Protecting members from inappropriate reporting to the National Practitioner Data Bank

Content provided by the AMA Organized Medical Staff Section
A physician’s surrender of privileges during an investigation into his or her competence or conduct has always been reportable to the National Practitioner Data Bank (NPDB), even when the investigation ultimately clears the physician of any wrongdoing.

However, recent revisions to The NPDB Guidebook—a manual developed by the federal government to provide guidance on NPDB-related requirements—prompt hospitals and other reporting entities to adopt a broader definition of investigation and to interpret any leave of absence as a “surrender of privileges.” Moreover, the revised Guidebook reiterates that a physician need not be notified that he or she is under investigation in order for a NPDB report to be made.

Unfortunately, these current reporting requirements may cause significant harm to physicians. For example, under the revised reporting requirements, a physician who unwittingly takes a leave of absence for health reasons during an investigation—say, a physician who takes a leave after the birth of a child—must be reported to NPDB even if she was unaware of the investigation and even if she intends to request reinstatement of all privileges upon her return.

Before taking a leave of absence or otherwise surrendering any privileges, physicians should always seek to determine whether they are the subject of any investigation. Medical staffs can further safeguard their members against unnecessary and unfair reporting by adopting medical staff bylaws that:

- Clearly define what constitutes an investigation
- Clearly define when an investigation begins and ends
- Require that physicians be notified before the initiation of an investigation

Guidance from the American Medical Association

To help guide you through this process and others, the American Medical Association (AMA) publishes the Physician’s Guide to Medical Staff Organization Bylaws. Now in its sixth edition, this resource is available by visiting ama-assn.org/go/bylaws.

The following excerpts are reprinted from the current e-book (published March 2017) and are most relevant to revising your bylaws in such a way as to establish parameters for investigations consistent with federal law and regulations.

About the AMA Organized Medical Staff Section

The AMA Organized Medical Staff Section (OMSS) is the only physician-led, national group that advocates for medical staff organizations and their members. Physicians affiliated with medical staffs, whether employed or in private practice, rely on the OMSS to support them and their efforts to improve patient care and otherwise effect positive change in their practice environments. Learn more about OMSS and how you can become involved by visiting ama-assn.org/go/omss.

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### 2.2.3 In Good Standing

The phrase “in good standing” is common in medical staff bylaws, used typically as a qualification for holding office or serving in other leadership capacities. Without a clear definition of the phrase, duly elected leaders could be removed from office because charges even of a specious nature have been made against them. Needless interruption in service can be avoided if the bylaws define the phrase to clarify that members who are under investigation, but against whom no disciplinary actions have been taken, remain eligible to carry out membership prerogatives.

**Sample Bylaw: In Good Standing**

“In good standing” means, at the time of the assessment of standing, neither his/her membership nor his/her privileges are involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reasons.

*North Carolina Medical Society Model Medical Staff Bylaws Definition #6*

### 2.2.4 Investigation

Under the Healthcare Quality Improvement Act (HCQIA), a physician’s or dentist’s resignation of membership or any privileges during or in lieu of an investigation must be reported to the National Practitioner Data Bank. Therefore, clarification of what constitutes an “investigation” reduces unnecessary reporting. Investigations themselves are not reportable; only a surrender of privileges while an investigation is on-going is subject to Data Bank reporting. What constitutes “surrenders” is discussed in Section 3.26, Leaves of Absence, Section 6.12, Resigning/Relinquishing/Surrendering Privileges, Section 7, Peer Review, and Section 10, Reporting Actions to Governmental Agencies. A clear identification of when an investigation starts and stops should promote appropriate and compliant reporting. The April 2015 National Practitioner Data Bank Guidebook[^32] broadens previous Guidebook descriptions of investigation, stating “An 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 makes a decision to not further pursue the matter.” How a medical staff begins and ends an inquiry should be specified in medical staff bylaws, as in the definition below and as discussed in Section 7, Peer Review.

[^32]: Available at [http://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp](http://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp)
The HCQIA requirement for a Data Bank report whenever a physician surrenders privileges during the course of an investigation does not mandate that the physician be notified of any such investigation. Further, reporting is mandated even when the investigation is unrelated to the privileges surrendered. Unfortunately, these reporting requirements can significant harm to physicians. For example, a physician who unwittingly takes a leave of absence for health reasons during an investigation—say, a physician who takes a leave after the birth of a child—must be reported to the Data Bank, even if she was unaware of the investigation and intends to request reinstatement of all privileges upon her return, and even if the investigation ultimately finds no wrong-doing on the part of the physician. Written notice of an ongoing investigation could allow physicians to make informed decisions about surrendering privileges to avoid being reported to the Data Bank. (See Section 6.12, Resigning/Relinquishing/Surrendering Privileges, for related bylaws language and template notification letters.) Further, the Data Bank Guidebook identifies written notice as evidence of when an investigation commences, which evidence reporting entities need to justify reporting.

Bylaws should establish parameters for investigations consistent with federal law and regulation.

**Sample Bylaw: Investigation**

Investigation means the formal medical staff process targeted to review an issue or issues with the competence or professional conduct of a specific member/privileges holder identified by a medical staff committee or department. Investigations begin with the medical staff [committee] [department] decision to begin an inquiry, and terminate with the hospital’s final action on the medical staff recommendation or the conclusion of the medical staff investigation without recommendation of adverse action.

Members/privileges holders shall receive written notice upon the commencement of any investigation, disclosing the initiation and scope of investigation and advising the subject that any resignation, surrender, relinquishment or cessation of medical staff membership or any clinical privileges, including a leave of absence, whether related to the investigation or not, while the investigation is ongoing, will be reported to the National Practitioner Data Bank. Routine professional practice evaluation does not constitute an investigation.
3.26 Leaves of Absence

To ensure uniform handling of members’ requests for leaves of absence, bylaws should include appropriate procedures. Military leaves of absence, in particular, should be addressed to assist physicians participating in military reserves and the National Guard.

Note that the April 2015 National Practitioner Data Bank Guidebook\(^5^0\) interprets a leave of absence as a surrender of privileges, which would be reportable if the physician is under investigation, even if the physician is not aware that an investigation is on-going. Prior to taking voluntary leaves of absence, physicians should ascertain that no investigation has begun.

Sample Bylaw: Leaves of Absence

**Leave Status**
At the discretion of the medical executive committee, a medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the medical executive committee stating the approximate period of leave desired, which may not exceed \[ _____ \]. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff.

**Termination of Leave**
At least 30 days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the medical executive committee. The staff member shall submit a summary of relevant activities during the leave, if the executive committee so requests. The medical executive committee shall make a recommendation concerning reinstatement of the member’s privileges and prerogatives, and the procedure provided in Section_____ shall be followed.

\(^5^0\) Available at [http://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp](http://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp).

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Failure to Request Reinstatement
Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial memberships.

Medical Leave of Absence
The medical executive committee shall determine the circumstances under which a particular medical staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the medical executive committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a medical leave which is not granted for a medical disciplinary cause or reason.

Military Leave of Absence
Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the medical executive committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Section(s)_____, but may be granted subject to monitoring and/or proctoring as determined by the medical executive committee.

*California Medical Association Model Medical Staff Bylaws §3.8*

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3.27 Term of Membership
The term of medical staff membership is limited to a maximum of two years, under Joint Commission Standard MS 07.01.01, Element of Performance 3. Membership is subject to renewal by application, at which time assessment of the member’s practice takes place, typically following the same procedures by which initial applicants are evaluated.
Performance 8, states “The medical staff requires that a practitioner who has been granted privileges by the hospital to do so performs a patient’s medical history and physical examination and required updates.”

<table>
<thead>
<tr>
<th>Sample Bylaw: Histories and Physicals</th>
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<tr>
<td>Every patient receives a history and physical within twenty-four hours of admission, unless a previous history and physical performed within thirty days of admission is on record, in which case that history and physical will be updated within twenty-four hours of admission. Every patient admitted for surgery must have a history and physical within 24 hours prior to surgery, unless a previous history and physical performed within thirty days prior to the surgery is on record, in which case that history and physical will be updated within twenty-four hours of the surgery. Only those granted privileges to do so conduct history and physicals or update histories and physicals. Privileges to conduct a history and physical or an update to a history and physical are granted only to physicians or oral/maxillofacial surgeons who are members of the medical staff or seeking temporary privileges.</td>
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Medical Association of Georgia Model Medical Staff Bylaws §V.B.7

6.12 Resigning/Relinquishing/Surrendering Privileges

Members of the medical staff should be allowed to resign all or part of their privileges. Generally, no application process is required by accrediting bodies or regulations for members to resign privileges, so bylaws need not establish a procedure for approval of a physician’s decision to relinquish his/her privileges. Further, restrictions placed to prevent members from resigning interfere with members’ ability to determine what services they choose to provide. To avoid unnecessary bureaucracy, members can be allowed to simply submit notification of resignation to the Medical Staff Office, which is appropriately charged with administering privileges resignations.

National Practitioner Data Bank regulations require the reporting of any relinquishment of privileges occurring while an investigation is ongoing, even if the relinquishment is unrelated to physician competence or the investigation is unrelated to the privileges relinquished, as discussed in Section 2.2.4, Investigation. Physicians should not resign any privileges for any reason without assessing whether the

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resignation will generate a National Practitioner Data Bank report. Documentation should be provided clearly stating whether the physician is under investigation at the time of any surrender of privileges.

Sample Bylaw: Resignation of Privileges
A practitioner or member who determines that he or she no longer exercises, or wishes to restrict or reduce the exercise of, some or all privileges which he or she has been granted shall send written notice, through the Medical Staff office, to the Credentials Committee and Medical Executive Committee. A copy of this notice shall be included in the member or practitioner’s credentials file. Prior to the effective date of resignation, the member or practitioner shall be provided with written disclosure of any pending investigations involving his or her membership or privileges, which would result in a National Practitioner Data Bank report should the resignation take place. No resignation is effective until the member or practitioner who resigns his or her staff appointment and/or clinical privileges fully and accurately completes all portions of all medical records for which he or she is responsible.

Template: Request for Documentation of Investigation Status
Dear [Chief of Staff]:
Effective [date], I intend to resign my [medical staff membership and clinical privileges] [the privileges listed below while retaining membership and all other privileges]. Please provide me with a written, signed declaration that I am under no investigation that would cause this resignation to be reported to the National Practitioner Data Bank or other governmental agency. I reserve the right to withdraw this resignation prior to [effective date.]
Sincerely,
[Signature /name of Requesting Member/Practitioner]

Template: Medical Staff Documentation of Investigation Status
Dear [Name of Resigning Member/Practitioner]:
There is no investigation pending involving you, your membership or privileges at [name of Hospital] as of [today’s date.] Should an investigation be initiated prior to [date], the effective date of your resignation, you will be notified that the investigation will require a report to the National Practitioner
Data Bank [and state agency], and your resignation held pending your written statement of intent to resign notwithstanding the investigation.

Sincerely,

[Signature /name of Chief of Staff]

OR

Dear [Name of Resigning Member/Practitioner]:

There is an investigation pending involving you, your membership or privileges at [name of Hospital] as of [today’s date.] For information about this investigation, please contact [Department Chair][Chief of Staff].

Sincerely,

[Signature /name of Chief of Staff]

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7. Peer Review

Peer review in its various forms is the primary tool to fulfill the medical staff’s responsibility for quality patient care. References to peer review in numerous sections throughout this Guide detail medical staff peer review in its various facets ranging from application review through hearing and appeals processes. Peer review occurs throughout a member’s tenure on the medical staff, and includes the accreditation agencies’ OPPE and FPPE procedural approaches, tools such as proctoring and “disruptive” behavior intervention, and corrective action.

The AMA defines peer review as:

“the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice. It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care. The responsibility assigned to and scope of peer review is the practice of medicine; i.e., professional services administered by a physician and the portion of care under a physician’s direction. Therefore, elements of medical care, which describe the knowledge, skills, attitudes,
and educational experiences of physicians and provide the foundation of physician activities, are subject to peer review and its protections. Those elements include, but are not limited to the following: patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. Activities that comprise medical care are subject to the scope and rigor of peer review and entitled to the protections and privileges afforded by peer review law.

“Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care. Accountability to patients and their care, to the medical profession and colleagues, and to the institution granting privileges is inherent to the peer review process” (AMA Policy H-375.962).

The important role of medical staff peer review in promoting quality hospital care is recognized and promoted by federal and state legal protections. The federal Health Care Quality Improvement Act of 1986 extends immunity to peer review activity and actions, conditioned on providing notice and fair hearing procedures to the subject physician, consistent with its standards, and on reporting action to the National Practitioner Data Bank. The April 2015 National Practitioner Guidebook calls for reporting any relinquishment of privileges, even if unrelated to the issue being investigated, while an investigation is underway, and repeatedly states that notice of investigation to the subject physician is not a prerequisite to filing a Data Bank report. To compensate for the lack of a notice requirement in the federal law, medical staff bylaws should provide for notice of investigation that also informs the physician of the ramifications of surrendering privileges during any investigation.

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65 42 U.S.C. §11101 et seq.
66 Available at http://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp.
Sample Bylaw: Notice of Investigation

Members and privileges holders shall receive written notice, upon the commencement of any investigation, disclosing the initiation and scope of investigation and advising the subject that any resignation, surrender, relinquishment or cessation of medical staff membership or any clinical privileges, including a leave of absence, whether or not related to the investigation, but while the investigation is ongoing, will be reported to the National Practitioner Data Bank.

State law protects medical staff peer review by, and may require certain procedures of, medical staffs conducting peer review. Indeed, different state laws define and protect peer review very differently. Medical staffs should carefully design and implement peer review procedures in bylaws to maximize available legal protections.

Peer review by peers is best protected in bylaws, because medical staff bylaws cannot be adopted without vote of the medical staff. Medical staffs must ensure that data gathered regarding care provided to hospitalized patients is professionally evaluated and used to improve quality. Peer review policies subject to change without medical staff approval, and authorizing administrative staff to take peer review actions, inappropriately cede this professional responsibility.

Sample bylaw: Peer Review

To fulfill its responsibility for the quality and safety of patient care, the medical staff conducts peer review exclusively according to its standards and processes in these bylaws.

Massachusetts Medical Society Model Medical Staff Bylaws Article VI.

7.1 Focused and Ongoing Professional Practice Evaluation – “FPPE” and “OPPE”

The Joint Commission describes peer review of applicants and members as either “focused professional practice evaluation” (FPPE) or “ongoing professional practice evaluation” (OPPE). Medical staffs typically use OPPE as a source of information to factor into decisions regarding members’ maintenance of existing privileges, as is required under Joint Commission Standard MS.08.01.03. FPPE is used primarily in the evaluation of members for whom there is no documented evidence of performance of...
10. Reporting Actions to Governmental Agencies

Medical staff bylaws should include procedures to promote compliance with reporting laws while preventing unnecessary reports.

At the federal level, the National Practitioner Data Bank (NPDB) gathers adverse data about physicians and dentists and to a lesser degree, due to the fact that reporting is optional, other practitioners. Failure to report adverse actions against physicians and dentists to the NPDB jeopardizes immunity available under the Health Care Quality Improvement Act, creating an incentive to report even if filing is not clearly mandated. The April 2015 NPDB Guidebook90 broadly interprets the regulatory requirement for reporting surrender of privileges to avoid or during the conduct of an investigation, calling for an

90 Available at http://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp.
expansive view of when investigation commences. The Guidebook also interprets taking a leave of absence or deciding against reapplication for a privilege as surrender, which is reportable if an investigation is on-going. Proper procedures in medical staff bylaws can provide direction to prevent loss of immunity and can close loopholes and clarify ambiguities left in the regulations and the Guidebook.

Although the NPDB offers the option of reporting actions taken against practitioners other than physicians and dentists, hospitals and medical staffs may choose not to report other practitioners. Whatever the determination, it should be included in the medical staff bylaws.

NPDB reports are permanent, surviving even the death of the physician reported, and must be obtained by hospitals whenever a physician applies for initial medical staff membership or seeks to renew membership or privileges. Managed care entities, medical groups, or other employers of physicians may query the NPDB regarding the physician so long as they are either a hospital or otherwise fall under the definition of “health care entity” in the Health Care Quality Improvement Act. Given the potential damage that inappropriate NPDB reports may cause a physician’s reputation and career, physicians and medical staffs have a clear interest in accurate NPDB reporting.

NPDB regulations have circumscribed mechanisms for correcting mistakes and misinformation. The reported individual cannot directly file a correction. Rather, the subject must attempt to persuade the reporting entity to correct its original report. To avoid a lengthy NPDB dispute process, medical staff bylaws should include a minimal dispute process between the physician and the reporting entity.

Sample Bylaw: National Practitioner Data Bank Reporting

National Practitioner Data Bank Reporting

The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the board of [trustees/directors]. The authorized representative shall report any and all revisions of an

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91 The NPDB’s reporting and querying requirements are found in regulations at 45 C.F.R. §60 et seq.
92 42 U.S.C. §11151(4)
adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

**Disputing Report Language**

If no hearing was requested, a member who is the subject of a proposed adverse action report to the Medical Board of California or the National Practitioner Data Bank may request an informal meeting to dispute the text of the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the chief of staff, the chair of the subject’s department, and the hospital’s authorized representative, or their respective designees.

If a hearing was held, the dispute process shall be deemed to have been completed.

*California Medical Association Model Medical Staff Bylaws §§7.8, 7.9*

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### 11. Officers and Representatives of the Medical Staff

Under Joint Commission Standard MS.01.01.01, Element of Performance 18, the medical staff bylaws must include “the process, as determined by the organized medical staff and approved by the governing body, by which the organized medical staff selects and/or elects and removes the medical staff officers.” Note that such provisions should be written into bylaws, as opposed to being included in a separate “organizational manual.”

#### 11.1 Elections

Selection and removal of medical staff officers, without interference from the hospital governing body, including any requirement for governing body approval, affirmance or concurrence of medical staff elections, is a fundamental element of medical staff self-governance ([AMA Policy H-235.980](AMA Policy H-235.980), [AMA Policy H-220.962](AMA Policy H-220.962), [AMA Policy H-225.957](AMA Policy H-225.957)). Board control over the outcome or interference in the process of medical staff elections for any reason contradicts this policy—and violates accreditation