



National Practitioner Data Bank Healthcare Integrity and Protection Data Bank



FACT SHEET ON THE NATIONAL PRACTITIONER DATA BANK

Background of the National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) was established by Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended (Title IV). Final regulations governing the NPDB are codified at 45 CFR Part 60. On January 28, 2010, the NPDB expanded the information collected and disseminated through the NPDB with the final ruling for Section 1921 of the *Social Security Act*. Reporting and querying under Section 1921 began March 1, 2010. Responsibility for NPDB implementation resides with the Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services (HHS).

The intent of Title IV of P.L. 99-660 is to improve the quality of health care by encouraging State licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice payment and adverse action history. Adverse actions can involve licensure, clinical privileges, professional society membership, and exclusions from Medicare and Medicaid.

Originally the operations of the NPDB were directed only toward collecting and releasing information under Title IV. However, in 1987 Congress passed Public Law 100-93, Section 5 of the *Medicare and Medicaid Patient and Program Protection Act of 1987* (Section 1921 of the *Social Security Act*), authorizing the Government to collect information concerning sanctions taken by State licensing authorities against all healthcare practitioners and entities.

Section 1921 was enacted to provide protection from unfit healthcare practitioners to beneficiaries participating in the *Social Security Act's* healthcare programs and to improve the anti-fraud provisions of these programs. Congress later amended Section 1921 with the *Omnibus Budget Reconciliation Act of 1990*, Public Law 101-508, to add "any negative action or finding by such authority, organization, or entity regarding the practitioner or entity."

The U.S. Department of Health and Human Services (HHS) issued a Notice of Proposed Rulemaking for Section 1921 on March 21, 2006 and issued the Final Rule for Section 1921 of the *Social Security Act* as published in the *Federal Register* on January 28, 2010. The Data Banks opened Section 1921 for reporting and querying on March 1, 2010.

Section 1921 expands the information collected and disseminated through the NPDB to include reports on all licensure actions taken against all healthcare practitioners, not just physicians and dentists, as well as healthcare entities. Peer Review Organizations and Private Accreditation Organizations must report any negative actions or findings taken against healthcare practitioners or organizations. Queriers have access to State licensure actions taken against all healthcare practitioners and Section 1921 provides limited querying by Quality Improvement Organizations, Federal and State Healthcare Programs, State Medicaid Fraud Control Units and other law enforcement agencies. Section 1921 also will allow entities new to the NPDB to access Section 1921 data through the NPDB. For more information on Section 1921, see the *Fact Sheet on Section 1921*.

Interpretation of NPDB Information

The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. Eligible entities should use the information contained in the NPDB in conjunction with information from other sources when granting clinical privileges or in employment, affiliation, or licensure decisions.

The information contained in the NPDB is intended to direct discrete inquiry into and scrutiny of specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges. NPDB information is an important supplement to a comprehensive and careful review of a practitioner's professional credentials. The NPDB is intended to augment, not replace, traditional forms of credentials review. As a nationwide flagging system, it provides another resource to assist State licensing boards, hospitals, and other health care entities in conducting extensive, independent investigations of the qualifications of the health care practitioners they seek to license or hire, or to whom they wish to grant clinical privileges.

Settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician, dentist, or other health care practitioner. Thus, a payment made in settlement of a medical malpractice action or claim shall not be construed as a presumption that medical malpractice has occurred.

The information in the NPDB should serve only to alert State licensing authorities and health care entities that there **may** be a problem with a particular practitioner's professional competence or conduct. NPDB information should be considered together with other relevant data in evaluating a

practitioner's credentials (e.g., evidence of current competence through continuous quality improvement studies, peer recommendations, health status, verification of training and experience, and relationships with patients and colleagues).

Confidentiality of NPDB Information

Information reported to the NPDB is considered confidential and shall not be disclosed except as specified in the NPDB regulations at 45 CFR Part 60. The Office of Inspector General (OIG), HHS, has been delegated the authority to impose civil money penalties on those who violate the confidentiality provisions of Title IV. Persons or entities who receive information from the NPDB either directly or indirectly are subject to the confidentiality provisions and the imposition of a civil money penalty if they violate those provisions. When an authorized agent is designated to handle NPDB queries or reports, both the entity and the agent are required to maintain confidentiality in accordance with Title IV requirements.

For each violation of confidentiality, a civil money penalty of up to \$11,000 can be levied. In any case in which it is determined that more than one party was responsible for improperly disclosing confidential information, a penalty of up to the maximum \$11,000 limit can be imposed against each responsible individual, entity, or organization.

Eligible Entities

Entities entitled to participate in the NPDB are defined in the provisions of P.L. 99-660 and the NPDB regulations. Eligible entities are responsible for meeting Title IV reporting and querying requirements, as appropriate. Each eligible entity must certify its eligibility to the NPDB in order to report to or query the NPDB. Refer to the *Fact Sheet on Entity Eligibility*, available at www.npdb-hipdb.hrsa.gov.

The NPDB is available to State licensing boards; hospitals and other health care entities, including professional societies; Federal agencies; and others as specified in the law to provide information on the professional competence and conduct of physicians, dentists, and, in some cases, other health care practitioners. The NPDB collects information on medical malpractice payments and adverse licensure, clinical privilege, professional society membership actions. The NPDB also contains information regarding practitioners who have been declared ineligible to participate in Medicare or Medicaid under the *Social Security Act*.

Entities required to report and entitled to query under Section 1921 are defined in the provisions of Public Law 100-93, the Medicare and Medicaid Patient and Program Protection Act of 1987, as amended. Each eligible entity must certify its eligibility to the NPDB in order to report and/or query Section 1921 data.

Section 1921 requires each State to adopt a system of reporting to the Secretary of HHS certain adverse licensure actions taken against all healthcare practitioners and healthcare entities by any authority of the State that is responsible for the licensing of such practitioners or entities. Additional information may include any negative action or finding that a State licensing authority, peer review organization, or private accreditation entity has concluded against a healthcare practitioner or healthcare entity.

Entities that may obtain State licensure actions and negative actions or findings concluded against licensed healthcare practitioners and entities reported to the NPDB under Section 1921 will not be allowed to obtain information regarding medical malpractice payments or adverse clinical privileges and professional society membership actions on practitioners. The following group of queriers will have access to information reported to the NPDB under Section 1921 only:

- Agencies administering Federal healthcare programs, including private sector entities administering such programs under contract.
- State agencies administering or supervising State healthcare programs.
- Authorities of a State or its political subdivisions responsible for licensing health care entities.
- State Medicaid Fraud Control Units.
- U.S. Attorney General and other law enforcement officials.
- U.S. Comptroller General.
- Utilization and Quality Control Peer Review Organizations (now known as Quality Improvement Organizations).

Organizations that are eligible under Title IV to receive medical malpractice payments or adverse licensure, clinical privileges, and professional society membership actions on practitioners are also eligible to receive Section 1921 data. Section 1921 data is not available to the general public. However, persons or organizations are permitted to request information in a form that does not identify any particular practitioner or entity.

Querying

The NPDB is a resource to assist State licensing boards, hospitals, and other health care entities in conducting investigations of the qualifications of the health care practitioners they seek to license or hire, or to whom they wish to grant membership or clinical privileges.

Eligible entities may query as follows:

- **Mandatory Querying:** Hospitals **must** query when a practitioner applies for privileges and every 2 years

on practitioners on the medical staff or holding privileges. Hospitals are also required to query the NPDB when a practitioner wishes to add to or expand existing privileges and when a practitioner submits an application for temporary privileges.

- **Voluntary Querying:** Hospitals **may** query at other times as necessary for professional review activity.

Other health care entities that provide health care services and have a formal peer review process, including professional societies, **may** query when entering an employment or affiliation relationship with a physician, dentist, or other health care practitioner, or in conjunction with professional review activities.

State licensing boards **may** query at any time on physicians, dentists, and other health care practitioners.

Health care practitioners **may** self-query at any time.

Plaintiff's attorneys or a plaintiff representing himself or herself (pro se) **may** query under certain circumstances.

The NPDB is prohibited by law from disclosing information on a specific practitioner to a medical malpractice insurer, defense attorney, or member of the general public.

Sanctions for Failing to Query the NPDB

Any hospital that does not query on a practitioner (1) at the time the practitioner applies for a position on its medical staff or for clinical privileges at the hospital, and (2) every 2 years concerning any practitioner who is on its medical staff or has clinical privileges at the hospital, is presumed to have knowledge of any information reported to the NPDB concerning the practitioner. A hospital's failure to query on a practitioner may give a plaintiff's attorney or a plaintiff representing himself or herself access to NPDB information on that practitioner, for use in litigation against the hospital.

Fees for Requesting Information

Fees are charged for all queries to the NPDB and are announced in the *Federal Register*. Query fees are based on the cost of processing requests and providing information to eligible entities. The NPDB only accepts payments for query fees by pre-authorized Electronic Funds Transfer (EFT) or credit card (VISA, MasterCard, Discover, or American Express). To establish an EFT account, complete an on-line *Electronic Funds Transfer Authorization* form. You may obtain the form from the NPDB-HIPDB Web site. For information on Data Bank querying fees and acceptable payment methods, see the *Fact Sheet on Query Fees*.

Practitioner Self-Queries

A practitioner may self-query the Data Banks at any time by visiting the NPDB-HIPDB Web site at www.npdb-hipdb.hrsa.gov. All self-query fees must be paid by credit card. For detailed instructions about self-querying, see the *Fact Sheet on Self-Querying*.

Reporting

The information required to be reported to the NPDB is applicable to physicians and dentists and, in some cases, other health care practitioners who are licensed or otherwise authorized by a State to provide health care services. The NPDB, under section 1921, expands to include all licensure actions taken against all healthcare practitioners, not just physicians and dentists and healthcare entities. Also, peer review organizations and private accreditation organizations must report any negative actions or findings taken against healthcare practitioners and organizations.

The NPDB is committed to maintaining accurate information and ensuring that health care practitioners are informed when medical malpractice payments or adverse actions are reported concerning them. The NPDB cannot edit any information contained in a report. Reporting entities are responsible for the accuracy of the information they report to the NPDB.

When the NPDB processes a Medical Malpractice Payment Report or an Adverse Action Report, notice is sent to the reporting entity and to the subject. Both parties should review the report for accuracy. Subjects may not submit changes to reports. If any information in a report is inaccurate, the subject must contact the reporting entity to request that it correct the information.

The subject of a Medical Malpractice Payment Report or an Adverse Action Report may add a Statement to the report, dispute either the factual accuracy of the information in the report or whether the report was submitted in accordance with NPDB reporting requirements, or both.

If the subject and the reporting entity cannot resolve the issues in dispute, the subject may request that the Secretary of HHS review the disputed report.

Medical Malpractice Payments

Each entity that makes a medical malpractice payment for the benefit of a physician, dentist, or other health care practitioner in settlement of, or in satisfaction in whole or in part of, a written claim or a judgment against that practitioner, must report certain payment information to the NPDB. A payment made as result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) and that does not identify an individual practitioner is not reportable.

Eligible entities must report when a lump sum payment is made or when the first of multiple payments is made.

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. A written complaint or claim can include, but is not limited to, the filing of a cause of action based on the law of tort in any State or Federal court or other adjudicative body, such as a claims arbitration board.

Medical malpractice payers must report medical malpractice payments within 30 days of the date a payment is made. The report must be submitted to the NPDB. Once processed, a copy of the report must immediately be sent to the appropriate State licensing board in the State in which the malpractice claim occurred. Reports must be submitted regardless of how, or if, the matter was settled (for instance, court judgment, out-of-court settlement, or arbitration).

Adverse Licensure Actions

Under section 1921, all licensure actions taken against all healthcare practitioners and healthcare entities must be reported to the NPDB. Such licensure actions include revocation, suspension, censure, reprimand, probation, and surrender. State medical and dental boards must also report revisions to adverse licensure actions. Adverse licensure actions must be reported to the NPDB within 30 days from the date of the action.

Adverse Clinical Privileges Actions

- **Mandatory Reporting:** Hospitals and other eligible health care entities **must** report professional review actions that adversely affect a physician's or dentist's clinical privileges for a period of more than 30 days. They must also report the acceptance of a physician's or dentist's surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting an investigation or professional review action. Revisions to such actions must also be reported.
- **Voluntary Reporting:** Hospitals and other health care entities **may** report adverse actions taken against the clinical privileges of licensed health care practitioners other than physicians and dentists. Revisions to such actions must also be reported.

Health care entities must report adverse actions within 15 days from the date the adverse action was taken or clinical privileges were voluntarily surrendered. The health care entity must print a copy of each report submitted to the NPDB and mail it to the appropriate State licensing board for its use. The *Report Verification Document* that health care entities receive after a report is successfully processed by the NPDB must be used for submission to the appropriate State licensing board. Adverse Professional Membership Actions.

- **Mandatory Reporting:** Professional societies must report specific information when any professional review action, based on reasons related to professional competence or conduct, adversely affects the membership of a physician or dentist. Reportable actions must be based on reasons relating to professional competence or professional conduct which affects or could adversely affect the health or welfare of a patient. Revisions to such actions must also be reported.
- **Voluntary Reporting:** A professional society of health disciplines other than medicine and dentistry may similarly report adverse actions taken against the membership of their health care practitioners. Revisions to such actions must also be reported.

Medicare/Medicaid Exclusion Reports

The NPDB currently includes information regarding practitioners who have been declared ineligible from participating in, or have been reinstated to participate in, Medicare or Medicaid. Hospitals, managed care organizations, and other providers are prohibited from billing Medicare and Medicaid for any services that might be rendered by these practitioners.

Medicare/Medicaid Exclusion Reports were added to the NPDB through a collective effort and Memorandum of Understanding among the HRSA, OIG, and the Centers for Medicare & Medicaid Services (CMS). This information is released in accordance with the *Social Security Act* and the *Privacy Act*. CMS retains full responsibility for the content and accuracy of Medicare/Medicaid Exclusion Reports; the NPDB acts only as a disclosure service. Notification of exclusion from Medicare and Medicaid programs is made by CMS.

Sanctions for Failing to Report to the NPDB

Medical Malpractice Payers

The HHS OIG has the authority to impose civil money penalties in accordance with Sections 421(c) and 427(b) of Title IV of P.L. 99-660, the *Health Care Quality Improvement Act of 1986*, as amended. Under the statute, any medical malpractice payer that fails to report medical malpractice payments in accordance with Section 421(c) is subject to a civil money penalty of up to \$11,000 for each such payment involved.

Hospitals and Other Health Care Entities

If HHS determines that a hospital or other health care entity, including a professional society, has substantially failed to report information in accordance with Title IV requirements, the name of the entity will be published in the *Federal Register*, and the entity will lose the immunity provisions of Title IV with respect to professional review activities for a period of 3 years, commencing 30 days from the date of publication in the *Federal Register*.

State Boards

State medical and dental boards that fail to comply with NPDB reporting requirements can have the responsibility to report removed from them by the Secretary of HHS. In such instances, the Secretary will designate another qualified entity to report NPDB information.

Attorney Access

A plaintiff's attorney or a plaintiff representing himself or herself (pro se) is permitted to obtain information from the NPDB under limited conditions:

- A medical malpractice action or claim must have been filed by the plaintiff against a hospital in a State or Federal court or other adjudicative body.
- The practitioner on whom the information is requested must be named in the action or claim.

Obtaining NPDB information on the specified practitioner is permitted only after evidence is submitted to HHS demonstrating that the hospital failed to submit a mandatory query to the NPDB regarding the practitioner named by the plaintiff in the action. This evidence is not available to the plaintiff through the NPDB. Evidence that the hospital failed to request information from the NPDB must be obtained by the plaintiff from the hospital through discovery in the litigation process. Defense attorneys are not permitted to query because the defendant can self-query.

Coordination with the HIPDB

The Healthcare Integrity and Protection Data Bank (HIPDB) was established through the *Health Insurance Portability and Accountability Act of 1996*, Section 221(a), Public Law 104-191. The HIPDB is a national data collection program for the reporting and disclosure of certain final adverse actions taken against health care practitioners, providers, and suppliers. The HIPDB collects information regarding licensure and certification actions, exclusions from participation in Federal and State health care programs, criminal convictions, and civil judgments related to health care, and other adjudicated actions or decisions.

To alleviate the burden on those entities that must report to both the HIPDB and the NPDB, a system has been created to allow an entity that must report to both Data Banks to submit the report only once. This Integrated Querying and Reporting Service (IQRS) is able to sort the appropriate actions into the NPDB, the HIPDB, or both. Similarly, entities authorized to query both Data Banks have the option of querying both the NPDB and the HIPDB with a single query submission.

All final adverse actions taken on or after August 21, 1996 (the date Section 1128E was passed), must be reported to the HIPDB. The HIPDB cannot accept any report with a date of action taken prior to August 21, 1996.

NPDB-HIPDB Assistance

For additional information, visit the NPDB-HIPDB Web site at www.npdb-hipdb.hrsa.gov. If you need assistance, contact the NPDB-HIPDB Customer Service Center by e-mail at help@npdb-hipdb.hrsa.gov or by phone at 1-800-767-6732 (TDD 703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.