On June 17, 2015, staff from the National Practitioner Data Bank hosted a webinar with members of the National Association Medical Staff Services. The following questions were asked during the webinar. While some answers were provided in real time, all questions are compiled here with answers for future reference.

**Q1:** Would the following action by a professional society be reportable: A unanimous vote at a special meeting of a professional society’s Board revokes and terminates the privileges and membership of a practitioner for “conduct injurious to and not in the best interests of the professional society”?

**A1:** It depends. The termination of the practitioner’s privileges and membership in a professional society would only be reportable to the NPDB if the following is true: the special meeting of the professional society’s Board qualifies as a professional review activity that employs a formal peer review process; and the termination of privileges and membership actions were taken based on the practitioner’s professional competence or conduct that adversely affects, or could adversely affect, the health or welfare of a patient.

**Q2:** Are hospitals required to query the NPDB on “honorary” medical staff members, such as retired practitioners granted “courtesy” privileges but who do not treat or interact directly with patients?

**A2:** Yes, hospitals are required every 2 years (biennially) to query the NPDB on all physicians, dentists, and other health care practitioners who are on its medical staff (courtesy, honorary, or otherwise) or who hold clinical privileges at the hospital. The requirement to query every two years exists even if the provider is permanently appointed to the honorary staff with no reappointment required.

**Q3:** If proctoring is required on all practitioners when a specific procedure is granted, and a proctor is required to be present on all of the proctored procedures, would that be considered reportable?

**A3:** If the proctoring is simply a matter of course when a practitioner is given new privileges to carry out a procedure, and the proctoring is not imposed as a professional review action arising out of a professional review activity, then that is not a reportable restriction of clinical privileges. To the extent that the proctoring results from a professional review activity, is based on competency and conduct concerns, limits clinical privileges, and is in place for more than 30 days, it would be reportable.
Q4: When a new physician is to begin working in a hospital, a proctor is assigned to them to oversee the first three cases they perform for a given procedure as a routine practice for all new physicians. In other instances, when a currently employed physician is granted the right to do a procedure they have not done in the hospital before, or they have come up for reappointment and have not done the procedure in a long time, they too must be proctored for the first three instances of performing this procedure. Are any of these proctoring situations reportable to the NPDB as clinical privileges actions?

A4: In the first instance, when a practitioner is starting for the first time at a hospital and the proctoring arises not from a professional review action, but as a matter of routine evaluation that takes place when a practitioner begins work, the proctoring is not reportable. With the case of a practitioner who is currently employed by a hospital, but is granted a new right to perform a procedure, the proctoring that goes along with the exercise of that procedure is not reportable, so long as this is a routine that all physicians must abide by when being granted new clinical privileges to perform procedures they have never completed.

Likewise, when a hospital requires that a physician must be proctored for their first three procedures simply because he or she has not done a procedure in a very long time, the proctoring would not reportable so long as it is considered routine peer review, and does not arise from a professional review activity. Proctoring is reportable when it is imposed as a professional review action related to professional competence or conduct, whereby a practitioner cannot carry out a procedure without a proctor’s approval or without the proctor being present, with such a restriction lasting longer than 30 days. To summarize, proctoring is only reportable when it is required of a physician because of some concern about the practitioner’s professional ability or conduct, a concern that was identified as a result of a professional review activity.

Q5: Can you offer further clarification on the scenario of an extended Focused Professional Practice Evaluation (FPPE)?

A5: FPPEs may typically be implemented as routine peer review that doesn’t meet the standard of an investigation. However, because different hospitals may implement peer review and professional review differently, there may be times when an FPPE signals the beginning of an investigation. One situation may be where an FPPE is extended.

If the FPPE is extended for one practitioner, or only for those practitioners with competency concerns, a hospital may consider this the start of an investigation. If a practitioner’s FPPE is extended for reasons other than professional competence, such as he or she failed to meet all the requirements in a given time period, then the hospital may decide this is not the beginning of an investigation, but a continuation of routine peer review. To determine if an extended FPPE is an investigation, the hospital should consider the guidelines of an investigation. Is the extended FPPE related to professional competence concerns, focused on a specific practitioner, and generally a precursor to a professional review action? To determine the answers to these questions, a hospital should look to their bylaws, the language of the FPPE itself, and other documentation.
Q6: If a physician is applying for reappointment but has not recently performed any procedures at the hospital to which they are applying, can their reappointment be granted automatically?

A6: It depends. Each facility should set their own standards and procedures for privileging and appointment decisions.

Q7: If a physician is suspended for 15 days for not completing medical records, and during that suspension the physician cannot admit new patients or schedule new surgical cases, but can continue with previously scheduled surgeries and treat emergencies or currently hospitalized patients, is that reportable? Is it reportable if the suspension is for more than 30 days instead of 15 days?

A7: In the first example of a suspension for 15 days, no, this is not reportable. Only professional review actions that restrict clinical privileges for more than 30 days are reportable.

In the second example, since the restriction is for more than 30 days, then yes, that is reportable.

Q8: If a suspension of more than 30 days or a similar action is an automatic process (i.e. not the result of a professional review action), is it reportable?

A8: No, this is not reportable. Automatic actions are not reportable, even if the action is for more than 30 days. Reportable restrictions of clinical privileges must be the result of a professional review action, not an administrative process.

Q9: Is it reportable when a physician is under a specific professional review activity for professional competency, and decides to retire?

A9: If a physician retires, and therefore resigns his or her clinical privileges while under investigation, the resignation is reportable regardless the reason for the retirement. Retirement is only reportable if it occurs while the physician is under investigation.

Q10: If a surgical incident occurs and the event is sent to an external peer reviewer, would that be considered the beginning of an investigation? The hospital may only send out a case for external peer review every couple of years.

A10: To be considered the start of an investigation, the hospital should determine whether the inquiry is focused on a particular practitioner for a specific concern of competence or conduct; whether it deviates from routine peer review; and whether this type of inquiry is generally a precursor to a professional review action. In this case, the fact that an inquiry followed a surgical incident, signals that this was a focused investigation into the competence of a particular practitioner. The fact that this hospital rarely sends cases out to external peer reviewers also indicates that this is the beginning of an investigation as it appears to be more intense than routine peer review. If the findings of the peer review could lead to a professional review action, then this would most likely be the start of an investigation.
Q11: If a health plan terminates a practitioner from its network after a review of claims reveals that the practitioner is not adhering to the health plans acceptable standards of care (e.g. too many spinal injections, not using the pre-authorization process properly), is this reportable? The practitioner is offered a fair hearing and appeal rights. Additionally, if the termination is immediate and the practitioner is offered a right to appeal within 30 days of the termination, do we wait the 30 day period of right to appeal before reporting to the NPDB?

A11: A health care termination is considered an other adjudicated action for reporting to the NPDB. Other adjudicated actions, as defined in NPDB regulations at 45 CFR 60.3, require the availability of a due process mechanism. In this instance, by availing the practitioner to a fair hearing and appeal, the network termination is a reportable other adjudicated action. If the health plan also restricts clinical privileges, than a second report may be required so long as the clinical privileges are restricted as a result of a professional review activity.

It is not necessary at the time that you file the report that the practitioner has taken advantage of the due process, only that due process was made available to him or her. Therefore, you may report the action at the time it is taken so long as due process was made available to the practitioner.