REPORT OF THE BOARD OF TRUSTEES

B of T Report 4-I-17

Subject: Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care

Presented by: Gerald E. Harmon, MD, Chair

At the 2016 Interim Meeting, the House of Delegates (HOD) adopted Policy D-355.996, “Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care,” with a progress report back at the 2017 Interim Meeting. This policy asks that:

- Our AMA will seek legislation and/or regulation that would require the Health Resources and Services Administration (HRSA) to clarify that reports to the National Practitioner Data Bank (NPDB) of medical malpractice settlements by physicians be limited to those cases in which the named physician was directly involved in the provision of or failure to provide healthcare services.

- Our AMA will seek legislation and/or regulation that would require HRSA to audit the NPDB for reports on physicians who were not involved in the treatment of a plaintiff, but were reported as a result of a healthcare entity’s settlement of a claim that included the names of those physicians in their administrative roles at the entity.

- Our AMA will seek legislation and/or regulation that would require HRSA to remove reports from the NPDB of any physician who was reported as the result of the settlement of a claim by a healthcare entity where the physician was not involved in the treatment of the plaintiff.

In addition to this resolution, the HOD also adopted new policy at the 2017 Annual Meeting that directly relates to reporting on physicians who were not involved in treatment or patient care.

Policy H-355.976(7), “National Practitioner Data Bank,” states that:

- Our AMA will: (a) request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial of physicians be (i) contingent upon competency or conduct related to the physicians’ provision of or failure to provide healthcare services that adversely affect the health or welfare of a patient, and (ii) only based on a professional review action and not for administrative or eligibility reasons; and (b) advocate that HRSA remove the name of any physician from the National Practitioner Data Bank reported for reasons not related to competence or conduct that adversely affected the health or welfare of a patient.
This report provides background on the NPDB, including its history and the integration of the Healthcare Integrity and Protection Data Bank into the NPDB; analyzes the reporting requirements in medical liability payments and medical staff appointments; highlights related AMA policy; and discusses AMA’s interactions with HRSA.

BACKGROUND: NATIONAL PRACTITIONER DATA BANK

The NPDB is a United States Government program that collects certain negative information on health care providers, including adverse licensure or clinical privileges actions, medical malpractice actions, and exclusion from participation in Medicare and Medicaid. The NPDB provides access to this negative information to only authorized users, such as hospitals and medical boards, but not the general public. The NPDB is managed by the Bureau of Health Workforce of the Health Resources and Services Administration in the U.S. Department of Health and Human Services.

History

The NPDB was created by Congress to restrict the ability of health care providers to move from state to state without disclosure or discovery of the provider’s previous disciplinary actions, licensure restrictions, or settled or adjudicated liability lawsuits. In addition, due to the threat of private money damages liability under federal laws, Congress wanted to provide incentives and protection for health care providers engaging in effective professional peer review.

The NPDB was established by the Health Care Quality Improvement Act of 1986 (HCQIA) and subsequent laws expanded the information collected and disclosed by the NPDB and modified its operations.

- Section 1921 of the Social Security Act authorizes the federal government to collect information concerning certain adverse licensure actions taken against any authority of the state responsible for the licensing of such practitioners or entities and reporting any negative action or finding that a state licensing authority, a peer review organization, or a private accreditation entity had taken against a health care practitioner or health care entity.
- Section 1128E of the Social Security Act established a national care fraud and abuse data collection program for the reporting and disclosing of certain final adverse actions taken against the health care provides. This data bank was known as the Healthcare Integrity and Protection Data Bank (HIPDB).
- Section 6403 of the Affordable Care Act amended sections 1128E and 1921 of the Social Security Act to eliminate duplication between the HIPDB and the NPDB. It also required the transferring of data collected in the HIPDB to the NPDB and to cease HIPDB operations. Information previously collected and disclosed by the HIPDB is now collected and disclosed by the NPDB. The transition of data from the HIPDB to the NPDB was completed in May 2013. This transition means that the NPDB jurisdiction is broader than its original intent and now includes all adverse actions from a medical licensing authority and any health care-related civil judgments or criminal convictions.

When a health care provider is subject of a NPDB report, the individual can—at any time—add a statement to the report or initiate a dispute. The statement becomes part of the report and remains with the report unless the individual edits or removes it. The statement is sent to the reporting entity, all queriers who received a copy of the report within the past three years, and is included in the future query responses.
An individual can also initiate a dispute and enter the report into “dispute status” to disagree with either the factual accuracy of the report or whether the report was submitted in accordance with NPDB requirements. Once in dispute status, the individual must contact the reporting entity and attempt to resolve the dispute directly. If the reporting entity fails to respond or responds unsatisfactorily, the individual can elevate the case to “dispute resolution.” In dispute resolution, HRSA will review and determine whether the information is accurate and reportable to the NPDB. If the information is inaccurate, HRSA will direct the reporting entity to revise or void the report. While NPDB was established to improve health care quality, protect the public from incompetent providers, and reduce health care fraud and abuse, HRSA needs to provide clarification to stop unnecessary reporting to the NPDB when the physician’s conduct or competency in question is not related to the health or welfare of a patient. Unnecessary reporting is damaging to a physician’s reputation, employment status, hospital medical staff privileges, and future employment opportunities. Specifically, AMA policy shows concerns regarding unnecessary reporting of medical liability payments and medical staff appointment denials.

**Reporting of Malpractice Payments**

The NPDB requires medical malpractice payers to report medical malpractice payments. The payment is for the benefit of a health care provider in settlement of a written claim or judgment for medical malpractice against that practitioner. A payment made as a result of a suit or claim solely against an entity (e.g., hospital) that does not identify an individual practitioner should not be reported to the NPDB. Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. A medical malpractice payer also reports a supervisory practitioner that is named in a complaint based on the actions of a subordinate practitioner (e.g., resident, student).

The written complaint or claim must be based on a provider’s provision of or failure to provide health care services. However, the NPDB statute, regulation, guidebook, or FAQs do not further define “provision of or failure to provide health care services.” Without any further clarification from HRSA, malpractice payers are reporting instances to the NPDB where the physician serves in an administrative only capacity and has no direct contact or relationship with the plaintiff that is demanding payment. In these instances, physicians are not providing health care services or failing to provide health care services. Therefore, these payments should not be reported to the NPDB because NPDB’s statutes and regulations limit the filing of medical malpractice reports based on whether a physician provided or failed to provide health care services.

**Reporting Medical Staff Appointment Denials**

The NPDB requires hospitals and other health care entities to report adverse clinical privileges actions. An adverse action includes any professional review action that adversely affects the clinical privileges of a physician for a period of more than 30 days. It also includes the acceptance of the surrender or restriction of clinical privileges while the physician is under investigation relating to possible incompetence or unprofessional conduct or when the surrender occurs in lieu of conducting an investigation. Clinical privileges include privileges, medical staff membership, and other circumstances in which a physician is permitted to furnish medical care by a health care entity. Thus, a medical staff denial is a type of clinical privilege.

Adverse clinical privileges actions are based on a physician’s competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient. Whether an action affects or could affect patient health or welfare is generally a determination that must be
made by the hospital or other entity taking the action. If, in the opinion of the entity, the provider’s actions could adversely affect the health or welfare of a patient, and the action is the result of a professional review, the action must be reported to the NPDB. Potential actions include lying on an application, not completing medical records, outbursts of anger, throwing charts and instruments in the operating room, and cutting and pasting notes and lab results from one patient’s electronic health record (EHR) to another patient’s EHR.

Administrative actions that do not involve a professional review action should not be reported to the NPDB. Thus, if an individual is denied clinical privileges because the individual failed to meet a hospital’s established threshold criteria (e.g., board certification), the hospital should not report this action to the NPDB. Furthermore, matters not related to the professional competence or professional conduct of a practitioner should not be reported. For example, adverse actions based primarily on a practitioner’s advertising practices, fee structure, salary arrangement, affiliation with other associations or health care professionals, or other competitive acts intended to solicit or retain business are excluded from NPDB reporting requirements.

While the NPDB Guidebook states that actions that do not involve a professional review action should not be reported, physicians are still being reported based on administrative and eligibility reviews. HRSA needs to provide further clarification as to what constitutes a professional review action and what constitutes an administrative or eligibility-based action. In addition, although HRSA states that it is the opinion of the reporting entity as to whether an action affects or could affect patient health or welfare, it would be beneficial to both reporting entities and health care providers to state factors that a hospital should consider in making this determination.

AMA OUTREACH WITH HRSA

AMA has consistently reached out to HRSA involving the NPDB, including proposed rule and guidebook comments. Because of the duplicative reports and often misleading information that can be found in the NPDB, previous correspondence has helped ensure that the NPDB remains unavailable for public access. Moreover, AMA’s comments on the draft guidebook ensured that censures, reprimands, or admonishments are not reported to the NPDB. Furthermore, AMA advocacy led to inclusion of the following language in the 2015 revision to the NPDB guidebook: “Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a practitioner’s provision of or failure to provide health care services.”

In August 2017, the AMA sent a letter to HRSA seeking clarification regarding malpractice payments and medical staff appointment denials and reiterating concerns surrounding the surrendering of clinical privileges while a provider is unaware of an ongoing investigation. The letter also requests a meeting between AMA and HRSA to discuss these issues. While Policy D-355.996 suggests that the AMA also seek potential legislation, advocating for a legislative change would provide an opportunity for some members of Congress and other groups to open the NPDB to the general public. Your Board believes a more prudent and practical approach is to continue to work with HRSA to provide the necessary clarifications for reporting to the NPDB.

CONCLUSION

As of the date this report was drafted, HRSA has not responded to AMA’s request for a meeting. The AMA will continue to urge HRSA to provide clarification and potentially remove individuals who were improperly reported to the NPDB.
REFERENCES

1 42 U.S.C. 11101 et seq.
2 Section 1921 of the Social Security Act as amended by section 5(b) of the Medicare and Medicaid Patient and Program Protection Act of 1987, Public Law 100–93, and as amended by the Omnibus Budget Reconciliation Act of 1990, Public Law 101–508.
4 Section 6403 of the Patient Protection and Affordable Care Act of 2010, Public Law 111–148.
7 Comment Letter from AMA to HRSA, Notice of Proposed Rulemaking Concerning Privacy Act; Exempt Record System, Apr. 18, 2011; Letter from AMA to HRSA; The National Practitioner Data Bank Public Data File, Sept. 23, 2011; Comment Letter from AMA to HRSA, Elimination of Duplication Between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank, Apr. 16, 2012; Comment Letter from AMA to HRSA, Draft Revised Guidebook for the National Practitioner Data Bank; Jan. 31, 2014; Comment Letter from AMA to HRSA, National Practitioner Data Bank Surrendering of Privileges, Nov. 8, 2016.
8 Letter from AMA to HRSA, NPDB Clarification on Medical Malpractice Payments and Adverse Clinical Privileges Actions, August 3, 2017.

APPENDIX – CURRENT AMA POLICY

Policy H-355.976, “National Practitioner Data Bank”
1. Our AMA believes that (A) the National Practitioner Data Bank requirements should be modified so that settlements and judgments of less than $30,000 are not reported or recorded; (B) reports, other than licensure revocation, in the Data Bank should be purged after five years; (C) proctoring of physicians for the purpose of investigation should not be reportable; (D) physicians should not be required to turn over copies of their Data Bank file to anyone not authorized direct access to the Data Bank; and (E) any physician’s statement included in the Data Bank file should automatically accompany any adverse report about that physician in distributions from the Data Bank.
2. Our AMA will (a) work with HHS to establish a mechanism to inform physicians when an inquiry to the Data Bank has been made; and (b) support efforts to require the same Data Bank reporting requirements for physicians, dentists and other licensed health care practitioners.
3. Our AMA: (a) opposes all efforts to open the National Practitioner Data Bank to public access; (b) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (c) opposes the implementation by the National Practitioner Data Bank of a self-query user fee.
4. Our AMA supports using all necessary efforts to direct the National Practitioner Data Bank to send all notifications to physicians by certified mail return receipt requested, and supports using all necessary efforts at the federal level to direct the National Practitioner Data Bank to begin the sixty day appeal process from the date the physician receives notification.
5. Our AMA will work with the appropriate federal agencies to ensure that the National Practitioner Data Bank reflects all disciplinary actions on appeal, and to remove from the physician’s record reported decisions which have been overruled.
6. Our AMA will continue to monitor the issue of reporting impaired physicians to the National Practitioner Data Bank and will seek further clarification of ambiguities or misinterpretations of the reporting requirements for impaired physicians.
7. Our AMA will: (a) request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial of physicians be (i) contingent upon competency or conduct related to the physicians’ provision of or failure to provide healthcare services that adversely affect the health or welfare of a patient, and (ii) only based on a professional review action and not for administrative or eligibility reasons; and (b) advocate that HRSA remove the name of any physician from the National Practitioner Data Bank reported for reasons not related to competence or conduct that adversely affected the health or welfare of a patient.
Policy H-355.975, “Opposition to the National Practitioner Data Bank”
1. Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank.
2. Our AMA affirms its support for the Federation of State Medical Boards Action Data Bank and seeks to abolish the National Practitioner Data Bank.
3. Our AMA urges HHS to retain an independent consultant to (A) evaluate the utility and effectiveness of the National Practitioner Data Bank, (B) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (C) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office.
4. Our AMA will take appropriate steps to have Congress repeal Section 4752 (f) of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank.
5. Our AMA seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report;
6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement.
7. Our AMA (A) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (B) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least $30,000 for the reporting of malpractice payments be established as soon as possible; (C) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (D) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information; and (E) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure.
8. Our AMA will review questions regarding reportability to the Data Bank and will provide periodic updates on this issue to the AMA House of Delegates.

Policy H-355.990, “National Practitioner Data Bank”
(1) The AMA shall continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank (NPDB).
(2) The AMA requests that the Health Resources and Services Administration (a) prepare and disseminate to physician and hospital organizations a white paper addressing its plans to enhance the confidentiality/security provisions of the reporting and querying process no later than December 1992; (b) conduct a statistically valid sample of health care entities, other than hospitals, on the entity file to determine if entities that are not eligible to query under the statute and regulation have gained access to the NPDB information, and disseminate the results to the NPDB Executive Committee no later than December 1992; (c) implement appropriate steps to ensure and maintain the confidentiality of the practitioner’s self-query reports no later than December 1992; (d) recommend to the Congress that small claims payments, less than $30,000, no longer be reported to the NPDB and provide the Executive Committee members the opportunity to attach their comments on the report that goes to the Congress; (e) allow by January 1, 1993, the practitioner to append an explanatory statement to the disputed report; and (f) release the evaluation report, prepared by Dr. Mohammad Akhter, on the NPDB’s first year of operation to the AMA by July 1992.
(3) The AMA will reevaluate at the 1992 Interim Meeting the progress on these issues. If the preceding requests are not met by the established due date and the House of Delegates is not satisfied with the progress on these issues, the AMA will again reevaluate the implementation of Policy H-355.991.
Policy H-355.974, “National Practitioner Data Bank”

1. Our AMA will advocate to the Health Resources and Services Administration that a physician’s surrender of clinical privileges or failure to renew clinical privileges while under investigation should not be reported to the National Practitioner Data Bank unless the physician has been notified that an investigation is underway.

2. Our AMA: (a) recommends that medical staff bylaws require that physicians be notified in writing prior to the start of any investigation; and (b) include this recommendation in our AMA Physician’s Guide to Medical Staff Organization Bylaws.