Healthcare Integrity and Protection Data Bank

GUIDEBOOK

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Preface

This *Guidebook* is meant to serve as a resource for users of the Healthcare Integrity and Protection Data Bank (HIPDB). It is one of a number of efforts to inform the health care community about the HIPDB and what is required to comply with the requirements established by Section 1128E of the *Social Security Act*, the legislation governing the HIPDB. This *Guidebook* contains information on the HIPDB that governmental agencies (including law enforcement), health plans, and health care practitioners, providers, and suppliers will need to interact with the HIPDB.

Final regulations governing the HIPDB will be published in the *Federal Register* and will be codified at 45 CFR Part 61. Responsibility for HIPDB implementation resides in the U.S. Department of Health and Human Services (DHHS).

The *Guidebook* is divided into broad topical sections. This Introduction contains general information on the HIPDB, which includes its history, the laws and regulations that govern it, and other information for authorized users. The Eligible Entities section describes the organizations that are eligible reporters and queriers. The HIPDB Practitioners, Providers, and Suppliers section defines the subjects of reports submitted to the HIPDB, and provides basic explanations about HIPDB self-queries and report information. The HIPDB Reports section identifies the types of actions that must be reported to the HIPDB, and the Disputes section provides information on the HIPDB dispute process.

Background

Health care fraud burdens the Nation with enormous financial costs and threatens health care quality and patient safety. Estimates of annual losses due to health care fraud range from 3 to 10 percent of all health care expenditures--between $30 billion and $100 billion, based on estimated 1997 expenditures of more than $1 trillion.

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA), Public Law 104-191, enacted August 21, 1996, requires the Secretary of DHHS (Secretary), acting through the Office of Inspector General (OIG) of DHHS and the United States Attorney General, to create a national health care fraud and abuse control program. Among the major components of this program is the establishment of a national data bank to receive and disclose certain final adverse actions against health care practitioners, providers, and suppliers. This data bank is known as the Healthcare Integrity and Protection Data Bank (HIPDB); the legislation which brought it into being also is referred to as Section 1128E of the *Social Security Act* (Section 1128E).

The legislation for the HIPDB stipulates that there be:

* Protection of privacy.

* Civil liability protection.

* Coordination with the National Practitioner Data Bank (NPDB).

* User fees for disclosure of information.

* Regular reports (not less than monthly).

* Dispute procedures.

Elaboration of these provisions are found throughout this *Guidebook*. Explanation of the protection of privacy, civil liability protection, and NPDB coordination are included in the following sections.

Interpretation of HIPDB Information

The purpose of the HIPDB is to combat fraud and abuse in health insurance and health care delivery and to promote quality care. The HIPDB is primarily a flagging system that may serve to alert users that a more comprehensive review of a practitioner's, provider's, or supplier's past actions may be prudent. HIPDB information is intended to be used in combination with information from other sources (e.g., evidence of current competence through continuous quality improvement studies, peer recommendations, verification of training and experience, and relationships with organizations) in making determinations on employment, affiliation, certification, or licensure decisions.

The information in the HIPDB should serve only to alert Government agencies and health plans that there *may* be a problem with a particular practitioner's, provider's, or supplier's performance. HIPDB information should *not* be used as the sole source of verification of a practitioner's, provider's, or supplier's professional credentials.

Confidentiality of HIPDB Information

Information reported to the HIPDB is considered confidential and shall not be disclosed except as specified in the HIPDB regulations at 45 CFR Part 61. The confidential receipt, storage, and disclosure of information is an essential ingredient of HIPDB operations. A comprehensive security system has been designed to prevent manipulation of, and access to the data by unauthorized staff or external sources via the Internet. The facility in which the HIPDB is housed meets DHHS security specifications, and the HIPDB's staff has undergone an in-depth background security investigation.

Persons or entities who receive information from the HIPDB either directly or indirectly are subject to the confidentiality provisions. When an Authorized Agent is designated to handle HIPDB queries or reports, both the entity and the agent are required to maintain confidentiality in accordance with HIPDB requirements.

The *Privacy Act*, 5 USC §552a, protects the contents of Federal systems of records on individuals, like those contained in the HIPDB, from disclosure without the individual's consent, unless the disclosure is for a routine use of the system of records as published annually in the *Federal Register*. The published routine uses of HIPDB information do not allow disclosure to the general public. The limited access provision of Section 1128E of the *Social Security Act* supersede the disclosure requirements of the *Freedom of Information Act* (FOIA), 5 USC §552, as amended.

The confidentiality provisions of Section 1128E do not prohibit an eligible entity receiving information from the HIPDB from disclosing information to others who are part of the investigation or peer review process, as long as the information is used for the purpose for which it was provided.

One example of the appropriate use of HIPDB information is a health plan that discloses the information it received from the HIPDB to health plan officials responsible for reviewing a chiropractor's application for affiliation. In this case, both the health plan personnel who received the information and the health plan officials who subsequently reviewed it during the employment process are subject to the confidentiality provisions of HIPDB.

The confidentiality provisions do not apply to the original documents or records from which the reported information is obtained. The HIPDB's confidentiality provisions do not impose any new confidentiality requirements or restrictions on those documents or records. Thus, these confidentiality provisions do not bar or restrict the release of the underlying documents, or the information itself, by the entity taking the adverse action. For example, if a health plan that reported an adverse action against a chiropractor pursuant to the provisions of the HIPDB receives a subpoena for the underlying records, it may not refuse to provide the requested documents on the grounds that HIPDB bars the release of the records or information.

Individual health care practitioners, providers, and suppliers who obtain information about themselves from the HIPDB are permitted to share that information with whomever they choose.

The statute requires the Secretary to assure that HIPDB information is provided and used in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services. **Patient names are not to be submitted in HIPDB reports**.

Persons or entities who receive information from the HIPDB either directly or indirectly are subject to the above confidentiality provisions. The statute does not specify a penalty for violating the

confidentiality provisions of the HIPDB. However, other Federal statutes may subject individuals and entities to criminal penalties, including fines and imprisonment, for the inappropriate use or disclosure of HIPDB information.

Official Language

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

Disclosure of the HIPDB Information

Section 1128E limits the disclosure of information in the HIPDB. HIPDB information is available, upon request, to:

* Federal and State Government agencies.

* Health plans.

* Health care practitioners, providers, and suppliers requesting information concerning themselves.

* Persons or organizations requesting information in a form which does not permit the identification of any particular patient or health care practitioner, provider, or supplier.

The limited access provision of Section 1128E does not allow the disclosure of HIPDB information to the general public.

Civil Liability Protection

The immunity provisions in Section 1128E protect 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 similar immunity to DHHS in maintaining the HIPDB.

Coordination Between the HIPDB and the NPDB

The NPDB is a national data bank that was established through Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended. It is primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. The NPDB acts as a clearinghouse of information relating to medical malpractice payments

and adverse actions taken against the licenses, clinical privileges, and professional society memberships of physicians, dentists, and other licensed health care practitioners.

To alleviate the burden on those entities that must report to both the HIPDB and NPDB, a system has been created to allow an entity that must report the same adverse action to both Data Banks to submit the report only once. This Integrated Querying and Reporting System (IQRS) is able to sort the appropriate actions into the HIPDB, the NPDB, or both. Similarly, entities authorized to query both Data Banks have the option of querying both the NPDB and the HIPDB with a single query submission.

All final adverse actions taken on or after August 21, 1996 (the date Section 1128E was passed), must be reported to the HIPDB. The HIPDB cannot accept any report with a date of action taken prior to August 21, 1996.

User Fees

User fees will be charged for all queries for HIPDB information submitted by non-Federal agencies and health plans and for self-queries submitted by health care practitioners, providers, or suppliers. Section 1128E exempts Federal entities from paying these fees. Refer to the NPDB-HIPDB website for details regarding the payment of HIPDB user fees.

What is an Eligible Entity?

Entities eligible to participate in the Healthcare Integrity and Protection Data Bank (HIPDB) are defined in the provisions of Section 1128E of the *Social Security Act* and in the HIPDB Final Rule. Eligible entities are responsible for meeting Section 1128E reporting and/or querying requirements, as appropriate, and must certify in writing their eligibility to report to and/or query the HIPDB.

The HIPDB provides information to entities and individuals who are eligible to receive HIPDB information. The HIPDB collects information regarding licensure and certification actions, exclusions from participation in Federal and State health care programs, criminal convictions, and civil judgments related to health care. While Section 1128E requires the reporting of such adverse actions, there are currently no mandatory querying requirements associated with the HIPDB.

To be eligible to report to and/or query the HIPDB, an entity must be:

* A Federal or State Government agency.
* A health plan.

Each entity is responsible for determining its eligibility to participate in the HIPDB and must certify that eligibility to the HIPDB in writing.

Defining Entities

Federal or State Government Agency

Federal or State Government agencies include, but are not limited to, the following:

* The U.S. Department of Justice (e.g., the Federal Bureau of Investigation, the U.S. Attorney, the Drug Enforcement Administration).
* The U.S. Department of Health and Human Services (e.g., the Food and Drug Administration, the Health Care Financing Administration, the Office of Inspector General).
* Any other Federal agency that either administers or provides payment for the delivery of health care services, including (but not limited to) the U.S. Department of Defense and the U.S. Department of Veterans Affairs.
* Federal and State law enforcement agencies, including States Attorneys General and law enforcement investigators (e.g., County and District Attorneys, County Police Departments).

* State Medicaid Fraud Control Units.
* Federal or State agencies responsible for the licensing or certification of health care practitioners, providers, and suppliers. Examples of such State agencies include Departments of Professional Regulation, Health, Social Services (including State Survey and Certification and Medicaid Single State agencies), Commerce, and Insurance.

Health Plan

The term "health plan" refers to a plan, program or organization that provides health benefits, whether directly or through insurance, reimbursement or otherwise. Entities may be recognized as "health plans" if they meet the basic criterion of "providing health benefits." Health plans include, but are not limited to:

* A policy of health insurance.

* A contract of a service benefit organization.

* A membership agreement with a health maintenance organization or other prepaid health plan.

* A plan, program, or agreement established, maintained, or made available by an employer or group of employers; a practitioner, provider, or supplier group; a third-party administrator; an integrated health care delivery system; an employee welfare association; a public service group or organization; or a professional association.

* An insurance company, insurance service, or insurance organization that is licensed to engage in the business of selling health care insurance in a State, and which is subject to State law which regulates health insurance.

Health plans may include those plans funded by Federal and State governments, including:

* Medicare.
* Medicaid.
* The U.S. Department of Defense.
* The U.S. Department of Veterans Affairs.
* The Bureau of Indian Affairs programs.

Registering with the HIPDB

Eligible entities are responsible for meeting Section 1128E reporting and/or querying requirements. Entities not currently registered with the HIPDB are responsible for determining their eligibility before registering with the HIPDB. The HIPDB issues a Data Bank Identification Number (DBID) and a password to each successfully registered entity. An entity that does not have this information is not registered with the HIPDB. Entity registration packages may be obtained by calling the NPDB-HIPDB Help Line at 1 (800) 767-6732.

The consolidated *Entity Registration Form* allows entities to register simultaneously for both the HIPDB and the NPDB. The information requested on this form provides the HIPDB with essential information concerning your entity, such as your organization's name, address, Federal Taxpayer Identification Number (TIN), and ownership; your organization's authority to participate in the HIPDB and/or the NPDB under each of the statutes governing the Data Banks (Section 1128E for the HIPDB; and Title IV and Section 1921 of the *Social Security Act* for the NPDB); your organization's primary function or service; and, for those entities authorized by law to query both Data Banks, whether queries are to be submitted to the HIPDB only, to the NPDB only, or to both Data Banks. This information allows the HIPDB to register your entity's authorization to participate in the HIPDB, to determine your entity's reporting and/or querying requirements and restrictions, and to direct query and report responses appropriately.

The *Entity Registration Form* also contains certification information that must be completed by an entity's Certifying Official. The entity's Certifying Official certifies the legitimacy of the registration information provided to the HIPDB and/or the NPDB. The certification section must contain an original ink signature and a signature date. Faxed, stamped, or photocopied signatures are unacceptable. The title of the Certifying Official, a telephone number, and an E-mail address also must be provided.

Once the completed *Entity Registration Form* is received and processed, the HIPDB assigns a unique, confidential Data Bank Identification Number (Data Bank ID or DBID) and sends an *Entity Registration Verification* document to the entity. This document contains the entity's confidential DBID and password, as well as the information that was provided to the HIPDB on the *Entity Registration Form*. The Certifying Official should read the document carefully and, if the document contains any errors, follow the instructions provided on the document for correcting the inaccurate information.

HIPDB responses to reports and queries are retrieved via the HIPDB's Integrated Querying and Reporting Service (IQRS). Entities and Agents must log onto the NPDB-HIPDB website to retrieve their report and query responses. Responses that are not viewed or printed within 30 days of being placed by the HIPDB into the IQRS will be deleted, and the entity or Agent will be required to resubmit the information.

Entity Recertification

The HIPDB requires periodic recertification of eligibility by entities. The HIPDB will send the current registration information to each active entity. The entity's Certifying Official should review the information to ensure that it is correct, indicate the applicable certification statement, sign the document, and return it to the HIPDB.

Data Bank Identification Numbers

Each entity that registers with the HIPDB is assigned a unique DBID and password. DBIDs are used by the HIPDB to identify registered entities and Agents, and must be provided on all reports, queries, and correspondence submitted to the HIPDB.

Your entity's DBID is a link into the HIPDB computer system and should be safeguarded to prevent inadvertent disclosure. A DBID is revealed only to the entity or Agent to which it is assigned. In the event that your entity's DBID is compromised, follow the instructions in "Deactivating a Data Bank Identification Number" section below.

The assignment of a DBID is not a representation by HHS that an entity meets the eligibility criteria for participation in the HIPDB, as specified in Section 1128E. It is each entity's responsibility to determine whether it meets the eligibility criteria and to certify that eligibility to the HIPDB.

DBIDs are assigned only to entities that certify their eligibility to the HIPDB and to Authorized Agents who act on behalf of registered entities; ***DBIDs are not assigned to Authorized Submitters or other individuals associated with a reporting or querying entity.***

Deactivating a Data Bank Identification Number

If at any time your entity relinquishes eligibility to participate in the HIPDB, you must notify the HIPDB to deactivate your DBID. The *Entity Registration Update* form, which can be retrieved from the NPDB-HIPDB website, must be completed in order to request deactivation. The reason for deactivation must be provided on the completed form when it is returned to the HIPDB for processing.

An eligible entity, by completing an Entity Registration Update form, may request at any time that its current DBID be deactivated and a new DBID assigned. For instance, if you believe that your entity's DBID has been compromised in any way, or if your entity merges with another entity. The reason for requesting a new DBID must be provided on the completed form when it is returned to the HIPDB for processing.

Reactivating a Data Bank Identification Number

If your entity's DBID is currently inactive and your entity determines that it should be active, the Certifying Official should obtain an *Entity Registration Update* form from our webiste to request that the DBID be reactivated. The reason for reactivation must be provided on the completed form when it is returned to the HIPDB for processing.

Updating Entity Information

If your entity's name, address, statutory authority, organization type, Certifying Official, or any other item of your registration information changes, your entity's Certifying Official should obtain an *Entity Registration Update* form from our website.

When the HIPDB receives updated entity information, the updated information is processed into the HIPDB computer system and an *Entity Registration Verification* document, reflecting the changes submitted, is mailed to the entity's Certifying Official. The Certifying Official should read the document carefully and, if the document contains any errors, follow the instructions provided on the document for correcting the inaccurate information.

Lost Your Data Bank Identification Number?

If your data become corrupted or you want to deactivate your current DBID and activate a new one, call the NPDB-HIPDB Help Line for assistance.

Individuals Who May Report to and/or Query on Behalf of Entities

Queries and reports may be submitted to, and responses may be retrieved from, the HIPDB on behalf of registered entities by Authorized Submitters or Authorized Agents. These individuals are defined as follows:

Authorized Submitter

An Authorized Submitter is the individual selected and empowered by a registered entity to certify the legitimacy of information reported to or requested from the HIPDB via the IQRS. In most cases, the Authorized Submitter is an employee of the organization submitting the report or query (such as an Administrator, Medical Staff Services Officer, or Risk Manager). An entity may choose to have multiple Authorized Submitters. For example, an entity may designate a particular individual within the organization to be the Authorized Submitter for reporting, and another individual to be the Authorized Submitter for querying. The Authorized Submitter is often the individual designated by the organization to submit and

retrieve report and/or query responses from the HIPDB; however, other response staff personnel may be designated, as desired.

Authorized Agents

Registered entities may elect to have outside organizations report to and/or query the HIPDB on their behalf. An organization that reports to and/or queries the HIPDB on an entity's behalf is referred to as the Authorized Agent. In most cases, an Authorized Agent is an independent contractor to the entity (e.g., National Council of State Boards of Nursing, Federation of Chiropractic Licensing Boards, Credentialing Verification Organization) used for centralized credentialing and/or professional oversight.

Entities must ensure that certain guidelines are followed when designating an Authorized Agent to report and/or query on their behalf. Entities should establish a written agreement with the Agent confirming the following:

* The Agent must be authorized to conduct business in the State.

* The Agent's facilities must be secure to ensure the confidentiality of HIPDB responses.

* The agreement with the Authorized Agent must explicitly prohibit the Agent from using information obtained from the HIPDB for any purpose other than that for which the disclosure was made. For example, two different health plans designate the same Authorized Agent to query the HIPDB on their behalf. Both health plans wish to request information on the same practitioner. The Authorized Agent must query the HIPDB **separately** on behalf of each health plan. The response to a HIPDB query submitted for one health plan cannot be shared with another health plan.

* The entity should ensure that the Authorized Agent has a copy of the most recent Guidebook (which includes the regulations and the civil money penalty regulations of the Office of Inspector General, HHS, at 45 CFR Part 1003) and should make the Authorized Agent aware of the sanctions that can be taken against the Authorized Agent if information is requested, used, or disclosed in violation of HIPDB provisions.

Designating Authorized Agents

Before an Authorized Agent may act on behalf of an entity, the entity must designate the Agent to interact with the HIPDB on its behalf. Registered entities that want to designate an Authorized Agent should obtain an *Authorized Agent Designation* form from the NPDB-HIPDB website. The entity must complete the form, providing the Authorized Agent's name, DBID (if known), address, and telephone number; and the entity's response routing and fee payment preferences, and return it to the HIPDB.

Authorized Agents must be registered with the HIPDB before they can be designated to report and/or query on behalf of eligible entities. If the Agent is not registered with the HIPDB, the Agent must obtain an *Authorized Agent Registration* form the NPDB-HIPDB website. Once the Agent is registered, a DBID and an electronic mailbox password will be assigned to that Agent, and the entity can designate that Agent to report and/or query on its behalf.

HIPDB responses to reports and queries submitted by an Authorized Agent will be routed to **either** the eligible entity **or** its Authorized Agent, as indicated by the entity on the *Authorized Agent Designation* form. If the entity wishes to retrieve responses from the IQRS via its own electronic mailbox, the entity must have access to the Internet (i.e., an Internet Service Provider) and an Internet browser (either Microsoft Internet Explorer or Netscape Communicator, Version 4.0 or newer).

An Authorized Agent should have only **one** DBID, even though more than one entity may designate the Agent to query the HIPDB. If an Authorized Agent has been issued more than one DBID, the Authorized Agent should obtain an *Agent Registration Update* form from our website, indicating which DBID it intends to use and to request that any other DBIDs be deactivated.

Any changes to an Authorized Agent designation, such as a change to response routing or termination of an Authorized Agent's authorization to query on an entity's behalf, must be submitted by the entity. If changes in an Authorized Agent designation are required, the entity should obtain an *Authorized Agent Designation Update* form from the NPDB-HIPDB website.

Questions and Answers

1. **How do I know if my organization is an eligible entity?**
   To be eligible to participate in the HIPDB, an organization must meet the definition of a Government agency or a health plan, as defined under Section 1128E of the *Social Security Act*. See §61.3, Definitions, of the HIPDB regulations.

2. **Can the HIPDB certify or verify that my organization is eligible to report or query?**
   Each entity must determine its own eligibility to participate in the HIPDB. The HIPDB regulations describe the criteria for eligibility. Other informational materials designed to assist you in determining your organization's eligibility can be found on the NPDB-HIPDB website.

3. **Does my entity have to notify the HIPDB when we have a new Certifying Official?**
   Yes. The eligible entity gives the Certifying Official authority to certify the legitimacy of registration information provided to the HIPDB. The person authorized by the entity to act as the Certifying Official may change at any time at the discretion of the entity. However, the HIPDB makes a record

of the staff title and name of the individual assigned as the Certifying Official and should be notified when changes occur.

4. Can my organization query the HIPDB if we are not mandated reporters under Section 1128E?

No. The statute defines queriers and reporters as the same organizations.

5. If my entity queries the HIPDB, is it also required to report? Conversely, if my entity reports to the HIPDB, is it automatically eligible to query?

Yes. Entities that report to HIPDB are automatically eligible to query.

6. Is my entity required to query the HIPDB?

No. Section 1128E does not set mandatory querying requirements for any entity.

7. Can my entity have more than one DBID?

If you have multiple departments or people who handle HIPDB querying and/or reporting, you may register each department or person separately and receive a separate DBID for each one. However, it should be noted that the different DBIDs cannot help each other (i.e., one department cannot download a response from a query entered by another department with a different DBID). Also, special care must be taken to be sure that the same report or query is not submitted twice.

8. Which law enforcement agencies will have access to the HIPDB?

The following are examples of law enforcement agencies that are eligible to access the HIPDB: the Office of Inspector General in the Department of Health and Human Services, the Department of Justice, the Federal Bureau of Investigation, the State Medicaid Fraud Control Units, the State Attorneys General, the District Attorneys, and the State law enforcement agencies that are involved in health care investigations. In addition, other Federal Inspectors' General and other Federal law enforcement agencies that are involved in health care investigations are eligible to access the HIPDB.

9. Are hospitals eligible to access the HIPDB?

Section 1128E does not allow hospitals to query or report to the HIPDB unless the hospital meets the definition of a health plan or Federal or State agency.

Overview

The HIPDB collects and maintains information regarding final adverse actions taken against health care practitioners, providers, and suppliers. HIPDB information is intended to be used to help combat health care fraud and abuse, and to improve the quality of patient care. Examples of the types of actions in which HIPDB information should be used in combination with information from other sources include, but are not limited to: affiliation, certification, credentialing, contracting, hiring, and licensure.

Definitions

Since there is considerable overlap in the roles of practitioners, providers, and suppliers (e.g., a skilled nursing facility is an institutional provider, but also can be a supplier of health care items and equipment), the terms "practitioner," "provider," and "supplier" are not intended to describe distinct, mutually exclusive categories, nor are the examples provided intended to be exhaustive.

Licensed Health Care Practitioner, Licensed Practitioner, and Practitioner

An individual who is licensed or otherwise authorized by the State to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized.

Health Care Provider

* A provider of services as defined in Section 1861(u) of the Social Security Act .
* Any health care entity that provides health care services and follows a formal peer review process for the purpose of furthering quality health care (including an HMO, PPO, or group medical practice).
* Any other health care entity that, directly or through contracts, provides health care services.

Health Care Supplier

A provider of medical or other health care services as described in Section 1861(s) of the *Social Security Act*; or any individual or entity who furnishes, whether directly or indirectly, or provides access to, health care services, supplies, items, or ancillary services (including, but not limited to, durable medical equipment suppliers; manufacturers of health care items; pharmaceutical suppliers and manufacturers; health record services such as medical, dental and patient records; health data suppliers; and billing and transportation service suppliers). The term also includes any individual or entity under contract to provide such supplies, items, or ancillary services; health plans as defined in 45 CFR 61.3 (including employers that are self-insured); and health insurance producers (including but not limited to agents, brokers, solicitors, consultants, and reinsurance intermediaries).

Examples of Practitioners (Include, but are not limited to):

Chiropractor

Counselor
Counselor, Mental Health
Professional Counselor
Professional Counselor, Alcohol
Professional Counselor, Family/Marriage
Professional Counselor, Substance Abuse

Dental Service Provider
Dentist
Dental Resident
Dental Assistant
Dental Hygienist
Denturist

Dietician/Nutritionist
Dietician
Nutritionist

Emergency Medical Technician (EMT)
EMT, Basic
EMT, Cardiac/Critical Care
EMT, Intermediate EMT, Paramedic

Nurse/Advanced Practice Nurse
Registered (Professional) Nurse
Nurse Anesthetist
Nurse Midwife
Nurse Practitioner
Licensed Practical or Vocational Nurse

Nurses Aide/Home Health Aide
Nurses Aide
Home Health Aide (Homemaker)

Eye and Vision Service Provider
Ocularist
Optician
Optometrist

Pharmacy Service Provider
Pharmacist
Pharmacist, Nuclear
Pharmacy Assistant

Physician
Allopathic Physician (MD)
Allopathic Physician Intern/Resident
Osteopathic Physician (DO)
Osteopathic Physician Intern/Resident

Physician Assistant
Physician Assistant, Allopathic
Physician Assistant, Osteopathic

Podiatric Service Provider
Podiatrist
Podiatric Assistant

Psychologist, Clinical

Rehabilitative, Respiratory, and Restorative Service Provider
Art/Recreation Therapist
Massage Therapist
Occupational Therapist
Occupational Therapy Assistant
Physical Therapist
Physical Therapy Assistant
Rehabilitation Therapist
Respiratory Therapist
Respiratory Therapy Technician

Social Worker

Speech, Language, and Hearing Service Provider
Audiologist
Speech/Language Pathologist

Technologist
Medical Technologist
Cytotechnologist
Nuclear Medicine Technologist
Radiation Therapy Technologist
Radiologic Technologist

Other Health Care Practitioner
Acupuncturist
Athletic Trainer
Homeopath
Medical Assistant
Midwife, Lay (Non-nurse)
Naturopath
Orthotics/Prosthetics Fitter
Perfusionist
Psychiatric Technician

Examples of Health Care Providers and Suppliers (Include, but are not limited to):

Individuals

Health Care Facility Administrator
Adult Care Facility Administrator
Hospital Administrator
Long-Term Care Administrator

Health Insurance Provider/Supplier
Insurance Agent
Insurance Broker

Organizations

Ambulance Service/Transportation Company

Group or Practice
Chiropractic Group/Practice
Dental Group/Practice
Medical Group/Practice
Mental Health/Substance Abuse Group/Practice
Optician/Optometric Group/Practice
Physical/Occupational Therapy Group/Practice
Podiatric Group/Practice

Health Care Supplier/Manufacturer
Biological Products Manufacturer
Blood Bank
Durable Medical Equipment Supplier
Fiscal/Billing/Management Agent
Nursing/Health Care Staffing Service
Organ Procurement Organization
Eyewear Equipment Supplier
Pharmacy
Pharmaceutical Manufacturer
Portable X-Ray Supplier
Purchasing Service

Health Insurance Company

Home Health Agency/Organization

Hospice/Hospice Care Provider

Hospital
General/Acute Care Hospital
Psychiatric Hospital
Rehabilitation Hospital
Federal Hospital

Other Health Care-Related Occupation
Accountant
Bookkeeper
Business Manager
Business Owner
Corporate Officer
Researcher, Clinical
Salesperson

Hospital Unit
Psychiatric Unit
Rehabilitation Unit

Laboratory/CLIA Laboratory

Nursing Facility/Skilled Nursing Facility

Research Center/Facility

Other Health Care Facility
Adult Day Care Facility
Ambulatory Surgical Center
Ambulatory Clinic/Center
End Stage Renal Disease Facility
Health Center/Federally Qualified Health Center/Community Health Center
Intermediate Care Facility for Mentally Retarded/Substance Abuse
Mammography Service Provider
Mental Health Center/Community Mental Health Center
Outpatient Rehabilitation Facility/Comprehensive Outpatient Rehabilitation Facility
Radiology/Imaging Center
Residential Treatment Facility/ Program
Rural Health Clinic

Managed Care Organization
Health Maintenance Organization
Preferred Provider Organization
Provider Sponsored Organization
Religious/Fraternal Benefit Society Plan

Practitioner, Provider, and Supplier Self-Queries

Practitioners, providers, and suppliers may query the HIPDB regarding themselves (self-query) at any time. A practitioner, provider, or supplier may initiate a self-query by completing, printing, and returning the self-query form found on the NPDB-HIPDB website to the following address:

NPDB-HIPDB
P.O. Box 10832
Chantilly, VA 20151

Additional information on the self-query process can be obtained on the NPDB-HIPDB website.

A practitioner, provider, or supplier who submits a self-query to the HIPDB will receive in response either a notification that no information exists in the HIPDB, or a copy of all report information submitted by eligible reporting entities about the practitioner, provider, or supplier.

Fees are charged for all self-queries to the HIPDB, and must be paid by credit card. Further details regarding the payment of self-query fees are found on the NPDB-HIPDB website.

Practitioner, Provider, or Supplier Information in the HIPDB

The HIPDB is committed to maintaining accurate information and ensuring that health care practitioners, providers, and suppliers are informed when adverse actions are reported. When the HIPDB receives a report, the information is processed by the HIPDB computer system exactly as submitted by the reporting entity. Reporting entities are responsible for the accuracy of the information they report to the HIPDB.

When the HIPDB processes a report, a *Report Verification Document* is sent to the reporting entity, and a *Notification of a Report in the Data Bank(s)* is sent to the subject. The practitioner, provider, or supplier who is the subject of the report should review the report for accuracy, including such information as current address, telephone number, and place of employment. **Subjects may not submit changes to reports.** If any information in a report is inaccurate, the subject must contact the reporting entity to request that it file a correction to the report. The HIPDB is prohibited by law from modifying information submitted in reports.

If the reporting entity refuses to correct the *Adverse Action Report* or the *Judgment or Conviction Report*, the subject of the report may:

* Add a statement to the report.
* Initiate a dispute of the report.
* Add a statement and initiate a dispute.

For further details regarding the HIPDB dispute process, refer to the Disputes section of this *Guidebook*.

Questions and Answers

1. How do I correct my address if it is wrong in a report?

Because neither the HIPDB nor a subject of a report may modify information contained in a report, you must contact the reporting entity (identified in the *Notification of a Report in the Data Bank(s)* document) and request that it correct the address on the report. If the reporting entity does not honor your request to correct the inaccurate address, you may dispute the report. Refer to the Disputes section of this *Guidebook* for more information about the HIPDB dispute process.

2. Can a health plan or a State Licensing Board require that I give them the results of my self-query?

The response you receive to a self-query is yours to do with as you wish. Various licensing, credentialing, and insuring organizations may require a copy of your self-query response before you may participate in their program. Any arrangement between you and one of these organizations is voluntary; HHS does not regulate such arrangements.

3. The reporter has denied your request to correct the report. The regulations say that only the reporter can make changes to the report. What can the subject do?

You may add a 2,000-character statement to the report, stating what you believe occurred. Also, if you believe the reporter does not meet the appropriate criteria to even submit a report, or if there are factual inaccuracies in the report, you may initiate a dispute of the report. Refer to the Disputes section of this *Guidebook* for more information about the HIPDB dispute process.

Overview

The HIPDB is a resource to assist health plans and Federal and State Government agencies to conduct law enforcement investigations and reviews of the qualifications of health care practitioners, providers, and suppliers. The primary goals of the HIPDB are to help prevent fraud and abuse in the national health care system and to improve the quality of patient care. In addition, queriers may use HIPDB information in making decisions regarding affiliation, verification, contracting, credentialing, employment, and licensure of practitioners, providers, and suppliers.

The HIPDB collects and disseminates to eligible queriers information on:

* Health care-related civil judgments taken in Federal or State court.
* Health care-related criminal convictions taken in Federal or State court.
* Injunctions.
* Federal or State licensing and certification actions, including revocations; reprimands; censures; probations; suspensions; and any other loss of license, or the right to apply for or renew a license, whether by voluntary surrender, non-renewability, or otherwise.
* Exclusions from participation in Federal and State health care programs.
* Any other adjudicated actions or decisions defined by regulation (see the Reports chapter of this *Guidebook*).

HIPDB Information is available, upon request, to:

* Federal and State Government agencies.
* Health plans.
* Health care practitioners, providers, and suppliers requesting information concerning themselves (self-query).
* Persons or organizations requesting information in a form which does not permit the identification of any particular patient or health care practitioner, provider, or supplier.

The limited access provisions of the Section 1128E do not allow the disclosure of HIPDB information to the general public.

The HIPDB system will not allow entities to submit queries which do not include information in all mandatory fields. The HIPDB suggests that entities include, as part of the application process, information needed to complete mandatory fields for HIPDB queries.

Types of Queriers

Federal and State Government Agencies

Criminal justice authorities, government investigators, and prosecutors may query the HIPDB to further investigations on health care practitioners, providers, and suppliers. Federal and State prosecutors (e.g., Federal Bureau of Investigation, U.S. Attorney) may also use HIPDB information in making decisions to accept plea agreements or in making sentencing recommendations to the court.

Other governmental organizations may query the HIPDB with respect to credentialing, licensing, or certification of health care practitioners, providers, and suppliers. Some components in this group administer or provide payment for health care items or services, while others audit, evaluate, and review program operations to ensure effectiveness and efficiency. Those organizations responsible for licensing and certification functions may choose to query the database to confirm or collect information during the review of initial or renewal applications. Similarly, other Federal or State agency users (e.g., State Medical Board, Food and Drug Administration) may choose to query the HIPDB to determine a practitioner's, provider's, or supplier's eligibility for participation, or to ensure that subjects have been reported properly.

Health Plans

Health plans may have a variety of reasons for querying the HIPDB, principally in relation to credentialing or contracting with practitioners, providers, and suppliers. Health plans may query on specific subjects who have applied or are being considered for association with the plan.

Health plans also may query the HIPDB to detect and investigate potential fraudulent and abusive activity related to the payment or delivery of health care services. Typically, health plan units develop cases for presentation to Government investigators and prosecutors, who, in turn, take the information and move toward criminal, civil, or administrative actions. HIPDB information may also be used by the health plan's parent organization to pursue civil actions against a specific practitioner, provider, or supplier.

Practitioners, Providers, and Suppliers

Practitioners, providers, and suppliers may request information about themselves (self-query) from the HIPDB at any time, for any purpose.

Submitting a Query to the HIPDB

Eligible entities prepare and submit queries using the NPDB-HIPDB's Integrated Querying and Reporting Service (IQRS). Entities may submit single-name or multiple-name (batch) queries electronically to the HIPDB via modem through the Internet. When the HIPDB processes query data submitted via the IQRS, the query response is stored for the querying entity to retrieve through the IQRS.

Equipment Needed to Query Electronically

Eligible entities that wish to query must have Internet access and an Internet browser; either Microsoft Internet Explorer Version 4.01 Service Pack 2 (or higher) or Netscape Communicator Version 4.08 (or higher). In addition, a plug-in or stand-alone program that can read files in Portable Document Format (PDF), such as Adobe Acrobat Reader 4.0, is required. A printer is required to print responses to queries and reports.

Querying Through an Authorized Agent

The HIPDB's response to a query submitted by an Authorized Agent on behalf of an entity will be based upon two eligibility standards: (1) the entity must be entitled to receive the information, and (2) the Agent must be authorized to receive that information on behalf of that entity.

Before an Authorized Agent submits a query on behalf of an entity, the entity must indicate to the HIPDB whether the query responses are to be returned either to the entity or to the Agent; responses may not be returned to both. **The entity must have the capability to receive the response through the IQRS if the response is to be routed back to the entity**.

Authorized Agents must understand that they cannot use a query response for a particular practitioner, provider, or supplier on behalf of more than one entity. The HIPDB regulations specify that information received from the HIPDB must be used solely for the purpose for which it was provided. Therefore, an Authorized Agent that queries on a particular practitioner, provider, or supplier on behalf of one health plan may not use the query response for that practitioner, provider, or supplier for a different health plan.

An eligible querier that has designated an Authorized Agent is also permitted to query the HIPDB directly. Responses to queries submitted by the entity will be returned to the entity, regardless of routing designated for queries submitted by the Agent.

Lost Your HIPDB Password?

If you have already registered for the HIPDB and cannot locate your password, call the NPDB-HIPDB

Help Line for assistance. The Help Line will assist you in obtaining a new password for your organization.

Query Processing

When the HIPDB receives a properly completed query, the information is entered into the HIPDB computer system. The computer system performs a validation process that matches subject (i.e., practitioner, provider, or supplier) identifying information submitted in the query with information previously reported to the HIPDB. Information reported about a specific practitioner is released to an eligible querier **only** if the identifying information provided in the query matches the information in a report.

Each query processed by the HIPDB computer system is assigned a unique Document Control Number (DCN). This Document Control Number is used by the HIPDB to locate the query within the computer system. The DCN is prominently displayed in a query response. If a question arises concerning a particular query, the entity must reference the DCN in any correspondence to the HIPDB.

Character Limits

Each field in a query (such as Name, Work Address, and License Number) is limited to a certain number of characters, including spaces and punctuation. The IQRS will not allow the entity to use more than the allotted number of characters. **The HIPDB will not change any information submitted in a query.**

Query Responses

Each time a query is successfully processed by the HIPDB computer system, a query response is stored for the querying entity to retrieve through the IQRS. Practitioners, providers, and suppliers who self-query will receive paper responses sent by First Class U.S. mail.

When there is no information in the HIPDB about a subject practitioner, provider, or supplier, the querier will receive in response only the subject identifying information provided in the query and a notification that no information about the subject practitioner, provider, or supplier is contained in the HIPDB. Query information is not retained on subjects for whom no adverse actions have been reported.

Query Response Times

A query on one practitioner, provider, or supplier is considered a single-name query; a query on more than one practitioner, provider, or supplier is considered a multiple-name query. Each single-name query is assigned a unique DCN. A multiple-name query is assigned a Batch DCN, and each name within the query is assigned an individual DCN.

All queries submitted electronically via the IQRS are normally processed within four to six hours of receipt. However, during periods of high volume, the processing time may be longer.

Ideally, information from the HIPDB will be considered during the credentialing process. However, the HIPDB law does not require querying entities to receive query responses from the HIPDB before proceeding with hiring or the issuance of licenses. Because the HIPDB is one of several resources for the credentials review process, entities may act on applications according to their established criteria and information obtained from other sources.

Missing Query Responses

If you submit a query to the HIPDB via the IQRS and have not received a response within one week, call the NPDB-HIPDB Help Line to request a query status.

Correcting Query Information

If the information you submitted in a query does not accurately identify the practitioner, provider, or supplier on whom you intended to query, your query will not match HIPDB reports submitted with correct identifying information. To query the HIPDB with the proper identifying information on the subject, submit a new, correctly completed query to the HIPDB.

Failure to Query

Querying the HIPDB is optional. There are no mandatory querying requirements placed on eligible queriers.

Questions and Answers

1. When I register with the HIPDB, am I automatically registered to use the IQRS?

Yes. Your organization's DBID and password for the IQRS are included on the *Entity Registration*

Verification document mailed to your organization at the time your entity is registered with the HIPDB. If you lose your DBID or password, contact the NPDB-HIPDB Help Line.

2. Can I submit queries to the HIPDB on diskette, as I did for the NPDB?

No. All queries submitted to the HIPDB must be submitted electronically, via the IQRS.

3. If I cannot find, or did not receive, a response to a query, may I request a copy from the HIPDB?

No. The HIPDB currently does not have the capability to produce duplicate responses. If you did not receive a response to a query and were not charged for the query, the query has not been processed by the HIPDB and should be resubmitted. Once processed by the HIPDB, query responses will be maintained on the IQRS for 30 days. After 30 days, the responses will be deleted from the IQRS, and the entity will have to resubmit the query to receive a response.

4. Can I designate more than one Authorized Agent to query for my entity?

Yes. The HIPDB computer system can accommodate multiple Authorized Agents for each querying entity.

5. If I decide to designate an Authorized Agent, or to change from one Agent to another, how long will it take before the Authorized Agent can query for my organization?

If the Agent is already registered with the HIPDB and has been assigned a DBID, the HIPDB will send notification documents to your organization. You should check the document to ensure that all information is correct. Your Authorized Agent will be able to query on your organization's behalf immediately upon your receipt of the notification documents.

If the Agent is not already registered with the HIPDB, the Agent must call the NPDB-HIPDB Help Line to obtain an *Authorized Agent Registration* form. Once the Agent is registered, a DBID and password will be assigned to that Agent, and the entity can designate that Agent to report and/or query on its behalf.

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.

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.

The Dispute Process

The HIPDB is committed to maintaining accurate information and ensuring that health care practitioners, providers, and suppliers are informed when adverse actions are reported. When the HIPDB receives a report, the information is processed by the HIPDB computer system exactly as submitted by the reporting entity. Reporting entities are responsible for the accuracy of the information they report to the HIPDB.

When the HIPDB processes a report, a *Report Verification Document* is provided to the reporting entity, and a *Notification of a Report in the Data Bank(s)* is sent to the subject. The subject should review the report for accuracy, including such information as current address, telephone number, and place of employment. **Subjects may not submit changes to reports.** If any information in a report is inaccurate, the subject must contact the reporting entity to request that it file a Correction to the report. The HIPDB is prohibited by law from modifying information submitted in reports.

If the reporting entity declines to change the report, the subject may initiate a dispute of the report through the HIPDB dispute process, add a statement to the report, or both. The dispute process is not an avenue to protest a judgment or to appeal the underlying reasons of an adverse action affecting the subject's license or inclusion in a Federal or State health care program. Neither the merits of a criminal or civil suit nor the appropriateness of, or basis for an adverse action may be disputed.

Subjects who wish to add a statement to and/or dispute the factual accuracy of a report should follow the instructions on the *Notification of a Report in the Data Bank(s)*. Subjects who do not have the original *Notification of a Report in the Data Bank(s)* may obtain a *Subject Statement and Dispute Initiation* form from the NPDB-HIPDB website.

Subject Statements

The subject of a report may add a statement to a report at any time. When the HIPDB processes a statement, notification of the statement is sent to all queriers who received the report within the past 3 years, and will be included with the report when it is released to future queriers.

Subject Statements are limited to 2,000 characters, including spaces and punctuation. **Subject Statements must not include any patient names.** Drafting a statement in accordance with the character limits ensures that the statement will contain the information a subject deems most important. All characters beyond 2,000 will not be accepted.

A Subject Statement is part of the specific report for which it is filed. If the report is changed by the reporting entity, the statement attached to the report also will be removed. If a statement is needed with

the new report, a new statement will have to be submitted to the HIPDB, referencing the Document Control Number (DCN) of the new report.

Subject Disputes

The subject of an *Adverse Action Report* or *Judgment or Conviction Report* contained in the HIPDB may dispute either the factual accuracy of a report or whether a report was submitted in accordance with the HIPDB's reporting requirements, including the eligibility of the entity to report the information to the HIPDB. A subject may *not* dispute a report in order to appeal the underlying reasons for an adverse action.

If a subject believes that information in a report is factually inaccurate (for instance, an incorrect adverse action code or judgment date) or should not have been reported (for instance, a suspension or criminal conviction not related to health care), the subject must attempt to resolve the disagreement directly with the reporting entity. **Changes to the report may be submitted only by the reporting entity**.

When the HIPDB processes a dispute, notification of the dispute is sent to all queriers who received the report within the past 3 years, and will be included with the report when it is released to future queriers.

A dispute is part of the specific report for which it is filed. If the report is changed by the reporting entity, the dispute notation attached to the report also will be removed. If the subject believes that the new version of the report is factually inaccurate, the subject must initiate a new dispute of the changed report.

Secretarial Review

If the reporting entity declines to change the disputed *Adverse Action Report* or *Judgment or Conviction Report* or takes no action, the subject may request that the Secretary of DHHS review the disputed report. The Secretary will review disputed reports only for accuracy of factual information and to ensure that the information was required to be reported.

The Secretary will not review:

- The merits of a civil judgment or criminal conviction.

- The appropriateness of, or basis for a health plan's adjudicated action or a Government agency's or State Licensing Board's adverse action.

To request the review of a disputed report by the Secretary, the subject must sign and return to the HIPDB the Secretarial Review request page attached to the *Report Revised, Voided, or Status Changed*

document related to the disputed report. Please note that the dispute and any accompanying documentation must be sent to the HIPDB, not directly to the Secretary.

The subject also must:

- State clearly and briefly in writing which **facts** are in dispute and what the subject believes are the facts.
- Submit documentation substantiating that the reporting entity's information is inaccurate. Documentation must directly relate to the facts in dispute and must substantially contribute to a determination of the factual accuracy of the report. Documentation may not exceed 10 pages, including attachments and exhibits.
- Submit proof that the subject attempted to resolve the disagreement with the reporting entity, but was unsuccessful. Proof may be a copy of the subject's correspondence to the reporting entity and the entity's response, if any.

The subject of the report should wait for 30 days from the date of initiating discussions with the reporting entity before requesting Secretarial Review of the disputed report, to allow the reporting entity time to respond to a dispute.

Pertinent Documentation

If the dispute relates to an *Adverse Action Report*, pertinent documentation might include a copy of:

- The findings of fact and recommendations of the health plan or State Licensing Board.
- The final report of the hearing panel or other appellate body upon which the description of the acts or omissions was based.

If the dispute relates to a *Judgment or Conviction Report*, pertinent documentation might include a copy of:

- The court judgment.
- The injunction document.

If necessary, the Secretary will ask the reporting entity to supply additional information confirming that the report was submitted in accordance with HIPDB regulations. Entities must respond to a request for more information from the Secretary within 15 days. After reviewing all documentation related to the dispute,

the Secretary will determine whether the information in the disputed report is accurate and should have been reported to the HIPDB.

Secretarial Review Results

When the HIPDB receives proper notice of a request for Secretarial Review, the materials will be forwarded to the Secretary of DHHS for review. There are three possible outcomes for Secretarial Review of a dispute:

- The Secretary concludes that the report is accurate.
- The Secretary concludes that the report is inaccurate.
- The Secretary concludes that the issues in dispute are outside the scope of Secretarial Review.

Report Accurate as Submitted

If the Secretary concludes that the information in the report is accurate, the Secretary will send an explanation of the decision to the subject practitioner, provider, or supplier. The subject may then submit, within 30 days, a statement that will be added to the report. The statement is limited to 2,000 characters, including spaces and punctuation, and will be entered into the HIPDB computer system exactly as submitted. The new Subject Statement will replace any statement the subject submitted previously.

The subject of the report, the reporting entity, and all queriers who received notice of the disputed report within the past 3 years will receive a *Report Revised, Voided, or Status Changed* document containing the Secretary's explanation and the subject's statement. Future queriers will receive the subject's statement with the report.

Report Inaccurate as Submitted

If the Secretary concludes that the report is inaccurate, the Secretary will direct the HIPDB to correct the information in the report. The subject of the report, the reporting entity, and all queriers who received notice of the disputed report within the past 3 years will receive a *Report Revised, Voided, or Status Changed* document informing them of the correction.

If the Secretary concludes that the report was submitted in error, the Secretary will direct that the report be voided from the HIPDB. The subject of the report, the reporting entity, and all queriers who received notice of the disputed report within the past 3 years will receive a *Report Revised, Voided, or Status Changed* document informing them that the report has been voided.

Dispute Outside the Scope of Secretarial Review

If the Secretary concludes that the issue in dispute is outside the scope of review, the Secretary will direct the HIPDB to add an entry to that effect to the report and to remove the dispute notation from the report. The subject may then submit, within 30 days, a statement that will be added to the report. The statement is limited to 2,000 characters, including spaces and punctuation, and will be entered into the HIPDB computer system exactly as submitted.

The subject of the report, the reporting entity, and all queriers who received notice of the disputed report within the past 3 years will receive a *Report Revised, Voided, or Status Changed* document informing them of the Secretary's decision.

Reconsideration of the Secretary's Decisions on Disputes

Although DHHS does not have a formal appeals process for reconsideration of the Secretary's decisions on disputes, DHHS will review such requests. The subject practitioner, provider, or supplier must submit a written request for reconsideration to the office that issued the Secretary's determination. The subject should be specific about any new information that was unavailable at the time of Secretarial Review and/or which issues the subject believes were not appropriately considered during the review process. The Secretary will either affirm the prior determination or issue a revised finding. DHHS will, however, give priority to initial requests for Secretarial Review.

Improper Requests for Secretarial Review

A request for Secretarial Review is considered improper when the report in question has not previously been disputed by the subject practitioner, provider, or supplier. Before requesting Secretarial Review, a subject must:

- First, attempt to resolve the disagreement with the reporting entity.

- Second, dispute the report according to the instructions provided on the *Notification of a Report in the Data Bank(s)* document.

If a subject submits an improper request for Secretarial Review, the HIPDB will notify the subject practitioner, provider, or supplier that resolution with the reporting entity must be attempted first.

Examples of Disputes

Due Process - Alleged Denial

Example: A practitioner alleged that a health plan denied him due process because the health plan ignored the testimony of medical experts or other witnesses called to prove various points the practitioner felt were important to the defense.

Outcome: The Secretary determined that the dispute request was outside the scope of review and made an entry to that effect in the report. The dispute notation was removed from the report.

Narrative Description - Inaccurate

Example: A supplier disputed a report of a licensure disciplinary action taken by a State licensing agency stating that the narrative regarding the act was inaccurate. The supplier requested that the description be changed to reflect the findings of the agency.

Outcome: The Secretary reviewed the narrative against the findings reported by the licensing agency and determined that the report would be accurate if the actual language from the agency's findings were used. The Secretary directed the HIPDB to change the narrative. The dispute notation was removed from the report.

Licensure- Voluntary Surrender

Example: A nurse disputed a report that she had surrendered her license. The nurse disputed the report on the basis that she had surrendered due to personal reasons, unrelated to her practice. The nurse stated that she surrendered her license because she was moving to another State.

Secretary's Response: The Secretary requested that the State licensing board submit contemporaneous documentation showing that the reasons for the surrender were not as a result of the nurse simply surrendering her license to move to another State. The State licensing submitted documentation which showed that the nurse was under investigation for patient abuse and had agreed to the surrender in lieu of further disciplinary action. The Secretary determined that the action was reportable and made an entry to that effect in the report. The dispute notation was removed from the report.

Criminal Conviction

Example: A provider disputed a report of a health care-related criminal conviction. The provider argued that he was never convicted of a crime. The provider argued he had pleaded *nolo contendere* to an allegation of submitting false claims to a health plan and this did not constitute a criminal conviction.

Secretary's Response: The Secretary ruled this was a reportable event based on the definition of criminal conviction as referenced in the HIPDB regulations. The definition of criminal conviction includes a *nolo contendere* plea as a criminal conviction. The dispute notation was removed from the report

Questions and Answers

1. **I am the executor of my wife's estate. I received notification of a report about her in the HIPDB. Can I dispute the report?**

   Yes. To dispute a report on your wife's behalf, you must provide documentation that you have been appointed the executor or legal representative of her estate. Acceptable documentation can be a photocopy of her will or other legal documentation showing you as the executor/legal representative.

2. **When a subject attempts to resolve a disagreement with a reporting entity, must the dispute be resolved within a certain time frame?**

   No. A subject must inform the reporting entity, in writing, of the subject's disagreement with the report and the basis for that disagreement, but there is no requirement that the dispute must be resolved within a certain amount of time.

3. **If a subject wishes to dispute a report, does the subject have to submit a statement at the time of dispute?**

   No. The subject *may* provide a statement with the initiation of dispute, but is not required to do so. A Subject Statement may be submitted at any time.

4. **Must a subject initiate a dispute in order to add a statement to a report?**

   No. The subject of a report may add a statement to a report independently of the dispute process.

5. **If the Secretary rules a dispute to be beyond the scope of review and places a notation to this effect in the HIPDB, can a subject also add a statement?**

Yes. Subjects will be notified of this option by the Secretary. A Subject Statement added to the report after dispute resolution will replace any prior Subject Statement.