



Published in IDC Quarterly, Third Quarter 1998

Reporting Requirements in the Health Care Field

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Introduction

Federal, state, and private regulations involving health care professionals and entities have increased significantly in recent years. At times, these regulations can have serious ramifications when defending medical malpractice claims. Too often, however, defense counsel for health care professionals are either unaware of or fail to inform their clients of these regulations when handling malpractice claims. This article is intended to provide a review of these regulations and their ramifications on medical malpractice defense.

The National Practitioner Data Bank

In 1986, Congress passed the Health Care Quality Improvement Act ("HCQIA")² in an effort to improve the quality of health care on a national basis by encouraging medical professionals to identify and discipline practitioners who engage in unprofessional behavior, and to restrict the ability of such practitioners to move from State to State without disclosure of their adverse performance records.³ To that end, HCQIA mandated the establishment of the National Practitioner Data Bank ("NPDB") to act as an "information clearinghouse" by collecting and releasing certain information related to the conduct of physicians, dentists, and other health care providers.⁴

In light of the NPDB, defense counsel now has additional concerns to consider when representing health care providers in medical malpractice cases.

The role of the NPDB is to act as a central repository of the following: (1) medical malpractice payment information; (2) licensure actions taken against physicians and dentists; (3) mandatory professional review actions taken against physicians and dentists, and optional reviews of other licensed practitioners; and (4) actions taken against medical professionals by the Drug Enforcement Agency.⁵

To gather this information, the NPDB requires several entities to report to it. For instance, medical malpractice payers must submit reports to the NPDB and the appropriate state licensing board within 30 days of any payment made on behalf of a physician, dentist, or other health care practitioner resulting from a written claim or judgment. The report must include the name of the licensed health care practitioner for whose benefit the payment is made, the amount of the payment, the name of any hospital with which the individual is affiliated, and a description of the acts and injuries upon which the claim was based.⁶ Significantly, individual practitioners (but not professional corporations or other business entities) are not required to report malpractice payments they make on their own behalf out of personal funds.⁷ Furthermore, malpractice payments made solely for the benefit of a corporation, such as a clinic, group practice, or hospital, are not reportable to the NPDB.⁸

Hospitals, other health care entities, and professional societies must also submit reports to the NPDB and state licensing boards within 15 days of an adverse action taken by the hospital or entity against its staff or employee.⁹ The reported action must have adversely affected the individual's clinical privileges for a period longer than 30 days and must have been taken for reasons related to the individual's professional competence or conduct.¹⁰ The hospital or entity must also report the voluntary surrender or restriction of privileges if the individual is under or is attempting to avoid investigation.¹¹

State licensing boards are the final entities required to report to the NPDB.¹² They must report, within 30 days, adverse licensure actions that are based on reasons related to the competence or conduct of a physician or dentist.¹³ The report of the state licensing board must include the name of the health care practitioner and a description of the acts or other reasons for the revocation, suspension, or surrender of license.¹⁴

The general public does not have access to the NPDB.¹⁵ Rather, the gathered information is available to several distinct classes of individuals or entities.¹⁶ The information is available to hospitals

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requesting information concerning a practitioner on their medical staff or to whom they have granted clinical privileges, or with respect to professional review activity.¹⁷ The information is also available to health care entities (including hospitals) which have entered or may be entering employment or affiliation relationships with a practitioner, or to which the practitioner has applied for clinical privileges or appointment to the medical staff, or with respect to professional review activity.¹⁸ In fact, hospitals must access the NPDB when a physician applies for a position on its medical staff, as well as every two years for every physician who is currently on its medical staff.¹⁹

The information in the NPDB is also available to persons or other entities if the request is for information that will not identify any particular entity or practitioner.²⁰ Such requests may include information regarding the location and nature of the claim and the amount of the payment made. State licensing boards may also request information, as can health care practitioners if the request is about themselves.²¹ Finally, attorneys or *pro se* litigants may obtain information if they have filed a medical malpractice action against a physician, and they submit evidence that a hospital employing the physician failed to request the physician's records from the NPDB at the time the physician applied for clinical privileges or a staff position or failed to request an update every two years.²²

HCQIA provides that payment of a settlement or judgment creates no presumption that malpractice has occurred.²³ Despite this presumption, no health care practitioner wants to be reported. Rightly or wrongly, many health care practitioners believe being reported carries a stigma that is the professional equivalent of a scarlet letter. On a more practical level, being reported can have a direct effect on the professional life of a physician or dentist, particularly since information cannot be expunged once provided. Hospital credentialing authorities might reject or no longer retain reported practitioners, particularly if they have been reported more than once. Such practitioners may be rejected or no longer retained solely to protect the hospital from exposure to future liability if the practitioner is later sued for malpractice.²⁴

Thus, in representing the health care practitioner, defense counsel has several responsibilities. Defense counsel should provide full disclosure to his client of the NPDB and its requirements. Oftentimes the health care practitioner is generally aware of the NPDB, but has an inaccurate knowledge of its requirements, scope, practical implications.

As the case proceeds, defense counsel and the health care practitioner must evaluate and weigh the

advantages and disadvantages in settling the case or taking the case to a verdict. Whereas health care practitioners in the past may have been more inclined to settle cases, particularly for their nuisance value, the existence of the NPDB arguably provides the practitioner with less incentive to settle, because any settlement, no matter how small, must be reported. Defense counsel and the practitioner will therefore have to balance the economic benefits to settling a case with the non-economic costs associated with being reported to the NPDB.

This evaluation process can be complicated if other entities - such as the insurer or a codefendant hospital who defense counsel also represents - are eager to settle the case. Whereas the health care practitioner may be reluctant to settle for the reasons expressed above, the hospital or insurer may have the opposite attitude, particularly if the settlement is for a nuisance value. Unlike for the individual practitioner, payments made on behalf of a hospital are not reportable to the NPDB. Defense counsel, therefore, should be sensitive to potential conflict of interest problems in this area, and advise the client that the potential exists for having a conflict about whether the case should be settled.²⁵

To protect the health care practitioner from being reported to the NPDB, particularly in cases where the lawsuit could be settled for nuisance value, defense counsel have increasingly structured settlements so that the practitioner is dismissed from the case and the settlement is paid by or on behalf of a codefendant hospital or other entity that does not have to report to the NPDB.²⁶ Although some may consider this tactic a deliberate attempt to circumvent the underlying policy of HCQIA, the U.S. Department of Health and Human Services, the agency responsible for implementing and administering the NPDB, apparently considers such tactics permissible. According to the NPDB Guidebook promulgated by the Department, a health care practitioner named in the written complaint or claim who is subsequently dismissed from the lawsuit and not named in the settlement release is not reportable to the NPDB.²⁷ Until Congress or the Department decides otherwise, this approach is likely to be continued.

The Medical Practice Act of 1987

In addition to the requirements imposed by the HCQIA, Illinois law imposes certain reporting requirements on health care institutions, professional associations, and professional liability insurers. Under the Medical Practice Act of 1987 ("the Act"),²⁸ these entities are required to file reports in certain circumstances with the Illinois Department of

Professional Regulation (IDPR) regarding a person's professional conduct and capacity. Specifically, health care institutions must report the termination or restriction of a person's clinical privileges when the institution has determined that a person has committed an act which may directly threaten patient care (but not of an administrative nature), or that the person may be mentally or physically disabled in such a manner as to endanger patients under the person's care.²⁹ Professional liability insurers/insurance companies, which offer policies of professional liability insurance to persons licensed under the Act, must report the settlement of any claim or cause of action, or final judgment rendered in any cause of action, which alleged negligence in the furnishing of medical care by such licensed person when the settlement or final judgment is in favor of the plaintiff.³⁰

Under section 23 of the Act, health care institutions, professional associations, and professional liability insurers only have a duty to make reports of persons licensed under the Act.³¹ The Act itself regulates persons who "practice medicine, or any of its branches, or treat human ailments without the use of drugs and without operative surgery."³² Although no reported case has addressed the issue, it is unlikely that the Act, or section 23 in particular, applies to dentists. First, as a requirement for licensure under the Act, an applicant must be a graduate of a medical or osteopathic college.³³ Dentists, however, are graduates of schools of dentistry.³⁴ With only a degree in dentistry, dentists are ineligible to be licensed under the Act, and thus not subject to section 23 of the Act. Second, dentists are already subject to the licensing requirements of the Dental Practice Act.³⁵ Again, although not addressed by any reported cases, a dentist is likely to be required to comply only with the provisions of the Dental Practice Act, as it is the more specific regulatory statute.³⁶ Interestingly, the Dental Practice Act does not contain a section that parallels section 23 of the Medical Practice Act. Accordingly, professional liability insurers have no duty under Illinois law to report the settlement of any claim or cause of action, or final judgment rendered in any cause of action, which alleged negligence in the furnishing of dental care by a licensed dentist when the settlement or final judgment is in favor of the plaintiff.

Upon the receipt of any report called for by the Medical Practice Act, the Medical Disciplinary Board of the IDPR shall notify the person who is the subject of the report in writing by certified mail.³⁷ The notification shall include a written notice setting forth the person's right to examine the report, and shall include the address where the file is kept, the name of the custodian of the file, and the custodian's telephone number.³⁸ Effective July 1, 1997, the

person who is the subject of the report must submit a written statement responding, clarifying, adding to, or proposing the amending of the report previously filed.³⁹ The failure to submit a written statement constitutes a Class A misdemeanor.⁴⁰ The statement must be received by the Medical Disciplinary Board no more than 60 days after the date on which the person was notified by the Medical Disciplinary Board of the existence of the original report. The statement will then become a permanent part of the file.⁴¹

The Medical Disciplinary Board shall then review all reports received by it, together with any supporting information and responding statements submitted by persons who are the subject of the reports. The initial review will occur between 60 and 180 days after the receipt of the initial report by the Medical Disciplinary Board.⁴² Upon the completion of the initial review, the Disciplinary Board must, in writing, make a determination as to whether there are sufficient facts to warrant further investigation or action.⁴³ Failure to make this determination in the time provided is construed as a determination that there are insufficient facts to warrant further investigation or action.⁴⁴ Should the Disciplinary Board make such a determination, the matter shall be deemed closed.⁴⁵ The Disciplinary Board shall prepare a summary report of final actions taken. This report must be sent to every health care facility licensed by the Illinois Department of Public Health, every professional association and society of persons licensed under the Medical Practice Act functioning on a statewide basis, the American Medical Association, the American Osteopathic Association, the American Chiropractic Association, all insurers, the Federation of State Medical Licensing Boards, and the Illinois Pharmacists Association.⁴⁶

The Health Care Fraud and Abuse Data Collection Program

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") was enacted to combat rising health care fraud and abuse.⁴⁷ Title II of HIPAA creates four separate approaches to attacking health care fraud and abuse, including: education of providers with the establishment of a national fraud and abuse data bank; extension of parties covered under the Act; and enhancement of enforcement and expansion of penalties.⁴⁸ Pursuant to these goals, effective January 1, 1997, the Secretary of the Department of Health and Human Services was directed to establish a national data bank to record information about providers and suppliers that have committed health care fraud or abuse.

Under the Federal provisions governing the data collection program, each government agency and health plan is under an obligation to report any “final adverse action” taken against a health care provider, supplier, or practitioner.⁴⁹ The data bank will record the names of each such provider or supplier, the care entities with which such providers or suppliers are affiliated, the nature of the fraudulent acts or omissions, and any injury resulting therefrom.⁵⁰ A “final adverse action” is defined to include:

- (i) Civil judgments against a health care provider, supplier or practitioner in Federal or State court related to the delivery of a health care item or service.
- (ii) Federal or State criminal convictions related to the delivery of a health care item or service.
- (iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—
 - (a) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,
 - (b) any other loss of license of the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or
 - (c) any other negative action or finding by such Federal or State agency that is publicly available information.
- (iv) Exclusion from participation in Federal or State health care programs (as defined in sections 1128B(f) and 1128(h), respectively).
- (v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.⁵¹

Malpractice claims and settlements are specifically excepted from the definition of “final adverse actions.”⁵² Additionally, any settlement in which no finding of liability is made need not be reported.

All government agencies and health plans have a continuing obligation to report corrections to information previously reported. Unless they knowingly report false information, plans and agencies are immune from civil liability for reports to the data bank.⁵³ As of this writing, the Department of Health and Human Services has not yet published its initial reporting date. Once established, the regulations provide for regular reports (but not less often than monthly).⁵⁴

Providers and suppliers of information reported to the data bank may access their information, and the Department of Health and Human Services is to establish specific procedures for obtaining information, as well as for addressing disputes regarding the accuracy of information reported.⁵⁵ The Federal guidelines do provide for the imposition of fees to retrieve information.

As this database is in its infancy, it is difficult to assess the reliability and usefulness of the information being collected. To date, there is insufficient data to assess whether the Data Collection Program has contributed to alleviating health care fraud and abuse. The information being accumulated is distinct from that of the National Practitioner Data Bank. In fact, the provisions regulating the Data Collection Program mandate that the Secretary of the Department of Health and Human Services implement the program in a manner as to avoid duplication with the reporting requirements established for the National Practitioner Data Bank.⁵⁶

The Data Sharing Project of the Physician Insurers Association of America

In 1985, the Physician Insurers Association of America (“PIAA”) established the Data Sharing Project to collect and disseminate information regarding medical malpractice claims.⁵⁷ First established in 1977, the PIAA is a non-profit trade association with a primary purpose of representing the interests of U.S. based physician owned or controlled professional liability insurance carriers. One of the founding purposes of the PIAA was to exchange information regarding malpractice industry trends and operations. The PIAA Data Sharing Project collects data on a semi-annual basis from twenty-four participating companies and was created primarily as a loss prevention tool.⁵⁸

The PIAA Data Sharing Project is utilized extensively by the insurance company members to provide evidence of medical conditions, procedures and practices that can give rise to medical malpractice claims. The Project uses a complex code system which incorporates the International

Classification of Diseases to identify medical conditions and treatments and on other systems of specialized codes to account for medical – legal issues.⁵⁹ The PIAA Data Sharing System tracks adverse medical outcomes in conjunction with financial trends for medical malpractice claims. The system includes documentation of pending claims, as well as claims that have been settled, with or without an indemnity payment. Significantly, and in contrast to the NPDB, the PIAA Data Sharing Project does not identify individual practitioners.

Since its inception in 1985, the Project has grown to include information in excess of 160,000 medical malpractice claims and legal actions.⁶⁰ The information collected is referenced into 45 separate categories in an effort to compile nationwide comprehensive malpractice loss statistics on an ongoing basis.⁶¹ The system is designed to investigate meaningful comparative trends. Unlike the NPDB, the PIAA Data Sharing Project collects specific information relating to the physicians medical specialty, nature of the illness of the patient, diagnoses, medical procedures performed, and other detailed data describing the medical treatment from which the malpractice claim arose.⁶² The majority of the data in the PIAA Data Sharing Project is focused upon the nature and details of the malpractice incident so it can be used as a comprehensive loss prevention resource. Over the past decade, the PIAA information collected has been utilized by its member companies to support loss prevention programs, to measure the cost of losses for certain medical procedures, and to assess financial trends in medical malpractice indemnity and expense payments.⁶³

Currently, twenty-four of the forty-eight domestic carriers affiliated with PIAA participate in the Data Sharing Project.⁶⁴ While only participating PIAA member insurance carriers may report data to the project, analytical output from the database is provided to any inquiring entity.⁶⁵ Information available does not specifically define what constitutes an appropriate entity to obtain collected information.

Critics of the PIAA database note that the failure to include information regarding the identity of physicians results in the lack of an exposure base to measure the incidence of claims for various demographic elements. The PIAA counters that the primary purpose of establishing the Data Sharing Project was to provide clinical loss prevention data which can be utilized in evaluating trends and educating physicians. The information gathered to date has been effectively utilized by the PIAA member companies in their risk management efforts and financial trending. The data allows users to evaluate conditions or procedures for any major

specialty group that most frequently result in an adverse outcome. Additionally, information relating to severity of injury is documented to predict recurrent events with the serious outcomes.

Conclusion

The regulatory schemes created under HCQIA, the Medical Practice Act of 1987, and HIPAA impose ever greater reporting burdens on those in the health care field. To serve his client effectively, defense counsel must be aware of these regulations and advise his client of their ramifications. This is particularly true with regard to the reporting requirements under HCQIA, since individuals must be reported to the NPDB without any regard to the degree of the alleged wrongdoing or the amount of the malpractice payment. If a settlement is reached or a judgment rendered against the health care practitioner, defense counsel should inform the practitioner that he will need to file a written statement responding to the report submitted as a result of the settlement or judgment.

Defense counsel should also be aware of and use the information available under the PIAA Data Sharing Project. The PIAA represents a valuable source of information in the risk management setting because it both measures the cost of losses for certain medical procedures and assesses financial trends in medical malpractice indemnity and expense payments. Whenever possible, defense counsel should consult this resource when evaluating a case for settlement or jury verdict potential. Defense counsel may also find the PIAA Data Sharing Project a valuable resource in non-litigation arenas, such as when giving seminars to hospital personnel or risk managers.

¹ The authors would like to thank Megan Chaparro for her assistance in the preparation of this article.

² See 42 U.S.C. §§ 11101-11152 (West 1997). Regulations governing the NPDB are codified at 45 C.F.R. § 60 (1989).

³ See National Practitioner Data Bank Guidebook, at A-2 (May 1996) [hereinafter NPDB Guidebook].

⁴ NPDB Guidebook, at A-2.

⁵ Lawrence E. Smarr, A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner data Bank: Policy, Purpose, and Application, 60 Law and Contemporary Problems 59, 62 (Winter 1997), citing National Practitioner Data Bank, National Practitioner Data Bank 1996 Annual Report (1997), at 2.

⁶ 42 U.S.C. § 11131(b) (West 1997); 45 C.F.R. § 60.7(b).

⁷ *American Dental Assoc. v. Shalala*, 3 F.3d 445 (D.C. Cir. 1993).

⁸ NPDB Guidebook, at E-9

⁹ NPDB Guidebook, at E-14 and E-22.

¹⁰ 42 U.S.C. § 11133(a)(1)(A); NPDB Guidebook, at E-15; 45 C.F.R. § 60.9(a)(1)(i) and (A).

¹¹ 42 U.S.C. § 11133 (a)(1)(B) (i-ii); NPDB Guidebook, at E-15; 45 C.F.R. § 60.9(a)(1)(ii).

¹² 42 U.S.C. § 11133(b); 45 C.F.R. § 60.8(a).
¹³ 45 C.F.R. § 60.8(b) (1989); NPDB Guidebook, at E-21.
¹⁴ Id.
¹⁵ 42 U.S.C. § 11137(b)(1); 45 C.F.R. § 60.13(a).
¹⁶ 45 C.F.R. § 60.11(a).
¹⁷ 45 C.F.R. § 60.11(a)(1).
¹⁸ 45 C.F.R. § 60.11(a)(4).
¹⁹ 45 C.F.R. § 60.11.
²⁰ 45 C.F.R. § 60.11(a)(7).
²¹ 45 C.F.R. § 60.11(a)(2).
²² 45 C.F.R. § 60.11(a)(5).
²³ See 42 U.S.C. § 11137(d).
²⁴ See Nolan N. Atkinson, How the National Practitioner Data Bank Affects Medical Malpractice Clients, 39 ALI-ABA Course of Study 111, 114 (Nov. 6, 1997).
²⁵ Johnson, Reports to the National Practitioner Data Bank, 265 JAMA 407-08, 410-11 (1991).
²⁶ See Ryzen, The National Practitioner Data Bank Problems and Proposed Reforms, 13 The Journal of Legal Medicine, 409, 437 (1992).
²⁷ NPDB Guidebook, at E-9.
²⁸ See 225 ILCS 60/1 et seq. For the reader's information, this Act has been repealed effective January 1, 2007, pursuant to 5 ILCS 80/4.17 (West 1996).
²⁹ 225 ILCS 60/23(A)(1).
³⁰ 225 ILCS 60/23(A)(3).
³¹ 225 ILCS 60/23.
³² 225 ILCS 60/3.
³³ 225 ILCS 60/11(A)(1)(a).
³⁴ See Dorland's Illustrated Medical Dictionary, at 442 (28th ed. 1994) (defining a dentist as "a person who has received a degree from an accredited school of dentistry and is licensed to practice dentistry by a state board of medical examiners").
³⁵ See 225 ILCS 25/1 et seq. For the reader's information, this Act has been repealed effective January 1, 2006, pursuant to 5 ILCS 80/4.16 (West 1996).
³⁶ See *Maxwell v. Hobart Corp.*, 216 Ill. App. 3d 108, 111, 576 N.E.2d 268, 270 (1991) (where two statutes deal with the same subject, one specific and one general, the more specific statute controls); *cf. People v. Urban*, 196 Ill. App. 3d 310, 313, 553 N.E.2d 740, 742 (1990) (Cannabis Control Act preempts general criminal conspiracy statute, where the defendant was charged with conspiracy to deliver between 30 and 500 grams of a substance containing cannabis).
³⁷ 225 ILCS 60/23(E).
³⁸ 225 ILCS 60/23(E).
³⁹ 225 ILCS 60/23(E).
⁴⁰ 225 ILCS 60/23(G).
⁴¹ 225 ILCS 60/23(E).
⁴² 225 ILCS 60/23(E).
⁴³ 225 ILCS 60/23(E).
⁴⁴ 225 ILCS 60/23(E).
⁴⁵ 225 ILCS 60/23(E).
⁴⁶ 225 ILCS 60/23(E).
⁴⁷ 42 U.S.C. § 1320A-7e(b)(1).
⁴⁸ Jack A. Rovner, Health Care Fraud and Abuse Control After HIPAA, 9 no. 6 Health Law. 17 (1997).
⁴⁹ 42 U.S.C. § 1320a-7e(b)(1).
⁵⁰ 42 U.S.C. § 1320a-7e(b)(2).
⁵¹ 42 U.S.C. § 1320a-7e(g)(1)(A).
⁵² 42 U.S.C. § 1320a-7e(g)(1)(B).
⁵³ 42 U.S.C. § 1320a-7e(e).
⁵⁴ 42 U.S.C. § 1320a-7e(b)(4).
⁵⁵ 42 U.S.C. § 1320a-7e(c)(2).
⁵⁶ 42 U.S.C. § 1320a-7e(f).
⁵⁷ Smarr, *supra* note 4 at 59.
⁵⁸ Id. at 72.
⁵⁹ Physicians Insurers Association of America, Data Sharing Project Reference Manual (1985).

⁶⁰ Smarr, *supra* note 4 at 62.
⁶¹ Id. at 65.
⁶² Id.
⁶³ Id.
⁶⁴ See generally PIAA Manual, *supra* note 3.
⁶⁵ Id.