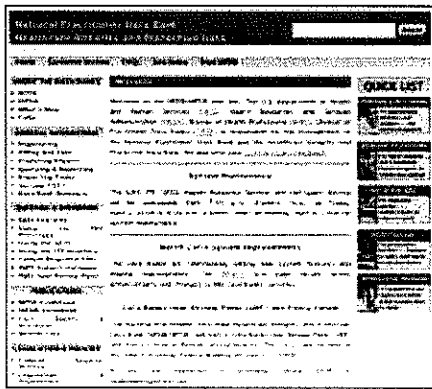


# The National Practitioner Data Bank: How Does It Actually Work?

By CHRIS YEILDING

The National Practitioner Data Bank (NPDB) is a permanent record of sorts for physicians, dentists, and other health care practitioners which serves as a self-described "alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials." Required submissions to the NPDB include information regarding medical malpractice payments as well as adverse licensure, privilege, and professional society membership actions. Unfortunately, the law is not always clear as to whether a particular action is a reportable event.



Once a report has been submitted to the NPDB, the statutes and regulations provide a procedure to challenge an NPDB report, but the cards are stacked against the physician once the report has been filed.

Information reported to the NPDB is not accessible by the general public, but it is accessible to state licensing boards and to any health care entity where the physician is employed or affiliated (i.e., has privileges) or is seeking employment or privileges. In fact, hospitals must submit a query to the NPDB each time a physician applies for privileges. A hospital also must submit a query to the NPDB every two years regarding each physician currently on its medical staff. If a query turns up an adverse report, the hospital does not necessarily have to reject the request for privileges or revoke or suspend existing privileges. However, in the event any issues arise in the future regarding a physician such as a malpractice claim, the hospital needs to be able to show that it conducted the required queries to the NPDB, that it considered any reports that the queries revealed, and took any appropriate action. More to the point, a hospital's failure to conduct the required NPDB queries regarding a physician may entitle a plaintiff's attorney to access otherwise confidential NPDB information regarding that physician to be used in litigation against the hospital.

Reporting entities required to report certain specified events to the NPDB include hospitals, medical malpractice

payers, state licensing boards, and certain federal agencies. State licensing boards are required to report adverse licensing actions. Hospitals must report professional review actions that adversely affect

a physician's or dentist's clinical privileges for a period of more than 30 days. The action must be based on the physician's professional competence to be reportable. As with many legal issues, application of this standard can be complicated given the facts of a particular situation.

Hospitals also must report the acceptance of a physician's or dentist's surrender or restriction of privileges while under investigation for potential professional incompetence or improper professional conduct or in return for not conducting an investigation or professional review action. A physician cannot avoid an NPDB report by simply resigning from one hospital and moving on to another.

Medical malpractice insurers must report to the NPDB all payments made on behalf of a physician in settlement or in payment of a judgment or written claim. This is despite the fact that in most settlements, the defendant expressly does not admit any liability or wrongdoing, and many settlements are reached for a variety of reasons that do not have anything to do with the professional competence of a physician. Physicians must be mindful of NPDB reporting when considering a malpractice settlement. Notably, the practitioner can successfully avoid a report by paying the settlement with his or her own funds.

If an entity submits a report to the NPDB, the subject physician will receive notice. The physician may challenge the report by first giving the reporting

*Continued on page 24*

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## Women and Stroke, *continued from page 19*

be cited as a reason why treatment for women is different. She predicted that, as more stroke registries come on board, particularly in the "stroke belt" states, rich data will help confirm when in their lives and to what degree women suffer stroke. Treatment changes could follow.

Research cited in the *Stroke* journal in February also reveals that gender-specific educational efforts regarding stroke are lacking. One study at the University of Connecticut asked predominately white, well-educated and high-income women ages 50 to 70 years — and who had at least one stroke risk factor — to respond to a stroke-knowledge questionnaire. Only 5.7 percent of the women with atrial fibrillation and 15.5 percent of women with heart disease identified their health condition as a stroke risk. What's more, just 63.9 percent of the women with atrial fibrillation reported taking warfarin, which is an anticoagulant, or a blood thinner to reduce stroke risk.

"In the past, we thought stroke was a disease of males. I, in fact, will give talks occasionally, and women in the audience are quite surprised when I start talking about the risk of stroke in women. That's an opportunity for education. If anything, the lifetime risk is greater for a woman than it is for a man, and some of our educational literature that's out there may not be what we need. ... I think better patient and community education efforts clearly are needed," Gaines said.

This is particularly important since women are suffering stroke at younger ages — and not always related to pregnancy. Gaines said migraine headaches are a risk factor for younger women, as are birth-control pills and smoking. "Add those three things together, and you increase the risk a fair amount," he said.

Vanhook said one of her research interests is younger women. Another is "come back" after stroke. While some victims may recover, many others are plagued with disabilities related to movement, speech and memory. Vanhook has been studying "come back" women ages 40-78 a year after the stroke and living at home. She's now ready to extend the study — and here's another gender difference: She'd like to study "come back" men and is having trouble recruiting male study participants.

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## Red Flag Rule Takes Aim, *continued from page 21*

information.

- A request is made for new, additional or replacement cards or the addition of authorized users on the account shortly after a change of address request.

- A new revolving credit account is used in a manner commonly associated with known patterns of fraud patterns.

- The use of a covered account is inconsistent with established patterns of activity on the account.

- There is unexplained usage of a covered account that has been inactive for a reasonably lengthy period of time.

Administering an Identity Theft Prevention Program requires board approval, staff training, and ongoing oversight.

"It's important for entities to have their corporate compliance officer be aware of these regulations and implement policies that address key provisions," Williams said.

Fortunately, the Red Flag regulations provide creditors with a great deal of discretion in identifying the threats

they must address and the appropriate preventive measures.

### Damages

The FTC may impose civil money penalties of up to \$2,500 per violation. Also, state Attorneys General have the authority to enforce the rules and may recover damages up to \$1,000 for each willful or negligent violation, plus reasonable attorney fees. And even though the act does not authorize private individuals to bring an action to enforce the Red Flag Rule, a person harmed by identity theft may be able to bring an action against a health center under state law.

"Even if you outsource your compliance, it's not enough," said Asbell. "Most compliance software cannot meet your needs for complying with the new legislation. You need to retain a specialist in the area of identity theft to conduct the training and provide the documentation that is required. Your attorney might help with documentation, but he can't provide the specialized training that your employees need."

## National Practitioner Data Bank, *continued from page 23*

entity the opportunity to address the concerns with the report. If the physician is not satisfied with the reporting entity's response, the physician may initiate a "dispute". The physician also may add a "subject statement" (his or her side of the story) to the NPDB report at any time. Both the dispute and the subject statement become part of the NPDB report. If the reporting entity does not respond to the dispute to the satisfaction of the physician, the physician may then request a review by the Office of the Secretary of Health and Human Services. The Secretary will not review the merits of the underlying action taken (such as a suspension of privileges) or the merits of a malpractice claim but will only review the factual accuracy of the NPDB report and whether the action was a reportable event. In the event the Secretary does not provide the relief sought, the physician may file a lawsuit in federal court under

the Administrative Procedure Act, challenging the administrative decision of the Secretary, but such review is under an arbitrary and capricious standard, which is highly deferential to the Secretary's decision. In short, it is difficult, but not impossible, to successfully challenge an NPDB report.

NPDB reporting issues can be complicated and lead to much frustration on the part of both reporting entities and practitioners in potentially inflammatory situations where one's permanent record is on the line. Hospitals and other reporting entities should ensure that an event is reportable before making a submission to the NPDB.



Chris Yielding is an associate at Balch & Bingham, LLP in the Birmingham office and is a member of the Healthcare Practice Group.

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