payment of $150,000. The arbitrator finds in favor of the defendant practitioner. However, due to the existence of the high-low agreement, the defendant's insurer makes a payment of $50,000 to the plaintiff (the low end payment). This payment is not reportable since it is being made pursuant to an independent contract between the defendant's insurer and the plaintiff.

Example 3: A high-low agreement is in place prior to trial. The parties agree to a low-end payment of $50,000 and a high end payment of $150,000. Before the fact finder returns a verdict, the parties settle the case for $50,000. This payment is reportable because it is made in settlement of the claim.

Example 4: A high-low agreement is in place prior to trial. The parties agree to a low-end payment of $50,000 and a high-end payment of $100,000. Rather than go to trial, the parties agree to binding arbitration to assess the amount of damages the plaintiff will receive. The arbitrator awards the plaintiff $50,000. In this case, the arbitration was conducted to determine the amount of recovery by the plaintiff, not whether or not the plaintiff will recover. Because no liability was to be determined at this arbitration proceeding, the payment is made in settlement of the claim and is reportable.

Reporting by Authorized Agents

The organization that makes the medical malpractice payment is the organization that must report medical malpractice payments to the NPDB.

A medical malpractice payer may choose to use an adjusting company, claims servicing company, or law firm, acting as its authorized agent to complete and submit NPDB reports. An insurance company may also wish to have all of its NPDB correspondence related to reports handled by an authorized agent. This is strictly a matter of administrative policy by the medical malpractice payer. When reporting a payment, the reporting entity information in the MMPR must be completed using the name, address, and DBID of the organization that made the payment.

For information on registering an authorized agent or designating one, see pages B-7 and B-8, respectively.

Payments by Multiple Payers

Any medical malpractice payer that makes an indemnity payment for the benefit of a practitioner must submit a report to the NPDB. Generally, primary insurers and excess insurers are obligated to make an indemnity payment for the benefit of a practitioner and so must submit a report to the NPDB. Typically, reinsurers are obligated to make an indemnity payment directly to the primary insurer, not for the benefit of the practitioner, and are not required to submit a report to the NPDB.

For example, if three primary insurers contribute to a payment, all three insurers are required to submit separate MMPRs to the NPDB. Each insurer should describe the basis for their payment in the narrative description of the settlement to avoid the impression of duplicate reporting.

Structured Settlements

A medical malpractice payer entering into a structured settlement agreement with a life insurance or annuity company must submit a payment report within 30 days after the lump sum payment is made by the payer to that company.

Payments made after the opening of the NPDB (September 1, 1990) under annuities existing **prior** to the NPDB opening are not reportable to the NPDB.

Subrogation-Type Payments

Subrogation-type payments made by one insurer to another are not required to be reported, provided that the insurer receiving the payment has previously reported the total judgment or settlement to the NPDB. Subrogation often occurs when there is a dispute between insurance companies over whose professional liability policy ought to respond to a lawsuit.

Example: A practitioner is insured in 1991 by Insurer X and changes over to Insurer Y in 1992. Both policies provide occurrence-type coverage. A medical malpractice lawsuit is filed in 1992. There is a dispute over whether the alleged medical malpractice occurred in late 1991 or early 1992. Under the 1992 policy, Insurer Y agrees to defend the lawsuit but obtains an agreement from the practitioner that it may pursue the practitioner's legal right to recover any indemnity and defense payments that should have been paid under Insurer X's policy. This is a subrogation agreement. The jury subsequently determines that the incident occurred in 1991 and awards $500,000 to the plaintiff. Insurer Y makes the $500,000 payment to the plaintiff and reports it to the NPDB. Insurer Y seeks subrogation of its indemnity and defense payments from Insurer X. Insurer X ultimately concedes and pays Insurer Y the $500,000 plus defense costs. Insurer X is not required to report its reimbursement of Insurer Y to the NPDB.

Offshore Payers

A medical malpractice payment made by an offshore medical malpractice insurer must be reported to the NPDB. An offshore insurer with an agent in the United States is subject to service (which means that it can be served with a Federal complaint); therefore, the reporting requirement can be enforced. It is not the NPDB's responsibility to identify these companies; rather, it is the responsibility of these companies to comply with the statute and register with the NPDB.

Payments Made Prior to Settlement

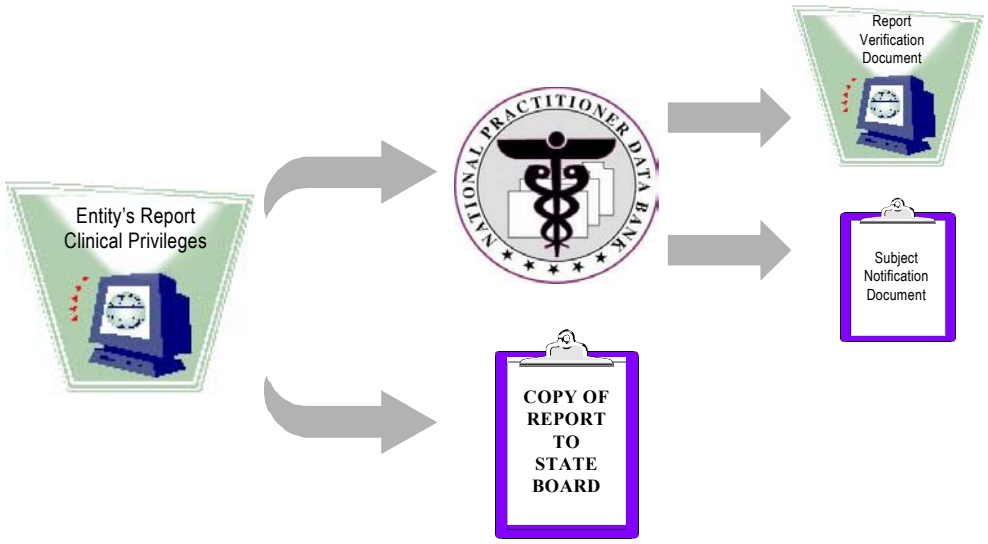
When a payment is made prior to a settlement or judgment, a report must be submitted within 30 days from the date the payment was made. Since the total amount of the payment is unknown, the medical malpractice payer should state this in the narrative description section of the report. When the settlement or judgment is finalized, the insurer must submit a Correction to the Initial Report.

When reporting medical malpractice payment information, please be aware that leaving the Payment Result reason and Date of Judgment or Settlement fields on the MMPR format blank indicates that the payment was made prior to a judgment or settlement. When a payment is made as a result of a judgment or settlement, these fields should be properly completed. Likewise, the Adjudicative Body Case Number, Adjudicative Body Name, and Court File Number fields should be left blank only when there was not a filing with an adjudicative body. See Table E-2 on page E-16 for information on determining reportable medical malpractice payments.

Table E-2. Determining Reportable Medical Malpractice Payments

Action	NPDB Reporting Responsibility
A malpractice settlement or court judgment includes stipulation that the terms are kept confidential.	Must file report.
Malpractice settlement is structured so that claimant receives an annual sum for each year he or she is alive.	Report the initial payment after NPDB opening; identify as multiple payments.
Malpractice settlement involves five practitioners.	Must file a separate report on each of the five practitioners.
Payment is made based only on oral demands.	No report is required.
Payment made by an individual.	A professional corporation or other business entity comprised of sole practitioner must file a report. No report is required for an individual making payment out of personal funds.
Payments made for corporations and hospitals.	Payments made for the benefit of a corporation such as a clinic group practice or hospital are not currently reportable. Payment is reportable when made for business entities comprised of sole practitioners.
Payments made for licensed residents and interns.	Must file report.
Practitioner fee refund.	Must file report if refund is made by an entity (including solo incorporated practitioners). No report is required if refund is made by an individual.
Dismissal of defendant from lawsuit.	No report required if defendant is dismissed prior to settlement or judgment. Report is required if dismissal results from condition in settlement or release.

REPORTING ADVERSE CLINICAL PRIVILEGES ACTIONS



Reporting Adverse Clinical Privileges Actions

Health care entities must report adverse actions within 15 days from the date the adverse action was taken or clinical privileges were voluntarily surrendered. **The health care entity must print a copy of each report submitted to the NPDB and mail it to the appropriate State licensing board for its use.** The *Report Verification Document* that health care entities receive after a report is successfully processed by the NPDB should be used for submission to the appropriate State licensing board.

Reportable adverse clinical privileges actions are **based on a physician's or dentist's professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient.** Hospitals and other eligible health care entities **must** report:

- Professional review actions that adversely affect a physician's or dentist's clinical privileges for a period of more than 30 days.
- Acceptance of a physician's or dentist's surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct or in return for not conducting an investigation or reportable professional review action.

Adverse actions taken against a physician's or dentist's clinical privileges include reducing, restricting, suspending, revoking, or denying privileges, and also include a health care entity's decision not to renew a physician's or dentist's privileges if that decision was based on the practitioner's professional competence or professional conduct. **Health care entities may report such actions taken against the clinical privileges of other health care practitioners.**

Adverse actions involving censures, reprimands, or admonishments should **not** be reported to the NPDB. Matters not related to the professional competence or professional conduct of a practitioner should **not** be reported to the NPDB. For example, adverse actions based primarily on a practitioner's advertising practices, fee structure, salary arrangement, affiliation with other associations or health care professionals, or other competitive acts intended to solicit or retain business are excluded from NPDB reporting requirements.

See Table E-3 on page E-21 for more information on determining reportable actions for clinical privileges.

Hospitals and other health care entities must report revisions to previously reported adverse actions. For more information on revisions, see page E-5, Revision to Action, in the Types of Reports section.

Multiple Adverse Actions

If a single professional review action produces multiple clinical privileges actions (for example, a 12-month suspension followed by a 5-month probation), only one report should be submitted to the NPDB. The Adverse Action Classification Code for the principal action should be submitted on the AAR, and the narrative description should describe the additional adverse actions imposed.

A Revision to Action must be submitted when each of the multiple actions is lifted. (Following the previous example, a revision must be submitted when clinical privileges are reinstated with probation after the suspension, and another revision must be submitted when the probationary period ends.)

If an adverse action against the clinical privileges of a practitioner is based on multiple grounds, only a single report must be submitted to the NPDB. However, all reasons for the action should be reported and explained in the narrative. The reporting entity may select up to four Basis for Action codes to indicate these multiple reasons. Additional reasons should be summarized in the narrative description.

Denial of Applications

A restriction or denial of clinical privileges that occurs solely because a practitioner does not meet a health care institution's established threshold eligibility criteria for that particular privilege is not reportable to the NPDB.

Such restrictions or denials are not deemed the result of a professional review action relating to the practitioner's professional competence or professional conduct, but are considered decisions based on eligibility.

For example, if an institution retroactively changes the eligibility criteria for a particular clinical privilege, a physician that does not meet the new criteria will lose previously granted clinical privileges; this loss of privileges is not reportable to the NPDB.

Adverse clinical privileges actions reportable to the NPDB result from professional review actions relating to the practitioner's professional competence or professional conduct.

Withdrawal of Applications

Voluntary withdrawal of an initial application for medical staff appointment or clinical privileges prior to a final professional review action generally is not reportable to the NPDB. However, if a practitioner applies for renewal of medical staff appointment or clinical privileges and voluntarily withdraws that application while under investigation by the health care entity for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or taking a professional review action, then the withdrawal of application for clinical privileges **is** reportable to the NPDB.

Investigations

Investigations should not be reported to the NPDB; only the **surrender or restriction of clinical privileges** while under investigation or to avoid investigation is reportable. This would include a failure to renew clinical privileges while under investigation.

A health care entity that submits an AAR based on surrender or restriction of a physician's or dentist's privileges while under investigation should have contemporaneous evidence of an ongoing investigation at the time of surrender, or evidence of a plea bargain. The reporting entity should be able to produce evidence that an investigation was initiated **prior** to the surrender of clinical privileges by a practitioner. Examples of acceptable evidence may include minutes or excerpts from committee meetings, orders from hospital officials directing an investigation, and notices to practitioners of an investigation.

Guidelines for Investigations

- An investigation must be carried out by the health care entity, not an individual on the staff.
- The investigation must be focused on the practitioner in question.
- The investigation must concern the professional competence and/or professional conduct of the practitioner in question.
- A routine or general review of cases is not an investigation.
- A routine review of a particular practitioner is not an investigation.
- An investigation should be the precursor to a professional review action.
- An investigation is considered ongoing until the health care entity's decision making authority takes a final action or formally closes the investigation.

Summary Suspension

A summary suspension is reportable if it is:

- In effect or imposed for more than 30 days.
- Based on the professional competence or professional conduct of the physician, dentist, or other health care practitioner that adversely affects, or could adversely affect, the health or welfare of a patient.
- The result of a professional review action taken by a hospital or other health care entity.

A summary suspension is often imposed by an individual, for instance, the chairman of a department. Commonly,

this action is then reviewed and confirmed by a hospital committee, such as a medical executive committee, as authorized by the medical staff bylaws. The suspension would then be viewed as a professional review action taken by the entity.

If the suspension is modified or revised as part of a final decision by the governing board or similar body, the health care entity must then submit a Revision to Action of the Initial report made to the NPDB.

If the physician, dentist, or other health care practitioner surrenders his or her clinical privileges during a summary suspension, that action must be reported to the NPDB. The action is reportable because the practitioner is surrendering the privileges either while under investigation concerning professional conduct or professional competence that did or could affect the health or welfare of a patient or in order to avoid a professional review action concerning the same.

Summary suspensions are considered to be final when they become professional review actions through action of the authorized hospital committee or body, according to the hospital bylaws.

The basis for this interpretation is that, pursuant to Part A of the *Health Care Quality Improvement Act* (42 U.S.C. §11112)(c)(2), a summary suspension is taken to prevent "imminent danger to the health of any individual."

The Act itself treats summary suspensions differently than other professional review actions: the procedural rights of the practitioner are provided for **following** the suspension, rather than preceding it. This reporting policy for summary suspensions is in keeping with the purpose of the Act, which is to protect the public from the threat of incompetent practitioners continuing to practice without disclosure or discovery of previous damaging or incompetent performance.

In establishing this policy on the reporting of summary suspensions, HHS assumes that hospitals use summary suspensions for the purpose stated in Part A of the Act: to protect patients from imminent danger, rather than for reasons that warrant routine professional review actions. HHS also emphasizes that this policy on summary suspension is solely for the purpose of reporting to the NPDB, and does not relate to the criteria for immunity under Part A of the Act.

Table E-3. Determining Reportable Actions for Clinical Privileges

Action	Reportable
Based on assessment of professional competence, a proctor is assigned to a physician or dentist for a period of more than 30 days. The practitioner must be granted approval before certain medical care is administered.	Yes
Based on assessment of professional competence, a proctor is assigned to supervise a physician or dentist, but the proctor does not grant approval before medical care is provided by the practitioner.	No
As a matter of routine hospital policy, a proctor is assigned to a physician or dentist recently granted clinical privileges.	No
A physician or dentist voluntarily restricts or surrenders clinical privileges for personal reasons; professional competence or professional conduct is not under investigation.	No
A physician or dentist voluntarily restricts or surrenders clinical privileges; professional competence or professional conduct is under investigation.	Yes
A physician or dentist voluntarily restricts or surrenders clinical privileges in return for not conducting an investigation of professional competence or professional conduct.	Yes
A physician's or dentist's application for medical staff appointment is denied based on professional competence or professional conduct.	Yes
A physician or dentist is denied medical staff appointment or clinical privileges because the health care entity has too many specialists in the practitioner's discipline.	No
A physician's or dentist's clinical privileges are suspended for administrative reasons not related to professional competence or professional conduct.	No
A physician's or dentist's request for clinical privileges is denied or restricted based upon assessment of clinical competence as defined by the hospital.	Yes

Examples of Reportable and Non-Reportable Actions

Example 1: A physician member of a hospital medical staff wishes to perform several clinical tests and procedures, but does not have the appropriate clinical privileges. The physician applies for an expansion of clinical privileges. The physician's Department Head and the Medical Staff Credentials Committee find that, based on their assessment of the physician's demonstrated professional performance, the physician does not have the clinical competence to perform the additional tests and procedures, and they recommend denial of the request for expanded clinical privileges. The hospital's governing body reviews the case, affirms the findings and recommendations, and denies the physician's request for expanded clinical privileges for reasons relating to professional competence.

The action is reportable because the denial of privileges adversely affects the clinical privileges of the physician for longer than 30 days.

Whether particular actions are reportable to the NPDB is often best determined by examining a hospital's medical staff bylaws, rules, and regulations with regard to provisions defining who is empowered to take a professional review action, what constitutes a professional review action that adversely affects the clinical privileges of a practitioner, and how that action relates to professional competence or professional conduct.

Example 2: A 30-day suspension is imposed as a result of a professional review action based on a physician's professional competence.

*The action is not reportable because the adverse action taken by the professional review body did not last for **more** than 30 days.*

Example 3: A hospital reviews a surgeon's professional competence and assigns a surgical proctor for 60 days. The surgeon cannot perform surgery without being granted approval by the surgical proctor.

Since the surgeon cannot practice surgery without approval from another surgeon, this restriction of clinical privileges is reportable.

Example 4: A 31-day suspension is imposed on a physician for failure to complete medical records.

Such a suspension would be reportable to the NPDB *if the failure to complete medical records related to the physician's professional competence or conduct and adversely affects or could adversely affect a patient's health or welfare.*

Example 5: A physician's application for surgical privileges is denied because the physician is not board certified in the particular clinical specialty or subspecialty.

The action is not reportable if the physician fails to meet the hospital's initial credentialing criteria applied to all medical staff or clinical privilege applicants. Examples of initial criteria may include: (1) minimum professional liability coverage, (2) board certification, (3) geographic proximity to the hospital, and (4) failure to have performed the minimum number of procedures prescribed for a particular clinical privilege.

Example 6: The hospital CEO summarily suspends a physician's privileges for failure to respond to an emergency department call.

The action is reportable if the suspension continues for longer than 30 days and the hospital bylaws state that summary suspension decisions by the medical executive committee are considered to be professional review actions. A CEO may be considered a committee assisting the governing body in a professional review activity. If this is the case and the physician has been summarily suspended, the hospital medical staff bylaws will usually provide for an appeal to the medical executive committee within a few days of the CEO's decision.

Example 7: A hospital's professional review body terminates a provider-based physician contract for causes relating to poor patient care, which in turn results in loss of privileges with no right to a hearing as provided in the contract and the medical staff bylaws.

The termination of the contract, in itself, is not reportable to the NPDB. The termination of the practitioner's clinical privileges because of the termination of the contract for reasons relating to professional competence or professional conduct is reportable if it is considered a professional review action by the hospital.

Hospitals are advised to consult with legal counsel to review the State's case law concerning due process.

Example 8: A physician surrenders medical staff privileges due to personal reasons, infirmity, or retirement.

The surrender is not reportable. The reasons for surrender are irrelevant unless the physician surrenders while under an investigation by a health care entity relating to possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation.

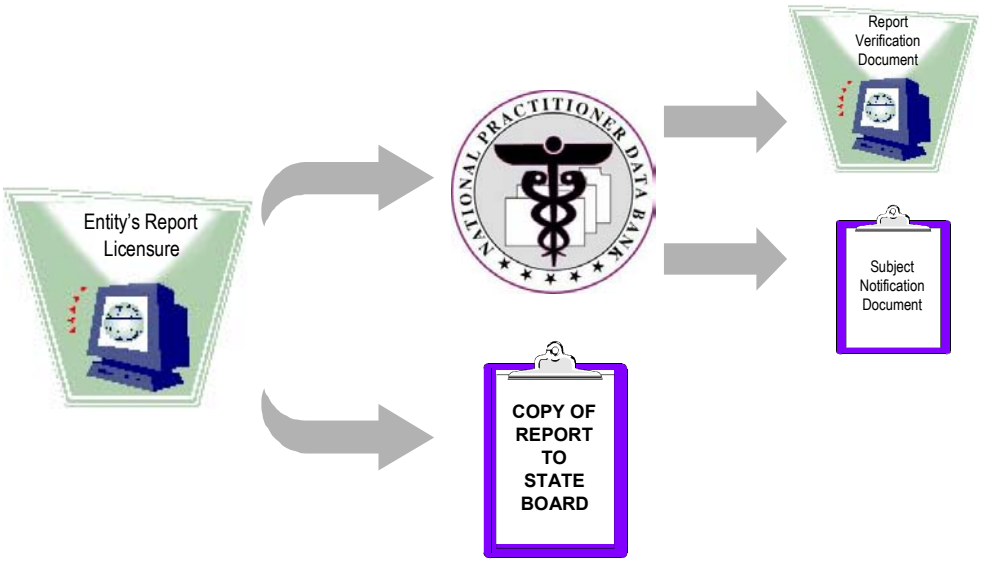
Example 9: A physician was under investigation four weeks prior to the expiration of his clinical privileges. The physician failed to renew his clinical privileges.

This event is considered a reportable surrender while under investigation. This action is reportable regardless of whether the physician knew he was under investigation at the time he failed to renew his clinical privileges. A practitioner's awareness that an investigation is being conducted is not a requirement for reportability.

Example 10: A physician holding courtesy privileges in a hospital applies for full staff privileges. The full staff privileges are granted. As a condition of staff privileges, the physician is required to be on-call in the Emergency Department for one weekend a month. Due to personal reasons, the physician is unable to fulfill his Emergency Department commitment. The hospital and the physician eventually agree to change his clinical privileges from full staff to courtesy.

The change in clinical privileges is not reportable. The change to the physician's privileges is not the result of a professional review action based on the physician's professional competence or conduct which affects or could adversely affect the health or welfare of a patient.

REPORTING ADVERSE LICENSURE ACTIONS



Reporting Adverse Licensure Actions

State medical and dental licensing boards must report adverse actions against physicians and dentists to the NPDB within 30 days from the date an adverse licensure action was taken.

State medical and dental boards must report to the NPDB certain disciplinary actions related to professional competence or professional conduct taken against the licenses of physicians or dentists. Such licensure actions include revocation, suspension, censure, reprimand, probation, and surrender. State medical and dental boards must also report revisions to adverse licensure actions, such as reinstatement of a license.

Effective Date of Action

An Adverse Action Report must be submitted within 30 days of the date of the formal approval of the licensure action by the State medical or dental board or its authorized official. Significant delays may occur between the formal approval of the action and the drafting of the order for publication; however, the trigger date for reporting the adverse action is based on the board's formal approval of the action.

Examples of Reportable Actions

The following adverse licensure actions, when related to the professional competence or professional conduct of a physician or dentist, must be reported to the NPDB:

- Denial of an application for license renewal.
- Withdrawal of an application for license renewal (should be reported as a voluntary surrender).
- Licensure disciplinary action taken by a State board against one of its licensees/applicants for licensure renewal based upon a licensure disciplinary action, related to the practitioner's professional competence or professional conduct, taken by another State board.

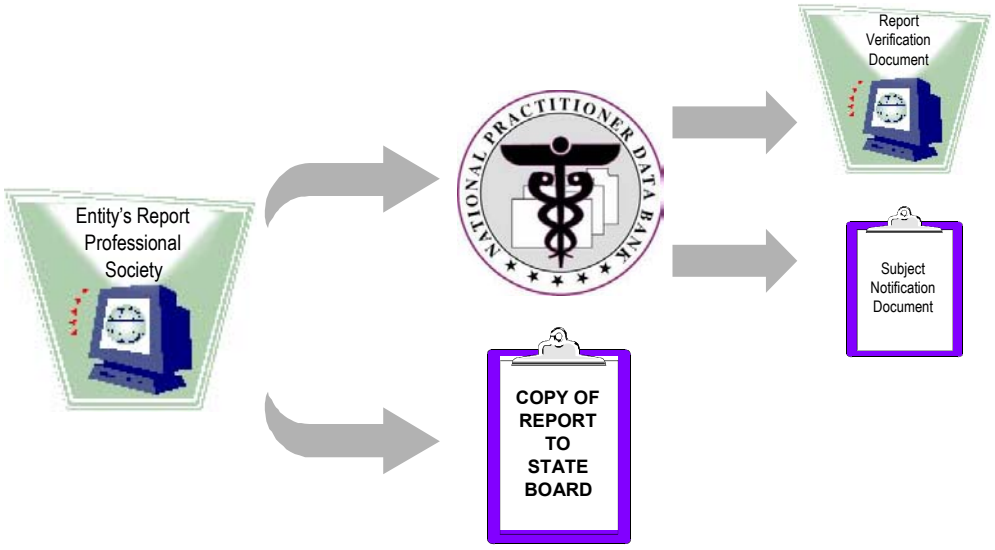
- Licensure disciplinary action taken by a State board based upon the practitioner's deliberate failure to report a licensure disciplinary action taken by another State board, when a report of such action is requested on a licensure renewal application.
- Fines and other monetary sanctions accompanied by other licensure action, such as revocation, suspension, censure, reprimand, probation, or surrender.

Examples of Non-Reportable Actions

The following adverse licensure actions should **not** be reported to the NPDB:

- Fines and other monetary sanctions unaccompanied by other licensure action, such as revocation, suspension, censure, reprimand, probation, or surrender.
- Denial of an initial application for license.
- A settlement agreement which imposes monitoring of a practitioner for a specific period of time, unless such monitoring constitutes a restriction of the practitioner's license or is considered to be a reprimand.
- A licensure disciplinary action which is imposed with a "stay" pending completion of specific programs or actions. However, if a "stay" of a disciplinary action is accompanied by probation, the probation is reportable.
- Voluntary relinquishment of a physician's license for personal reasons not related to his or her professional competence or professional conduct (for example, retirement).
- Licensure actions taken against non-physician, non-dentist, health care practitioners.

REPORTING ADVERSE PROFESSIONAL SOCIETY MEMBERSHIP ACTIONS



Reporting Adverse Professional Society Membership Actions

Professional societies must report adverse actions within 15 days from the date the adverse action was taken. A copy of each report sent to the NPDB should be printed and mailed to the appropriate State licensing board for its use.

The *Report Verification Document* that health care entities receive after a report is successfully processed by the NPDB should be used for submission to the appropriate State licensing board.

Reporting Requirements

Professional societies **must** report professional review actions based on reasons related to professional competence or professional conduct that adversely affect the membership of a physician or dentist. Professional societies **may** report such adverse membership actions when taken against health care practitioners other than physicians and dentists.

Reportable actions must be based on reasons relating to professional competence or professional conduct which affects or could adversely affect the health or welfare of a patient. Matters not related to the professional competence or professional conduct of a physician or dentist are not to be reported to the NPDB.

For example, adverse actions against a practitioner based primarily on his or her advertising practices, fee structure, salary arrangement, affiliation with other associations or health care professionals, or other competitive acts intended to solicit or retain business are excluded from NPDB reporting requirements.

An adverse action taken by a professional society against the membership of a physician or dentist must be reported to the NPDB when that action constitutes a professional review action taken in the course of professional review activity through a formal peer review process, provided that the action is based on the member's professional competence or

professional conduct. Adverse membership actions involving censures, reprimands, or admonishments should not be reported.

Reporting Medicare/Medicaid Exclusions

In 1997, reports of exclusions from the Medicare and Medicaid programs against health care practitioners* were added to the NPDB through a collective effort and a Memorandum of Understanding between HRSA, the HHS Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS). The NPDB now includes Medicare/ Medicaid exclusions from May 1979 to the present.

NPDB Medicare/Medicaid exclusions identify practitioners who have been declared ineligible for Medicare and Medicaid payments. Hospitals, managed care organizations, and other providers are prohibited from billing the Medicare and Medicaid programs for any services that might be rendered by these providers. Information from the Medicare/Medicaid exclusions is released in accordance with the *Social Security Act*.

The HHS Office of Inspector General has the authority to exclude individuals and organizations from participating in the Medicare and/or certain State health care plans under sections 1128(a), 1128(b), 1892, or 1156 of the *Social Security Act*. The exclusion also applies to all other Executive Branch procurement and non-procurement programs and activities. Disclosure of the Office of Inspector General Exclusion List to HRSA is under authority of section 1106(a) of the *Social Security Act*, 42 CFR 401.105, and the routine use exception of the *Privacy Act* (5 U.S.C. 522a(b)(3)). CMS retains full responsibility for the content and accuracy of CMS exclusion reports; the NPDB only acts as a disclosure service. Notification of exclusion from CMS programs is made by CMS. Inquiries on the appropriateness or content of CMS exclusion reports must be referred to CMS for response.

**The NPDB contains Medicare/Medicaid exclusions against health care practitioners (i.e., physicians, dentists, chiropractors, psychologists, etc.). Exclusions against individuals other than licensed health care practitioners and entities, in addition to exclusions against health care practitioners, can be found in the Healthcare Integrity and Protection Data Bank (HIPDB).*

Sanctions for Failing to Report to the NPDB

Medical Malpractice Payers

The HHS Office of Inspector General has the authority to impose civil money penalties in accordance with Sections 421(c) and 427(b) of Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended. Under the statute, any malpractice payer that fails to report medical malpractice payments in accordance with Section 421(c) is subject to a civil money penalty of up to $11,000 for each such payment involved.

The civil money penalties provided for under Sections 421(c) and 427(b) are to be imposed in the same manner as other civil money penalties imposed pursuant to Section 1128A of the *Social Security Act*, 42 U.S.C. 1320a-7a. Regulations governing civil money penalties under Section 1128A are set forth at 42 CFR Part 1003.

Hospitals and Other Health Care Entities

The Secretary of HHS will conduct an investigation if there is reason to believe that a health care entity has substantially failed to report required adverse actions. If the investigation reveals that the health care entity has not complied with NPDB regulations, the Secretary will provide the entity with written notice describing the noncompliance. This written notice provides the entity with the opportunity to correct the noncompliance, as well as notifies it of its right to request a hearing.

A request for a hearing must contain a statement of the material factual issues in dispute to demonstrate cause for a hearing and must be submitted to HHS within 30 days of receipt of notice of noncompliance. An example of a material factual issue in dispute is a health care entity refuting HHS's claim that the health care entity failed to meet reporting requirements.

A request for a hearing will be denied if it is untimely, lacks a statement of material factual issues in dispute, or if the statement is frivolous or inconsequential. Hearings are held in the Washington, DC, metropolitan area.

If HHS determines that a health care entity has substantially failed to report information in accordance with Title IV requirements, the name of the entity will be published in the *Federal Register*, and the entity will lose the immunity provisions of Title IV with respect to professional review activities for a period of 3 years commencing 30 days from the date of publication in the *Federal Register*.

State Boards

State medical and dental boards that fail to comply with NPDB reporting requirements can have the responsibility to report removed from them by the Secretary of HHS. In such instances, the Secretary will designate another qualified entity to report NPDB information. State medical or dental boards do not meet Title IV requirements when they fail to report licensure disciplinary actions required to be reported to the NPDB or fail to notify HHS when they are aware a health care entity is failing to report adverse actions it has taken against physicians and dentists.

When an HHS investigation substantiates such reporting failures, a written notice of noncompliance is sent to the State medical or dental board. This notice allows State medical and dental boards an opportunity to correct the situation. If the State medical or dental board fails to comply with the HHS notice, then HHS will designate another qualified entity for reporting to the NPDB.

Professional Societies

A professional society that has substantially failed to report adverse membership actions can lose, for 3 years, the immunity protections provided under Title IV for professional review actions it takes against physicians and dentists based on their professional competence and professional conduct.

The Secretary of HHS will conduct an investigation if there is reason to believe that a professional society has substantially failed to report adverse membership actions taken as result of professional review activity.

If the investigation reveals that the professional society has not complied with Title IV reporting requirements, HHS will inform the professional society of its noncompliance in writing. This written notice provides the professional society with the opportunity to correct the noncompliance, as well as notifies it of its right to request a hearing.

A request for a hearing must contain a statement of the material factual issues in dispute to demonstrate cause for a hearing and must be submitted to HHS within 30 days of receipt of notice of noncompliance. An example of a material factual issue in dispute is a professional society refuting HHS's claim that the health care entity failed to meet reporting requirements.

A request for a hearing is denied if it is untimely, lacks a statement of material factual issues in dispute, or if the statement is frivolous or inconsequential. Hearings are held in the Washington, DC, metropolitan area.

If HHS determines that a professional society has substantially failed to report information in accordance with Title IV requirements, the name of the entity will be published in the *Federal Register*, and the professional society will lose the immunity provisions of Title IV with respect to professional review activities for a period of 3 years commencing 30 days from the date of publication in the *Federal Register*.

Questions and Answers

1. **How long are reports held in the NPDB?**

   Information reported to the NPDB is maintained permanently unless it is corrected or voided from the system. A Correction or Void may only be submitted by the reporting entity or directed by the Secretary of HHS.

2. **Can my organization provide a copy of an NPDB report to the subject practitioner?**

   The NPDB appreciates entities that attempt to maintain an open exchange with subjects. However, if you provide a copy of the report to the subject, be sure to remove or obliterate your organization's DBID. The DBID should remain confidential to the organization to which it is assigned.

3. **Where can I find lists of Adverse Action Classification Codes, Basis for Actions Codes, and Malpractice Act(s) or Omission(s) codes?**

   Adverse action classification codes and medical malpractice act(s) or omission(s) codes are provided in pop-up lists in the respective IQRS web input screens. These codes also are found in the applicable Interface Control Document (ICD) that is available on the NPDB-HIPDB website.

Reporting Medical Malpractice Payments

4. **I am the new authorized submitter for a medical malpractice payer. I found some documentation of payments that were not reported to the NPDB. What should I do?**

   If the payments were made on or after September 1, 1990 (when the NPDB opened), submit reports on those payments to the NPDB. The regulations prescribe that any entity that fails to report a payment required to be reported is subject to a civil money penalty of up to $11,000 for each such payment. Submit the report through the IQRS and then send a letter to the NPDB that explains the circumstance of the report being submitted late. The NPDB will maintain this information for audit purposes.

5. **As a medical malpractice payer, do I have to report payments made for a deceased subject?**

   Yes. One of the principal objectives of the NPDB is to restrict the ability of incompetent practitioners to move from State to State without disclosure of their previous damaging or incompetent performance. Fraudulent practitioners may seek to assume the identity of a deceased practitioner.

6. **Must a written complaint be directed to the subject cited in the claim?**

   No. The definition of a medical malpractice complaint includes complaints "brought in any State or Federal court or other adjudicative body." If a patient files a written complaint with, for example, a State board, and a medical malpractice payment results, the payment must be reported to the NPDB.

7. **How does a medical malpractice payer report a payment if a total amount has not been determined and the payer is making an initial partial payment?**

   Complete the MMPR screens according to the instructions on the IQRS. Note the amount of the first payment and, in the narrative section, explain that the total amount has not been determined and the first payment is a partial payment. When the final amount is determined, submit a Correction to the Initial report, and note the final amount in the narrative section.

8. **Should payment exclusively for the benefit of a clinic or hospital be reported?**

   Medical malpractice payments made solely for the benefit of a clinic or hospital are not currently reportable to the NPDB.

9. **Our insurance company reimbursed a practitioner for a medical malpractice payment the practitioner made to a patient. Is this reportable?**

   Yes. An insurance company that reimburses a practitioner for such a payment (makes a payment in response to the medical malpractice claim or judgment) must report that payment to the NPDB, as long as the patient submitted the demand in writing.

10. **If a patient makes an oral demand for a refund for services, is the resulting payment reportable to the NPDB?**

    No. Only payments resulting from written demands are reportable to the NPDB. Even if the practitioner transmits the demand in writing to the medical malpractice payer, the payment is not reportable if the patient's only demand was oral. However, if a subsequent written claim or demand is received from the patient and results in a payment, that payment is reportable.

11. **If an individual practitioner is not named in a medical malpractice claim or complaint, but the facility or practitioner group is named, should the payment be reported?**

    No, with one exception. If the named defendant is a sole practitioner identified as a "professional corporation," a payment made for the professional corporation must be reported for the practitioner.

12. **A supervisory practitioner is named in an action based on the services of a subordinate practitioner. How do I report the supervisory practitioner?**

    The report on the supervisory practitioner should be submitted using the same malpractice claim description code used for the subordinate. The reporting entity may provide an explanation that the supervisory practitioner was named based on the subordinate practitioner's services in the narrative description.

13. **What are the reporting requirements for self-insured employers who provide professional liability coverage for their employed practitioners?**

    Employers who insure their employees must report medical malpractice payments they make for the benefit of their employees.

14. **If a stipulation of settlement or court order requires that its terms remain confidential, how does a medical malpractice insurer report the payment to the NPDB without violating the settlement agreement or court order?**

    Confidential terms of a settlement or judgment do not excuse an entity from the statutory requirement to report the payment to the NPDB. The reporting entity should explain in the narrative section of the MMPR that the settlement or court order stipulates that the terms of the settlement are confidential.

15. **If there is no medical malpractice payment and Loss Adjustment Expenses (LAEs) are paid in order to release or dismiss a healthcare practitioner from a medical malpractice suit, should the LAE be reported?**

    No. If LAEs are not included in the medical malpractice payment, then they should not be reported to the NPDB.

16. **When reporting a medical malpractice payment, should loss adjustment expenses be included in the payment amount?**

    LAEs should be reported only if they are part of the medical malpractice payment. Reporting requirements include the total amount of the payment and a description and amount of the judgment or settlement and any conditions, including terms of payment. LAEs should be itemized in the description section of the report. LAEs refer to expenses other than those in compensation of injuries, such as attorney's fees, billable hours, expert witness fees, deposition, and transcript costs. If LAEs are not included in the payment amount, they need not be reported.

17. **Are payments made for the benefit of residents, interns, and students reportable?**

    Payments made for the benefit of licensed residents and interns **are** reportable to the NPDB; payments made for the benefit of unlicensed medical or dental students are **not** reportable to the NPDB.

Reporting Adverse Licensure Actions

18. **How should a State board report an action with several levels or components, for instance, a 6-month license suspension followed by a 2-year probation?**

    The board should report the code of the principal sanction or action and describe its full order, including lesser actions, in the narrative of the AAR. An additional report is not necessary when the lesser sanction or action is implemented since it was included in the description in the Initial Report.

19. **How should a State medical or dental board report actions when they are changed by court order?**

    The board should report the initial adverse action as usual; the judicial decision is reported as a Revision to Action. For example, if a board revoked a physician's license and a judicial appeal resulted in the court modifying the discipline to probation for 1 year, then the board would be required to report both its initial revocation action and the court-ordered revision to a 1-year probation. When a court stays a board's order, this action may be reported as a Revision to Action, using the Adverse Action Classification Code for Reduction of Previous Action (1295). When a court overturns a Board's order, the Board should void the Initial Report.

20. **When reporting a reprimand by a State licensing board, what Length of Action should be entered on the report form?**

    The indefinite block should be marked on the appropriate report screen in the IQRS for reprimands reported to the NPDB.

Reporting Adverse Clinical Privileges Actions

21. **If we revoke a practitioner's clinical privileges because the practitioner lost his/her license, do we report the revocation?**

    Administrative actions that do not involve a professional review action are not reportable to the NPDB. Only actions resulting from professional review and lasting more than 30 days that are related to the professional competence or professional conduct of a practitioner should be reported to the NPDB. Thus, if the revocation of clinical privileges is automatic, the action should not be reported to the NPDB.

22. **Are adverse actions on clinical privileges reportable prior to hearings?**

    The action is not reportable until it is made final by the health care entity. An exception is made if an immediate (that is, summary) suspension or restriction subject to subsequent notice and hearing is enforced because of imminent danger to an individual's health and safety.

    A summary suspension of clinical privileges is not routinely considered a reportable event. However, if a summary suspension lasts longer than 30 days and is considered by the hospital or other health care entity to be a professional review action (which means that it is so defined in the organization's bylaws), then the entity must report the summary suspension. If the reported suspension is subsequently altered following a hearing or other procedures, the entity must submit a Revision to Action or Void.

23. **Are adverse actions on clinical privileges reportable prior to appeals?**

    Adverse actions on clinical privileges are not reportable until they are made final by the health care entity. If an internal administrative appeal preceding final action by the entity is provided for in the entity's bylaws, then the action is not reportable until the conclusion of this appeal. However, if a previously reported adverse action is subsequently modified or vacated after an appeal by the practitioner, the health care entity is responsible for submitting a Revision to Action or Void.

24. **A health care entity took an adverse action against a practitioner, but the action was enjoined before it was implemented. Should the action be reported to the NPDB?**

    Adverse actions are reportable only if they are in effect for at least 30 days. An adverse action enjoined prior to implementation should not be reported. However, if the adverse action has been in effect for 30 or more days and is then enjoined, the adverse action should be reported and the enjoinment should be reported as a Revision to Action.

25. **Are investigations reportable if they do not reach a conclusion?**

    Investigations are not reportable events; however, if a practitioner surrenders or fails to renew clinical privileges, or if privileges are restricted while the practitioner is either under investigation by a health care entity for possible incompetence or improper professional conduct, or to avoid an investigation, the surrender or restriction must be reported to the NPDB.

26. **A practitioner is under investigation relating to possible incompetence or improper professional conduct and resigns from the hospital. If the practitioner did not receive notification of the investigation, is this a reportable event?**

    Under the provisions of the *Health Care Quality Improvement Act*, the practitioner is not required to have direct knowledge of the investigation. Hospitals should be able to produce evidence of an on-going investigation in the event of questioning. See the Investigations section of this chapter for more information.

    To be considered reportable, a practitioner's resignation must be tendered "in order to prevent a professional review action." A resignation tendered with the understanding that the hospital will cease an investigation or professional review action is reportable.

27. **Must a hospital or other health care entity report adverse actions concerning the clinical privileges of medical and dental residents and interns?**

    Not if the action was taken within the scope of the training program. Since residents and interns are trainees in graduate health professions education programs, they are not granted clinical privileges *per se*, but are authorized by the sponsoring institution to perform clinical duties and responsibilities within the context of their graduate educational program.

    However, a resident or intern may practice outside the scope of the formal graduate education program, for example, moonlighting in the Intensive Care Unit or Emergency Department. Adverse clinical privileges actions related to practice occurring outside the scope of a formal graduate educational program are reportable.

28. **If an initial application for clinical privileges is denied or the privileges granted are more limited than those requested, must this be reported to the NPDB?**

    Yes, if the denial or limitation of privileges is the result of a professional review action and is related to the practitioner's professional competence or professional conduct.

29. **If an "impaired practitioner" enters a rehabilitation program, is it reportable?**

    The **voluntary** entrance of an impaired practitioner into a rehabilitation program is not reportable to the NPDB if no professional review action was taken and the practitioner did not relinquish clinical privileges. If a practitioner takes a leave of absence and clinical privileges have not been taken away, then no report to the NPDB is required.

    If an impaired practitioner is required by a professional review action to **involuntarily** enter a rehabilitation program, **the professional review action** is reportable to the NPDB **if** it is based on the practitioner's professional competence or professional conduct and adversely affects the practitioner's clinical privileges for more than 30 days.

When completing the AAR input screen, the reporting entity can select an Adverse Action Classification Code of "Other" and explain in the narrative that the practitioner's privileges were restricted or suspended because of concerns regarding quality of care. Entities may wish to consult with their legal counsel regarding the wording of the narrative before it is submitted to the NPDB.

30. **An "impaired practitioner" member of a hospital medical staff has been repeatedly encouraged to enter a rehabilitation program. The practitioner continues to disregard the hospital's advice and offers of assistance. If an authorized hospital official, such as the CEO or Department Chair, directs the practitioner to give up clinical privileges and enter a rehabilitation program or face investigation relating to possible professional incompetence or improper professional conduct, is the surrender of clinical privileges reportable to the NPDB?**

    Yes. If the hospital CEO directs the practitioner to surrender his or her clinical privileges or face investigation by the hospital for possible professional incompetence or improper professional behavior, the surrender is reportable to the NPDB. The surrender of clinical privileges in exchange for not undergoing an investigation triggers a report to the NPDB, regardless of whether the practitioner is impaired [see §60.9 (a)(ii)(A) and (B) of the NPDB regulations].

31. **Laws related to drug and alcohol treatment programs have confidentiality provisions. Won't a report concerning a practitioner in a treatment program violate those provisions?**

    No. Only the adverse action affecting privileges must be reported; the fact that a practitioner entered a treatment or rehabilitation program should **not** be reported. If only the adverse action is reported as required, there is no violation of laws related to drug or alcohol treatment (42 USC, §290dd-3 and 290ee-3).

Reporting Adverse Membership Actions

32. **If a professional society denies membership to a practitioner, is it reportable to the NPDB?**

    The action must be reported to the NPDB if the denial of membership was based on a professional review action conducted through a formal peer review process and was based on an assessment of the practitioner's professional competence or professional conduct which affected or could affect the health and welfare of a patient or patients. Denial of membership for reasons **not** related to professional competence or professional conduct which affects or could adversely affect the health and safety of a patient (advertising practices or fee structures, for example) should not be reported to the NPDB.