Overview

The HIPDB acts as a flagging system; its principal goal is to prevent health care fraud and abuse and to improve the quality of patient care within the United States. Information on final adverse actions is collected from and disseminated to eligible entities. The HIPDB information should be considered with other relevant information in law enforcement investigations and evaluating the credentials of a practitioner, provider, or supplier.

Health plans and Federal and State Government agencies are responsible for reporting to the HIPDB final adverse actions taken against health care practitioners, providers, and suppliers. Final adverse actions include:

- Health care-related civil judgments entered in Federal or State court.
- Health care-related criminal convictions entered in Federal or State court.
- Federal or State licensing and certification actions.
- Exclusion from participation in Federal or State health care programs.
- Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

Settlements in which no findings or admissions of liability have been made are statutorily excluded from being reported. Additionally, actions with respect to medical malpractice claims are not reportable under the HIPDB's enabling statute.

All reports must be submitted electronically to the HIPDB. Reports may be submitted via the Internet using the NPDB-HIPDB Integrated Querying and Reporting Service (IQRS) at www.npdb-hipdb.com, or on diskette in a format specified by the HIPDB. The Interface Control Document (ICD), which specifies the format for diskette submission is available on the NPDB-HIPDB website.

Official Language

The official language of the HIPDB is English. All documents submitted to the HIPDB must be written in English. Documents submitted in any other language will not be accepted.

Computation of Time Periods

Health plans and Federal and State Government agencies must report final adverse actions to the HIPDB within 30 calendar days of the date the action was taken or the date when the reporting entity became

aware of the final adverse action, or by the close of the entity's next monthly reporting cycle, whichever is later.

In computing the time period for reporting to the HIPDB, the date of the act or event in question shall not be included. Saturdays, Sundays, and Federal holidays are to be included in the calculation of time periods. 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 the *Federal Rule of Civil Procedure #6*.

The information required to be reported to the HIPDB is applicable to all health care practitioners, providers, and suppliers.

The HIPDB system does not accept reports that do not include information in all mandatory fields. An entity's lack of mandatory information does not relieve it of its reporting requirements for the purposes of Section 1128E. The HIPDB suggests that entities obtain the information needed to complete mandatory fields for the HIPDB reports as part of their application process.

Time frame for Reporting Final Adverse Actions

Mandated HIPDB reporters must report all final adverse actions taken on or after August 21, 1996. This is the date of passage of the HIPDB legislation. The HIPDB cannot accept any report with a date of action taken prior to August 21, 1996.

Civil Liability Protection

The immunity provisions in Section 1128E protects individuals, entities, and their authorized agents from being held liable in civil actions for reports made to the HIPDB unless they have actual knowledge of falsity of the information. The statute provides the same immunity to DHHS in maintaining the HIPDB.

Types of Reports

Initial Report

The first record of an adverse action submitted to, and processed by, the HIPDB is considered the Initial Report. An Initial Report remains the current version of the report until a Revision to Action or a Correction or Void is submitted.

When the HIPDB processes an Initial Report submitted via the IQRS, a *Report Verification* document is stored for the reporting entity to retrieve through the IQRS. When an Initial Report is submitted on

diskette, the *Report Verification* document is sent to the reporting entity via the U.S. Postal Service. Additionally, a *Notification of a Report in the Data Bank(s)* is mailed to the subject of the report. The reporting entity and the subject of the report should review the information to ensure that it is correct.

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 HIPDB processes a Correction submitted via the IQRS, a *Report Verification* document is stored for the reporting entity to retrieve through the IQRS. When a Correction is submitted on diskette, the *Report Verification* document is sent to the reporting entity via the U.S. Postal Service. Additionally, a *Report Revised, Voided, or Status Changed* document is mailed to the subject of the report and to all queriers who received the previous version of the report within the past 3 years. The reporting entity and the subject of the report should review the information to ensure that it is correct, and queriers should note the changed report.

Void Previous Report

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

When the HIPDB processes a Void submitted via the IQRS, a *Report Verification* document is stored for the reporting entity to retrieve through the IQRS. When a Void is submitted on diskette, the *Report Verification* document is sent to the reporting entity via the U.S. Postal Service. Additionally, a *Report Revised, Voided, or Status Changed* document is mailed to the subject of the report and to all queriers who received the previous version of the report within the past 3 years. The reporting entity and the subject of the report should review the information to ensure that the correct report was voided, and queriers should note the void of the report.

Revision to Action

A Revision to Action is a new report denoting an action that relates to and modifies an adverse action previously reported to the HIPDB. The entity that reports an initial adverse action must also report any revision to that action.

Examples of Revisions to Action include the reinstatement of a license, the extension of an exclusion from a Government program, or the overturning of a judicial action. **A Revision to Action should not be reported unless the initial action was reported to the HIPDB.**

A Revision to Action is separate and distinct from a Correction. For example, if a reporting entity enters a Date of Action incorrectly, a Correction must be submitted to make the necessary change, and the Correction overwrites the previous version of the report. A Revision to Action is treated as an addendum to the previous report, but is filed as a separate, distinct action.

Example: A State licensing board submits an initial *Adverse Action Report* when it suspends a nurse practitioner's license for a period of 90 days. The suspension is later reduced to 45 days. Since this is a new action that modifies a previously reported action, the State licensing board must submit a new report using the Revision to Action option. The Initial Report documents that the State licensing board suspended the practitioner's license, and the Revision to Action documents that the State licensing board made a revision to the previous action.

When the HIPDB processes a Revision to Action submitted via the IQRS, a *Report Verification* document is stored for the reporting entity to retrieve through the IQRS. When a Revision to Action is submitted on diskette, the *Report Verification* document is sent to the reporting entity via the U.S. Postal Service. Additionally, a *Notification of a Report in the Data Bank(s)* is mailed to the subject of the report. The reporting entity and the subject of the report should review the information to ensure that it is correct.

Notice of Appeal

A Notice of Appeal is a report notifying the HIPDB that a subject has formally appealed a previously reported adverse action. A Notice of Appeal is separate and distinct from a subject's dispute of a HIPDB report. For more information regarding the HIPDB dispute process, refer to the Disputes section of this *Guidebook*.

When the HIPDB processes a Notice of Appeal submitted via the IQRS, a *Report Verification* document is stored for the reporting entity to retrieve through the IQRS. When a Notice of Appeal is submitted on diskette, the *Report Verification* document is sent to the reporting entity via the U.S. Postal Service. Additionally, a *Report Revised, Voided, or Status Changed* document is mailed to the subject of the report and to all queriers who received the previous version of the report within the past 3 years. The reporting entity and the subject of the report should review the information to ensure that it is correct, and queriers should note that the action upon which the report is based has been appealed.

Report Processing

Each version of a report processed by the HIPDB computer system is assigned a unique Document Control Number (DCN). This number is used to locate the report within the HIPDB system. The DCN is prominently displayed on all report documents. The DCN assigned to the most current version of the report must always be referenced in any subsequent action involving the report. For example, if an entity

wishes to correct an Initial Report it submitted, the entity must provide the DCN of that report when submitting the Correction to the HIPDB.

Report Responses

HIPDB responses to reports submitted via the IQRS are normally processed within four to six hours. HIPDB responses to reports submitted on diskette are sent to the reporting entity via the U.S. Postal Service within 10 business days of receipt.

Missing Report Verification

If you submit a report to the HIPDB and it is not available for retrieval from the IQRS within 5 business days, or if you submit a report on diskette and do not receive a response within 20 business days, call the NPDB-HIPDB Help Line to request a report status.

Reporting Judgments or Convictions

Health care-related judgments and convictions that must be reported to the HIPDB include: criminal convictions, civil judgments, injunctions, and *nolo contendere*/no contest pleas related to health care.

Federal or State Health-Care-Related Criminal Convictions

Federal, State, and local prosecutors must report criminal convictions against health care practitioners, providers, and suppliers related to the delivery of health care items or services. Section 1128E defines a criminal conviction as described in Section 1128(I) of the *Social Security Act*.

For the purposes of the HIPDB, a criminal conviction includes those cases:

- When a judgment or conviction has been entered against the individual or entity in a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment or conviction or other record relating to criminal conduct has been expunged.

- When there has been a finding of guilt against the individual or entity in a Federal, State, or local court.

- When a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court.

- When the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment or conviction has been withheld.

Examples of Reportable Criminal Convictions

(The following are actual descriptions of criminal convictions)

- A mental health institution is convicted of condoning physically abusive methods in controlling their patients and is sentenced to a large fine.

- The Chief Executive Officer of a health plan, a licensed physician, is convicted of embezzlement from the health plan and is sentenced to 4 years in prison.

- A chiropractor accepts kickbacks from a medical supply company in exchange for patient referrals. Both the chiropractor and the medical supply company are convicted, and each is sentenced to a $20,000 fine.

- A practitioner accepts small sums of money for referral to a specialist. The offense results in a deferred conviction in which he must satisfy a 2-year probationary period before the conviction is dropped.

- A Durable Medical Equipment (DME) company is sentenced as a result of pleading guilty to receiving an illegal kickback of $489,000. The DME company received the kickback payment as inducement to permit another DME supplier to provide incontinence kits to Medicare beneficiaries. These beneficiaries lived in a chain of nursing homes owned by the same management as the DME company. As a result of the kickback payment, Medicare paid approximately $3.6 million for incontinence supplies which were not medically necessary. The court ordered that the company pay a fine of $293,400 and that the defendant corporation be placed on probation for 2 years. During that period, the company was directed to implement and submit to the court a corporate compliance program, including a schedule for implementation.

- Two owners/operators of two separate ambulance companies were sentenced for their part in a Medicaid fraud scheme. Each was sentenced to 12 months and one day incarceration to be followed by 3 years supervised probation, and ordered to pay $2,000 in restitution. The owners purchased Medicaid information, which identified recipients who had been transported to the hospital by car or by public transportation, from an individual who worked at a local hospital. The owners used the information to create false claims, then billed Medicaid for ambulance services which were never provided. They received more than $120,000 as a result of the false claims.

- A man was sentenced for conspiracy to submit false Medicare claims in connection with his two durable medical equipment (DME) companies and his medical diagnostic company. His sentence included 21 months incarceration, payment of $1 million in restitution (offset by any money the Government recovers from the sale of his house) and 3 years supervised release. From 1992 to

1996, the company owner paid patient recruiters to bring Medicare beneficiaries to certain licensed physicians whom he paid to order DME and diagnostic testing. Through his companies, he then submitted Medicare claims for DME and oximetry tests that were not rendered or were not medically necessary.

- Two former owners of a home health agency (HHA) were sentenced for participating in a scheme to defraud Medicare. The co-owners included $296,000 in expenses not related to patient care in their cost reports. These expenses were fictitiously claimed as consulting and salary payments to family and friends. One of the HHA owners was sentenced to 8 months incarceration followed by 2 months in a halfway house as part of a 3-year supervised release program. The other was sentenced to 5 months imprisonment and 3 years supervised probation. The owners were also ordered to pay restitution totaling $244,472.

Examples of Non-Reportable Criminal Convictions

- A civil judgment against a physician is reached for medical malpractice and the jury awards $15,000 to the plaintiff.

- A practitioner is found to be addicted to a drug, and instead of being convicted for possession and abuse, the practitioner is given a deferred conviction and is sent to a rehabilitation facility.

Injunctions

Federal and State prosecutors and investigative agencies must report injunctions against health care practitioners, providers, and suppliers. The injunction must be related to the delivery of a health care item or service to be reportable.

Example of a Reportable Injunction

A pharmaceutical company distributes a drug that produces harmful side effects in rare cases, and the FDA imposes an injunction to stop the production of the drug.

Example of a Non-Reportable Injunction

A practitioner has an injunction imposed against him by his wife, whom he has been harassing.

Nolo Contendere/No Contest Plea

Federal and State prosecutors and investigative agencies must report *nolo contendere*/no contest pleas by health care practitioners, providers, and suppliers. A plea of *nolo contendere* has the same effect as

a plea of guilty as far as the criminal sentence is concerned, but may not be considered as an admission of guilt for any other purpose. The *nolo contendere*/no contest plea must be related to the delivery of a health care item or service to be reportable.

Example of a Reportable Nolo Contendere/No Contest Plea

A practitioner pleads *nolo contendere* to insurance fraud related to health care.

Example of a Non-Reportable Nolo Contendere/No Contest Plea

A provider pleads *nolo contendere* to insurance fraud not related to health care.

Health Care-Related Civil Judgments

Federal and State attorneys and health plans must report civil judgments against health care practitioners, providers, or suppliers related to the delivery of a health care item or service, regardless of whether the civil judgment is the subject of a pending appeal. If a Government agency is party to a multi-claimant civil judgment, it must assume the responsibility for reporting the entire action, including all amounts awarded to all the claimants, both public and private. When a government agency is not a party, but there are multiple health plans as claimants, the health plan which receives the largest award is responsible for reporting the total action for all parties.

Examples of Reportable Civil Judgments

- A judgment is made against a clinical laboratory, resulting in a $10,000 award for fraudulent billing and misleading marketing in a suit brought by health insurers and health care payers.

- A judgment against a nursing home imposes a $50,000 fine for neglect and for failure to adequately clean the patients' rooms.

- A judgment against an ambulance transportation company results in a $30,000 fine for filing false and fraudulent claims and receiving payment for ambulance transportation to destinations not permitted by law, not medically necessary, and for patients whose ambulatory state did not require such transportation.

- A health plan does not cover cosmetic procedures. A plastic surgeon misrepresents to health plan members that a certain type of cosmetic surgery is covered by health care insurance although it is not. The member has the cosmetic surgery. The surgeon sends in the claim to the health plan mischaracterizing the surgery as a non-cosmetic procedure and is paid by the health plan.

Subsequently, the health plan discovers the fraudulent claims and sues to recover the overpayment. A judgment is rendered awarding the health plan $300,000.

Examples of Non-Reportable Civil Judgments

- A judgment imposes a $40,000 fine on a medical supplies company for hiring discrimination.
- A judgment of $30,000 is rendered against a practitioner for medical malpractice.
- A settlement that is reached outside the court.
- A judgment against a practitioner stemming from an automobile accident not related to the delivery of a health care item or service.

Reporting Adverse Actions

Adverse actions that must be reported to the HIPDB include: licensure and certification actions, Government health care program certification actions, exclusions from Federal and State health care programs, health care related criminal convictions and civil judgments, and other adjudicated actions or decisions as established by regulation.

Adverse Licensure or Certification Actions

Federal and State licensing and certification agencies must report final adverse licensure actions taken against health care practitioners, providers, or suppliers. A reportable final adverse licensure action must be a formal or official action; it need not be specifically related to professional competence or conduct. Such actions include, but are not limited to:

- Formal or official actions, such as the revocation or suspension of a license or certification agreement or contract for participation in Federal or State health care programs (and the length of any such suspension), reprimand, censure, or probation.

- Any other loss of license, certification agreement, or contract for participation in Federal or State health care programs; or the right to apply for or renew a license or certification agreement or contract of the practitioner, provider, or supplier, whether by operation of law, voluntary surrender, non-renewal (excluding nonrenewals due to nonpayment of fees, retirement, or change to inactive status), or otherwise.

- Any other negative action or finding by a Federal or State agency that is publicly available information and is rendered by a licensing or certification authority, including, but not limited to, limitations on the scope of practice, liquidations, injunctions, and forfeitures. This also includes final adverse actions

rendered by a Federal or State licensing or certification authority, such as exclusions, revocations, or suspension of license or certification that occur in conjunction with settlements in which no finding of liability has been made (although such a settlement itself is not reportable under the statute). This definition excludes administrative fines or citations, corrective action plans and other personnel actions unless they are connected to the billing, provision or delivery of health care services and taken in conjunction with other licensure or certification actions such as revocation, suspension, censure, reprimand, probation, or surrender.

Federal and State adverse licensure actions are reported under the appropriate licensure category on the *Adverse Action Report*. Adverse actions taken with regard to a certification agreement or contract for participation in Federal or State health care programs are reported under the Government Administrative action category on the *Adverse Action Report*.

Examples of Reportable Actions

The following adverse licensure actions must be reported to the HIPDB:

- The denial of an application for licensure (initial or renewal).
- A licensure disciplinary action taken by a State Licensing agency based upon the practitioner's, provider's, or supplier's deliberate failure to report a licensure disciplinary action taken by another licensing agency, when a report of such action is requested on a licensure application.
- Voluntary surrender of a license.

Examples of Non-Reportable Actions

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

- A settlement agreement which imposes the monitoring of a practitioner, provider, or supplier for a specific period of time, unless such monitoring constitutes a restriction on the licensee, or is considered to be a reprimand.
- A licensure disciplinary action which is imposed with a "stay" pending completion of specific programs or actions.
- The voluntary relinquishment of a practitioner's license for personal reasons such as retirement or change to inactive status.
- Licensure actions taken against non-health care practitioners, providers, or suppliers.
- An initial application for licensure in which a physician has failed to pass the required licensure exam is not accepted by a State Medical Board. In this case, there is no formal or official action to deny the license, making the event non-reportable.

Exclusions from Participation in Federal/State Health Care Programs

Federal and State agencies must report health care practitioners, providers, or suppliers excluded from participating in Federal or State health care programs. The term "exclusion" means a temporary or permanent debarment of an individual or entity from participation in a Federal or State health-related program, in accordance with which items or services furnished by such person or entity will not be reimbursed under any Federal or State health-related program. Section 1128E limits the definition of Federal or State health care programs to those programs defined in Sections 1128B(f) and 1128(h), respectively, of the *Social Security Act*.

Exclusions from Federal or State health care programs are reported under the Exclusion or Debarment category on the *Adverse Action Report*.

Examples of a Reportable Exclusion

A practitioner is excluded from a State Medicaid program after pleading guilty to filing false claims.

A physician was indefinitely excluded from a State Medicaid program because her medical license was suspended in Texas. The doctor's license suspension was due to several complaints, including placing an epidural catheter in a patient's abdomen during child birth, instead of properly placing the catheter in the spinal canal.

Example of a Non-Reportable Exclusion

A practitioner is found guilty in a criminal proceeding of filing false claims to Medicare, but is not excluded from a Federal or State health care program. This would be reportable only as a health-care-related criminal conviction.

Other Adjudicated Actions or Decisions

Federal and State Government agencies and health plans must report adjudicated actions or decisions against health care practitioners, providers, and suppliers. The term "other adjudicated actions or decisions" means:

(1) formal or official final actions taken against a health care practitioner, provider, or supplier by a Federal or State Government agency or a health plan;
(2) which include the availability of a due process mechanism; and
(3) based on acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service.

A hallmark of any valid adjudicated action or decision is the availability of a due process mechanism. The fact that the subject elects not to use the due process mechanism provided by the authority bringing the action is immaterial, as long as such a process is available to the subject before the adjudicated action or decision is made final. In general, if an adjudicated action or decision follows an agency's established administrative procedures (which ensure that due process is available to the subject of the final adverse action), it would qualify as a reportable action under this definition. The definition specifically excludes clinical privileging actions taken by Federal or State Government agencies and similar paneling decisions made by health plans. For health plans that are not Government entities, an action taken following adequate notice and the opportunity for a hearing that meets the standards of due process set out in section 412(b) of the HCQIA (42 U.S.C. 11112(b)) also would qualify as a reportable action under this definition.

The termination by a health plan or Federal or State agency of a practitioner's contract to provide health care services is reportable to the HIPDB if it meets the definition of an "other adjudicated action."

Examples of Reportable Other Adjudicated Actions or Decisions

The following are reportable when they meet the criteria indicated above:

- A health plan has a preferred provider contract with a psychiatrist allowing the psychiatrist to be directly paid by the plan at negotiated rates for covered psychiatric services to be rendered to plan members. It is discovered that the psychiatrist is sexually abusing his patients. The health plan, prior to a criminal adjudication, seeks to have the psychiatrist removed as a contracted practitioner by terminating the psychiatrist's contract with the health plan. If the action against the psychiatrist results in the termination of the psychiatrist's contract, this would be reportable. In this case, the contract termination is reportable, not the health plan's revocation of the psychiatrist's clinical privileges.

- A health plan has a preferred provider contract with a surgeon allowing the surgeon to be directly paid by the plan at negotiated rates for covered surgical services to be rendered to plan members. Complaints are received by the plan regarding the poor quality of the surgeon's services and patient care. After having the opportunity to be heard regarding the allegations the plan terminates his practitioner contract based upon quality of services and poor patient care.

- A health plan personnel-related suspension without pay against a practitioner.
- A Federal or State Government Agency reduction in pay action against a practitioner.
- A personnel-related action such as reductions in grade for cause.
- A personnel-related action such as a termination.
- A Federal or State Government contract terminated for cause.

Examples of Non-reportable Other Adjudicated Actions or Decisions

- An overpayment determination against a practitioner made by a Federal or State Government health care program, its contractor, or a health plan.

- A denial of claim determination against a practitioner made by a Federal or State Government agency or a health plan.

- A revocation of a physician's clinical privileges by a health plan or Federal or State hospital.

Submitting Reports to the HIPDB

The IQRS is designed to capture all of the necessary information for the successful submission of *Adverse Action Reports* and *Judgment or Conviction Reports* to the HIPDB. It is important to remember that if a record is incomplete (i.e., information is missing in required fields), the IQRS does not allow a report to be submitted to the HIPDB until the missing information is added.

Character Limits

Each data field in the IQRS is limited to a certain number of characters, including spaces and punctuation. Data are processed by the HIPDB system exactly as they are submitted by the reporting entity; **the HIPDB will not change any data in a report.**

The narrative description field allows the reporting entity to enter up to 2,000 characters, including spaces and punctuation. Any characters over the 2,000-character limit will not be accepted by the IQRS.

Subject Information

All required data fields identifying the subject of the report must be completed before the report can be submitted. Reporters should provide as much information as possible about the subject practitioner, provider, or supplier, even in fields that are not required. The inclusion of this information helps to ensure the accurate identification of the subject of the report.

When Subject Information is Unknown

The HIPDB suggests that each reporting entity review the mandatory data fields for reporting practitioners, providers, and suppliers, and make an effort to collect this information for each possible subject BEFORE there is cause to file a report. A report cannot be filed if required information is missing.

Incorrectly Identified Subject

If an entity reports information on the wrong practitioner, provider, or supplier, the reporting entity must submit a Void of the incorrect report, then submit a new report for the correct subject.

Failure to Report

Federal and State Government Agencies

If HHS determines that a Government agency has substantially failed to report information in accordance with Section 1128E, the name of the entity will be published.

Health Plans

Any health plan that fails to report information on an adverse action required to be reported to the HIPDB will be subject to a civil money penalty of up to $25,000 for each such adverse action not reported.

Questions and Answers

1. **What information will my organization be required to report if we are a HIPDB mandated reporter?**

   This information can be found in the HIPDB regulations, and depends upon the type of final adverse actions your organization takes against health care practitioners, providers, and suppliers.

2. **When will my organization be required to start reporting if we are a HIPDB mandated reporter?**

   Mandated HIPDB reporters have an obligation to report all final adverse actions against health care practitioners, providers, and suppliers taken on or after August 21, 1996. This is the date the of

passage of the HIPDB legislation. *The HIPDB cannot accept reports of actions taken before August 21, 1996.*

3. What is the penalty for failure to report an action to the HIPDB?

Health plans are subject to a fine of up to $25,000 for each failure to report. The Secretary shall provide for the publication of the names of the Government agencies that fail to report as required.

4. Will HIPDB mandated reporters who also report to the NPDB have to report the same action separately to the two Data Banks?

No. The statute requires that the HIPDB be implemented in a manner that avoids the duplication of the reporting requirements established for the NPDB. Therefore, entities that must report actions to both the NPDB and HIPDB will submit each report once. The IQRS will then automatically route the reports to the appropriate Data Bank(s).

5. How long are reports held in the HIPDB?

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

6. Can my organization provide a copy of a HIPDB report to the subject practitioner, provider, or supplier?

The HIPDB 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 Data Bank Identification Number (DBID). The DBID must remain confidential to the organization to which it is assigned.

7. I'm trying to report a practitioner who did not attend a Professional School, but the *Professional School(s) Attended* and *Year(s) of Graduation* fields are mandatory. How should I complete these fields?

Place "None" in the *Professional School(s) Attended* field and place the year the individual was approved or first licensed in the field in the *Year(s) of Graduation* field.

Reporting Adverse Licensure Actions

8. How should a State Board report an action with several levels or components, for instance, a six-month license suspension followed by a two-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 *Adverse Action Report*. 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.

9. How should a State Licensing 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 one year, then the Board would be required to report both its initial revocation action and the court-ordered revision to a one-year

probation. When a court stays a Board's order, this action must also be reported as a Revision to Action.

10. When reporting a reprimand by a State Licensing Board, what Length of Action should be entered on the report form?

The Indefinite selection (formerly code "99") should selected on the appropriate report screen in the IQRS for reprimands reported to the HIPDB.

Reporting Exclusions or Debarments

11. After an exclusion period is over and the practitioner is reinstated, is the initial exclusion report voided?

No. The HIPDB retains reports of final adverse actions permanently, or until they are corrected or voided by the reporting entity or at the direction of the Secretary of HHS.

12. Is there a minimum period of exclusion time for an exclusion to be reportable?

No. Any amount of exclusion time is reportable.

Reporting Criminal Convictions

13. If an individual is convicted of a health care-related offense, does the 30 days to report begin when the individual is convicted or when the individual is sentenced?

The report must be submitted within 30 calendar days of the date that the subject is convicted.

14. Is a deferred conviction still reportable when the probationary period of the deferred conviction is successfully completed?

Yes. When the reporting agency is aware of the deferred conviction, the report must be submitted within 30 calendar days or the end of the monthly reporting cycle, whichever is later. The report should be submitted before the probationary period is completed, and reporting is not dependent upon the successful completion of the probation.

Reporting Injunctions

15. If an injunction is placed on a supplier, but the supplier plans to appeal the action, does the supplier still get reported?

Yes. If, after the appeal, the injunction is lifted, a Revision to Action must be filed.

Reporting Other Adjudicated Actions or Decisions

16. My organization, an HMO, recently terminated a physician. It seems like this action is reportable to both the HIPDB and the NPDB. How do I report this action?

If the physician's termination was considered a professional review action that resulted in the revocation of the physician's clinical privileges, the action is reportable to the NPDB. If the physician's termination was considered an other adjudicated action and resulted in the termination of the physician's contract with the HMO to provide health care services, it is reportable to the HIPDB. If the HMO revokes the physician's clinical privileges **and** terminates his contract, the HMO

must report the adverse clinical privileges action to the NPDB and the contract termination to the HIPDB.

Reporting Nolo Contendere/No Contest Plea

17. Is a plea of "guilty" the same as a plea of "*nolo contendere*"?

Yes, as far as the reportability of the action is concerned, however a plea of *nolo contendere* may not be considered as an admission of guilt for any other purpose.

Reporting Civil Judgments

18. A practitioner is guilty of medical malpractice and settles with the plaintiff. Is this reportable?

No. The HIPDB does not collect information on medical malpractice payments. However, if the practitioner was subsequently debarred from a Federal or State health care program as a result of the medical malpractice, the debarment would be reportable to the HIPDB.