National Practitioner Data Bank Update:
Required Reports and Lessons from Litigation

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I. NATIONAL PRACTITIONER DATA BANK OVERVIEW

a. The National Practitioner Data Bank ("NPDB") is an information database that maintains, receives and provides certain health care practitioner information in order to facilitate the review of practitioner credentials. It was created by Congress in an effort to improve health care quality, protect the public, reduce fraud and abuse.

b. The NPDB initially was established by Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended ("HCQIA"), to restrict physicians from moving from state to state without disclosure of previous malpractice payment history or adverse actions.¹ Under HCQIA, malpractice payments and certain adverse actions, such as licensure, clinical privileges, professional society membership, and Drug Enforcement Agency controlled substance registration actions and exclusions from participation in Medicare, Medicaid, and other Federal health care programs, must be reported to the NPDB.²

c. The scope of the NPDB was expanded by Section 1921 of the Social Security Act. Section 1921 expanded the scope of information collected by the NPDB to include state licensure and certification actions against health care practitioners, entities, providers and suppliers; negative actions or findings by peer review organizations and private accreditation organizations; certain final adverse actions taken by state law enforcement agencies, State Medicaid Fraud Control Units, and state agencies administering or supervising the administration of state health care programs, including exclusions from a state health care program, health care-related criminal convictions and civil judgments in state court, and other adjudicated actions or decisions specified in regulations.³ Notably, the final regulations implementing Section 1921 expanded the NPDB to include adverse licensure actions taken against all licensed healthcare practitioners and any negative actions or findings by state licensing agencies, peer review organizations, and private accreditation organizations against all health care practitioners and entities.⁴ For purposes of the NPDB, “other healthcare practitioners” means individuals other than physicians or dentists who are licensed or otherwise authorized (certified or registered) by a state to provide health care services; or individuals who, without

² Id. at §§ 11131- 11133, 11152.
³ Id. at §1396r–2.
authority, hold themselves out to be so licensed or authorized (e.g. Nurses, Advanced Practice Nurses, Physician Assistants, etc.).

d. Section 1128E of the Social Security Act further expanded information collected by the NPDB to include certain final adverse actions taken by federal government agencies and health plans against health care practitioners, providers, and suppliers, including federal licensing and certification actions, exclusions from participation in federal health care programs, health care-related criminal convictions and civil judgments, and other adjudicated actions or decisions specified in regulations.

e. NPDB regulations implementing these laws are codified at 45 CFR Part 60.

II. **MERGER OF NDPB AND HEALTHCARE INTEGRITY AND PROTECTION DATA BANK.**

a. Prior to May 6, 2013, the “Data Bank” referred to the NPDB and Healthcare Integrity and Protection Data Bank (“HIPDB”). While created for different purposes, overlap existed in some reporting and querying requirements. In order to remedy this and remove duplicative requirements, Congress passed Section 6403 of the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, which amended Sections 1921 and 1128E of the Social Security Act and required the Secretary to cease operating the HIPDB. As a result, information previously collected and disclosed by the HIPDB is now collected and disclosed by the NPDB.

b. The Final Rule was published in the Federal Register on April 5, 2013 and the merger became effective on May 6, 2013.

c. There is no change in reporting or querying requirements, but query results may include reports not previously available. Users who only queried the NPDB prior to the merger may see Federal and health plan actions/decisions in their query results that they were not able to receive before because they were only available through querying the HIPDB.

d. Query fees remain the same after the merger as before ($3.25 per practitioner for annual continuous query and $4.75 for one-time queries).

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III. **Statistical Data Page**


b. The NPDB Research Statistics page shows the total number of NPDB Medical Malpractice Payment Reports (MMPRs) and Adverse Action Reports (AARs) for practitioners by state.

c. Contains an interactive U.S. Map tool.

d. The NPDB Public Use Data File contains information on specific variables taken from Adverse Action Reports and Medical Malpractice Payment Reports received by the NPDB on licensed health care practitioners, as well as information from reports of Medicare and Medicaid exclusion actions. This file is updated quarterly and is designed to provide data for statistical analysis only.

e. The Data Analysis Tool (DAT) which permits users to perform data analyses and create their own customized data tables without using additional statistical software, was refreshed and enhanced with additional data.

f. The annual reports provide Data Bank specific information, including new operating procedures and improvements, as well as statistical tables. The NPDB annual reports provide statistics on reporting, malpractice payments, adverse actions, disputed reports, queries, and matches.

IV. **Other Recent NPDB Developments**


b. April 2013- Paperless Corrective Action Plans (CAPs) and Attestations were implemented, enabling State boards to complete compliance-related CAPs and Attestations entirely online.

c. August 2013- Express Self-query online identity verification, allowing most practitioners to verify their identity online and purchase their self-query.

d. February 2014- Agent query enhancements implemented in order to simplify the query/report process for agents who query or report on behalf of many entities.

V. **Reporting Overview**

a. As discussed above, certain payers, providers, state licensing boards, state and federal agencies and professional societies are required to report delineated information to the NPDB.
b. **Reporting: Medical Malpractice Payments**
   i. Payers, including self-insured hospitals and health care entities, must report medical malpractice payments made for the benefit of a practitioner that are:
   1. The result of a written complaint or claim demanding payment, and
   2. Based on the provision or failure to provide health care services.
   ii. Payments made by individuals on their own behalf or by payers on behalf of a health care entity are not reportable.

c. **Reporting: State Licensure Actions**
   i. State licensing authorities must report adverse actions taken against all practitioners and health care entities.
   ii. Adverse actions, with regard to state licensing authorities, are not limited to those related to professional conduct or competency.
   iii. Adverse actions, include:
      1. licensure revocations, restrictions, suspensions (including summary or emergency), surrenders, censures, reprimands, and probations;
      2. dismissal or closure of proceedings due to licensure surrender or leaving the jurisdiction;
      3. Withdrawal or denial of application for licensure renewal or non-renewals (with exceptions for nonpayment of fees, retirement or change to inactive status); and
      4. Certain publicly available negative actions or findings (such as limitations on practice, injunctions, liquidations and forfeitures).

d. **Reporting: Adverse Clinical Privilege Actions**
   i. Hospitals and health care entities with formal peer review processes must report:
      1. professional review actions, based on reasons related to professional competence or conduct that adversely affects, or could adversely affect, the health or welfare of a patient, and that adversely affect a physician’s or dentist’s clinical privileges for a period longer than 30 days; OR
      2. The physician’s or dentist's voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation.
   ii. Summary/emergency suspensions are reportable if they are in effect for more than 30 days, are based on professional competency or conduct that adversely affects, or could adversely affect, the health or welfare of a patient and are the result of a professional review action taken by the hospital or healthcare entity.

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iii. The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician, and which affects (or may affect) adversely the “clinical privileges,” or membership in a professional society, of the physician.10

iv. The term "professional review activity" means an activity of a health care entity with respect to an individual physician-
   1. to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,
   2. to determine the scope or conditions of such privileges or membership, or
   3. to change or modify such privileges or membership.11

v. The term "clinical privileges" includes privileges, membership on the medical staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care by a health care entity (group medical practice).12

vi. The term “adversely affecting” includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.13

vii. Professional Competency and Conduct
   1. Professional competence and conduct are not expressly defined and the determination of whether an action is based on a provider’s professional competency or conduct is generally left to facility.
   2. Examples provided by HQQIA and the NPDB of issues that are not related to professional competence and conduct include:
      a. Adverse actions based primarily on a practitioner’s advertising practices,
      b. fee structure,
      c. salary arrangement, and
      d. affiliation with other associations or health care professionals, or other competitive acts intended to solicit or retain business.14

viii. Non-reportable actions or voluntary resignations include:
   1. Voluntarily restriction or surrender of clinical privileges for personal reasons, infirmity or retirement when professional competence or professional conduct is not under investigation.15
   2. Certain administrative actions not related to professional competence or conduct.16

10 Id. at §11151(9).
11 Id. at §11151(10).
12 Id. at §11151(3).
13 Id. at §11151(1).
14 Id. at §11151(9). 2001 NPDB Guidebook, supra note 5, at E-18.
15 2001 NPDB Guidebook, supra note 5, at E-23.
16 Id. at E-33.

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ix. Investigations\footnote{2001 NPDB Guidebook, supra note 5, at E-19; 2013 Draft NPDB Guidebook, supra note 8, at E-31.}

1. Investigations are not reportable to the NPDB; rather, the surrender or restriction of clinical privileges while under investigation or to avoid an investigation or professional review action is reportable. An entity that submits a report based a surrender of privileges or restriction of privileges during an investigation should have evidence of an ongoing investigation or a plea bargain.

2. The 2001 Guidebook offers the following “guidelines” for investigations:
   a. An investigation must be carried out by the health care entity, not an individual on the staff.
   b. The investigation must be focused on the practitioner.
   c. The investigation must concern the professional competence and/or professional conduct of the practitioner.
   d. A routine or general review of cases is not an investigation.
   e. A routine review of a particular practitioner is not an investigation.
   f. An investigation should be the precursor to a professional review action.
   g. An investigation is considered ongoing until the health care entity’s decision making authority takes a final action or formally closes the investigation.

3. The draft NPDB Guidebook takes a more expansive view of investigations and adds that “the term “investigation” is not controlled by how that term may be defined in a health care entity’s bylaws or policies and procedures.” Under the draft Guidebook, “a routine, formal peer review process under which the health care entity evaluates, against clearly defined measures, the privilege-specific competence of all practitioners is not considered an investigation for the purposes of reporting to the NPDB. However, if the formal peer review process is used when issues related to professional competence or conduct are identified or when a need to monitor a physician’s performance is triggered based on a single event or pattern of events related to professional competence or conduct, this is considered an investigation for the purposes of reporting to the NPDB.” The draft Guidebook continues that the investigation begins as soon as the health care entity begins an “inquiry” and does not end until the health care entity’s decision-making authority takes a final action or formally closes the investigation.

e. Other Reportable Actions
   i. Negative actions or findings by peer review and private accreditation organizations;
   ii. Medicare/Medicaid exclusions;
iii. Adverse registration actions related to prescription of controlled substances;
iv. Health care related criminal convictions;
v. Health care related civil judgments;

1. Actions or decisions, excluding clinical privilege or panel membership, that:
   a. include due process;
   b. are formal and final actions taken by a state or federal government agency or health plan; AND
   c. are based on acts or omissions that affect, or could affect, the payment, provision, or delivery of a health care item or service.

f. **Timeframes**\(^{18}\)
   i. Reporting timeframes are generally within 30 days of the action or malpractice payment.
   ii. Exceptions in 2001 Guidebook
      1. Health care entities must report adverse actions within 15 days from the date the adverse action was taken or clinical privileges were voluntarily surrendered.
      2. Professional societies must report adverse actions within 15 days from the date the adverse action was taken.

VI. **QUERIES**

a. Hospitals must make NPDB queries.

b. State licensing boards, state and federal agencies health care entities and professional societies with formal peer review, health care providers, researchers, health plans, and fraud and abuse enforcement agencies/individuals may make NPDB queries.

VII. **SUMMARY OF REPORTING AND QUERYING OBLIGATIONS.** The following table summarizes reporting requirements and query access to authorized users per Title IV, Section 1921, and Section 1128E, respectively.\(^ {19}\)

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\(^{18}\) 2001 NPDB Guidebook, supra note 5, at E-2; 2013 Draft NPDB Guidebook, supra note 8, at E-4

\(^{19}\) National Practitioner Data Bank- About Us, [http://www.npdb-hipdb.hrsa.gov/resources/aboutStatData.jsp](http://www.npdb-hipdb.hrsa.gov/resources/aboutStatData.jsp)
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Health care-related civil judgments in Federal or state court
- Other adjudicated actions or decisions
- Researchers (de-identified, statistical data only)

*These entities have access to all information reported under Section 1128E and limited information under Section 1921.
**Reported by Federal Government agencies only.
***The NPDB regulations define "state law or fraud enforcement agency" to include but not to be limited to these entities.

VIII. SANCTIONS

a. Sanctions may be assessed for failure to report. Hospitals with mandatory query obligations may be sanctioned for failure to make a query. Sanctions may include civil monetary payments of up to $11,000 for failure to disclose malpractice payments or loss of HCQIA immunity for failing to report adverse actions.20

b. NPDB information is confidential and entities violating confidentiality may be assessed a civil monetary penalty.

IX. STATISTICAL TRENDS21

a. Statistics Overview
   i. From 2002 to 2011, Medical Malpractice Reports decreased significantly for all practitioners.
   ii. During that same time period, Adverse Action Reports increased for all practitioners, except those reports for physicians and dentists remained relatively stable
   iii. Adverse Action Reports for nurses nearly doubled from 2002 to 2011, from 11,029 to 21,586 (possibly related to implementation of Section 1921).
   iv. Adverse Action Reports for practitioners other than physicians, dentists and nurses increased from 8,368 in 2002 to 13,958 in 2011.

X. DRAFT NPDB GUIDEBOOK

a. On November 22, 2013, the U.S. Department of Health and Human Services ("HHS") released a draft version of a revised NPBD Guidebook ("Guidebook"). The purpose of the Guidebook is to provide information that authorized users need in order to interact with the NPDB. Authorized users include State licensing authorities; medical malpractice payers; hospitals and other health care entities; and physicians, dentists, and other licensed health care practitioners. HHS has solicited comments on the draft NPDB Guidebook, which were due on January 31, 2014.

b. The draft NPDB Guidebook
   i. Incorporates legislative and regulatory changes adopted since the 2001 edition, including the merger of the NPDB with the HIPDB;
   ii. Attempts to provide clarification regarding when reports and queries are necessary;
   iii. Provides additional reporting examples;
   iv. Provides useful reference charts for reporting and querying;
   v. Expands upon attorney access to NPDB information in certain malpractice cases.

c. Concerns with the draft NPDB Guidebook include:
   i. The definition of “investigation.” The draft NPDB Guidebook essentially takes the position that anything other than routine OPPE that is applied to all practitioners is an investigation, leaving little room for collegial intervention methods (E-41).
   ii. The draft NPDB Guidebook states that an “investigation” begins at the initial “inquiry” but does not provide sufficient guidance on the term “inquiry” (E-31).
   iii. The draft NPDB Guidebook notes that the term “investigation” is not controlled by how the health care entity defines “investigation” in its Medical Staff bylaws, policies or procedures (E-31).
   iv. The draft NPDB Guidebook clarifies that a practitioner does not have to be aware of an investigation for a resignation during an investigation to be reportable (E-41).
   v. Lack of clarity around emerging health care delivery models. The NPDB has issued guidance that an ACO could qualify as a health care entity, but it is not listed as an “Eligible Entity” in examples provided (B-1, B-3).
   vi. Procedures for health systems. The draft NPDB Guidebook restricts the sharing of NPDB information among affiliated hospitals and health care entities. From a logistical standpoint, it would be helpful if health system only needed to make one query, as opposed to one query from each applicable health care entity (B-17)
   vii. Language in the draft NPDB Guidebook could require queries for “Honorary” or “Emeritus” Medical Staff Members who hold no clinical privileges (D-4).
XI. REPORTING REQUIREMENTS.22

a. Investigations
   i. Is a practitioner’s resignation from the Medical Staff during a Focused Professional Practice Evaluation that was commenced as the result of a competency concern reportable?
      1. Yes, the FPPE is an investigation regarding the practitioner’s professional competency.
      2. Many facilities currently deem an “investigation” to have occurred when one has been commenced under the Medical Staff Bylaws or a Medical Staff Policy.
      3. Facilities often use FPPE and other processes as collegial intervention tools.
      4. Often times, physicians and health care entities will work as this level to resolve issues without having to make a NPDB report.
   ii. Should a practitioner’s surrender of clinical privileges during a routine case review (“Ongoing Professional Practice Evaluation”), applied to all practitioners holding clinical privileges, be reported to the NPDB?
      1. No, routine peer review of all practitioners is not reportable to the NPDB.
   iii. Is a practitioner’s resignation during the reappointment process reportable to the NPDB?
      1. Yes- the NPDB considers the reappointment process an investigation and therefore, the resignation is a surrender of privileges while under investigation.
      2. Similarly, if a practitioner’s opts not to reapply for appointment and clinical privileges during an open investigation, a report should be made to the NPDB.
   iv. In the event the reapplication process overlaps with an investigation into a practitioner’s professional competency, is a practitioner’s failure to reapply for Medical Staff membership and clinical privileges reportable?
      1. Yes, if a practitioner’s opts not to reapply for appointment and clinical privileges during an open investigation, a report should be made to the NPDB.
   v. Is a practitioner’s resignation during a preliminary inquiry into the practitioner's conduct reportable?
      1. It depends. Health care entities often use preliminary inquiries and collegial intervention methods to resolve issues without the need for formal investigations. A hospital may argue that a resignation during these processes is not reportable because an “investigation” has not commenced, while the NPDB would likely take the position that the resignation is reportable.
      2. Under the Draft NPDB Guidebook, a resignation during a preliminary inquiry would likely be considered reportable by the NPDB as the investigation begins with the initial inquiry.


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vi. A practitioner is under investigation for behavioral issues that could adversely affect patient care. The Medical Executive Committee completes its investigation and requires the practitioner to attend an anger management course. The practitioner resigns from the Medical Staff. Is the MEC action or practitioner’s resignation reportable?
   1. No, the course requirement does not restrict the practitioner’s privileges and the practitioner’s resignation occurred following the MEC’s completion of the investigation.

vii. Is a practitioner’s agreement not to perform a procedure pending the outcome of an investigation reportable?
   1. Yes, NPDB would likely take the position that such an agreement is a “surrender” of privileges while under investigation.

b. Proctoring/Supervision
   i. After a review of a practitioner’s cases, a proctor is assigned to the practitioner for more than 30 days due to competency concerns. The practitioner must receive the proctor’s approval before rendering care. Is this reportable?
      1. Yes, the assignment of the proctor and not being able to exercise privileges without approval is an adverse action lasting more than 30 days.
      2. Similarly, if the proctor was required to be present for surgeries, the restriction would be reportable.

   ii. What if the practitioner simply needed to obtain a second opinion on the appropriate course of care before exercising privileges?
       1. It depends. If the action required concurrence of opinion, the NPDB would likely take the position that the loss of independent decision making is a restriction of privileges that requires reporting.
       2. However, if the practitioner could proceed regardless of the second opinion, there would be no restriction on the practitioner’s privileges.

   iii. Is the appointment of proctors for a period of 60 days as part of hospital policy for all initial appointments reportable?
       1. Per the 2001 and Draft NPDB Guidebook, requiring proctors for all initial appointees is not reportable.

c. Adverse Action Based on Another Hospital’s Action
   i. Is a practitioner’s automatic loss of clinical privileges at Facility B as a result of the practitioner’s loss of clinical privileges at Facility A reportable?
      1. No, the loss of privileges at Facility B is not based on a professional review action.

d. Criminal Conduct Outside of the Hospital
   i. Is a practitioner’s suspension as the result of a DUI reportable?
1. Possibly. In order to be reportable, the suspension must be greater than 30 days and be based on concerns for patient safety.

XII. NPDB DISPUTE RESOLUTION

a. Overview

i. The subject of an NPDB report or a designated representative may dispute the report and enter the report into Dispute Status to only challenge:
   1. the factual accuracy of the report,
   2. or whether a report was submitted in accordance with NPDB reporting requirements.

ii. In order for the report to be reviewed for accuracy or whether it was properly submitted, the report must be elevated to Dispute Resolution.

iii. There are three possible outcomes from Dispute Resolution:
   1. The report is accurate as submitted;
   2. The report is inaccurate as submitted or was not submitted in accordance with NPDB requirements; or
   3. The dispute is outside the scope of Dispute Resolution.

iv. A report be elevated to Dispute Resolution, upon request, after the following:
   1. The subject of the report has entered the report into Dispute Status;
   2. The subject has waited 60 days after entering the report into Dispute Status, during which the subject has attempted to contact the reporting entity to attempt to resolve the issues raised by the report; and
   3. The subject has verified this effort.

v. The Dispute Resolution process does not include reviewing:
   1. The underlying reasons for the report, such as the merits of a medical malpractice claim or the appropriateness of, or basis for, other types of reports, or
   2. The extent to which entities followed due process procedures; due process issues must be resolved between the subject and the reporting entity.

b. Guidebook Examples

i. Accurate as Submitted

1. A hospital reported a clinical privileges action to the NPDB indicating that a surgeon resigned while under investigation. The surgeon objected, saying she did not know she was under investigation. She insisted that an investigation was never mentioned to her and there is no mention of investigations in the hospital bylaws. For these reasons, she said, the report should be removed from the Data Bank.

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23 See 2013 Draft NPDB Guidebook, supra note 8, at F-3 - F-5.
24 Id. at F-18, 19.
2. NPDB Response: A hospital must submit a report to the NPDB when a physician or dentist resigns his or her clinical privileges while under investigation, regardless of whether the health care practitioner is aware of the investigation. The hospital provided documentation of an ongoing investigation at the time the surgeon resigned her clinical privileges. Therefore, the report was found to be accurate as submitted.

ii. Inaccurate as Submitted

1. A report of a summary suspension of clinical privileges was submitted to the NPDB. The subject physician argued that the report was illegally submitted because the suspension was less than 30 days. The hospital reported the suspension of the physician’s clinical privileges on the 10th day of an indefinite suspension. As part of the suspension, the physician was required to undergo a psychiatric evaluation. The physician completed the required action on the 20th day of the suspension. The psychiatric evaluation was unremarkable, and clinical privileges were immediately restored. The hospital did not void the report from the NPDB.

2. NPDB Response: The reporting entity was directed to void the report because only clinical privileges actions in effect or imposed for more than 30 days may be reported to the NPDB, and the summary suspension the reporting entity took lasted only 20 days. When a summary suspension of clinical privileges is indefinite in length, it should not be reported until it has been in effect for more than 30 days.

iii. Outside the Scope of the Secretary’s Authority

1. A health care practitioner who was the subject of a clinical privileges action report alleged that the health care entity, during professional review, denied him due process. He claimed the reviewers ignored the testimony of medical experts and other witnesses called to prove various points that he believed were important to his defense.

2. NPDB Response: The claims the practitioner made were found to be outside the scope of review because they concerned the underlying reason for the report (i.e., whether due process was afforded the subject of the report) rather than the report’s factual accuracy or whether the report was submitted in accordance with NPDB reporting requirements.

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25 Id. at F-13.
26 Id. at F-15.
XIII. NPDB RELATED LITIGATION

   i. Physician was hospitalist at VA Hospital in Kansas. One of the plaintiff’s patients died following a procedure. Patient’s family sued the hospital, which settled the case of the physician’s objections. The hospital's investigation named the plaintiff as the responsible practitioner for the patient’s death. The hospital reported the settlement to the NPDB. Plaintiff brought suit under the Federal Tort Claims Act, alleging the negligent investigation and report will cause him future lost income, damage to his reputation and higher malpractice premiums.
   ii. Physician’s attempts at challenging the report through HHS, which determined that the physician’s claims were beyond the scope of the Secretary’s review.
   iii. Applying the “discretionary function test”, which excepts FTCA claims against the government for lack of subject matter jurisdiction that involve the performance of discretionary (matter of judgment or choice) functions on behalf of a federal agency or government employee, the court dismissed the case for the plaintiff’s failure to plead facts that support a finding that the conduct of the hospital's review panel fell outside the discretionary function exception.
   iv. The plaintiff also failed to rebut the presumption that the hospital’s review procedures met the necessary HCQIA standards.

   i. Hospital suspended a urologist for 60 days after the physician, in anger, broke a telephone, shattered copy machine glass, shoved a metal cart into an O.R., threw jelly beans down a hall, threw a medical chart and verbally abused a nurse. A NPDB report was filed.
   ii. The physician attempted to have the Secretary remove the hospital’s NPDB report. The Secretary found that the report was not inaccurate and rejected the physician’s request.
   iii. On review under the Administrative Procedure Act, the district court entered a judgment denying relief. The physician appealed.
   iv. The court noted that the Secretary reviews a report for factual accuracy deciding only if the report accurately describes the adverse action and the reporting hospital's explanation of the action. Disputes of the accuracy of the underlying facts are outside the scope of the Secretary’s review.
   v. The court found that the Secretary reasonably determined that the report was factually accurate in the only sense that was relevant under HCQIA.
   vi. The court further found that the Secretary appropriately determined that the 60-day suspension was a reportable event, noting “disruptive and abusive behavior buy a physician, even if not resulting in actual or
immediate harm to a patient, poses a serious threat to patient health or welfare.”

vii. Because the suspension plainly fit within the required reports under HCQIA, the court found that the Secretary’s determination was not arbitrary and capricious.

   i. A physician practicing general and vascular surgery had his cases reviewed based on complication.
   ii. The doctor received an adverse action recommendation, which required that he obtain a second opinion on procedures for non-life threatening conditions and acquire assistance from a second physician on all major cases.
   iii. The hospital filed a report of adverse action against the doctor with the National Practitioner Data Bank.
   iv. The doctor requested formal review of the Data Bank report by the Secretary of HHS.
   v. The physician filed suit against the Secretary, and contending that the hospital's data bank entry was inaccurate and should not have been reported.
   vi. The court found that the elements of a "professional review action" were satisfied because the hospital's recommendations had a negative impact on the doctor's clinical privileges, the hospital's committee met the definition of a "professional review body", the continuing review of the doctor's performance amounted to a "professional review activity", and the hospital took the action based upon an assessment of the doctor's independent competence.
   vii. Therefore, the hospital was required to submit an adverse action report and the court held that the Secretary's decision was not arbitrary or capricious.

   i. An OR nurse filed a complaint against a physician alleging that he had threatened the nurse. The MSEC temporarily suspended the physician and appointed an investigating committee. The investigating committee reported to the MSEC that the nurse reasonably perceived the physician’s actions as threatening.
   ii. Three days later, the MSEC met to discuss both the report and the physician's status. Following that discussion, the MSEC proposed that the physician be allowed to return provided he agreed to certain regular proctoring and psychological evaluations. The physician rejected this proposal and voluntarily relinquished his clinical privileges.
   iii. Believing the physician resigned while under investigation, the hospital reported the physician’s resignation to the NPDB.
   iv. The physician appealed to the Secretary of HHS, contending that he did not resign while under investigation.
   v. The Secretary ruled that the hospital properly reported the physician according to the Secretary, "[a]n investigation is . . . considered ongoing
until the health care entity's decision making authority takes a final action or formally closes the investigation." Because the MSEC had not taken a final disciplinary action nor formally closed its inquiry when the physician resigned, the Secretary found that the physician was still under investigation.

vi. While noting that the Secretary’s definition of an investigation was not promulgated through the regulatory purpose, the court concluded that the Secretary's interpretation was a product of thorough consideration and that expertise and consistency were in favor of honoring the Secretary's interpretation.

vii. As a result, the court concluded that the hospital properly reported the physician and that the lower court did not err in rejecting the physician’s attempt to reverse the Secretary’s decision.

viii. Notably, in its discussion of “investigations,” the court stated:

1. “A hospital's bylaws may shed light on whether the institution has initiated an investigation within the purview of the statute and, if so, whether that investigation is ongoing.”

2. However, “the federal judiciary and the agency to which the interpretive task has been entrusted have independent responsibilities for fashioning a global definition, and a hospital cannot frustrate that definition through its bylaws. If, say, a hospital's bylaws used the word "investigation" to describe a phenomenon that ended upon the completion of fact-gathering, the Secretary would not be compelled to interpret Congress's use of the word "investigation" in lockstep with that idiosyncratic definition.”