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A Summary of Public Citizen's Report on the Status of Reporting by Hospitals to the National Practitioner Data Bank

On May 27, 2009, Public Citizen, a nonprofit advocacy organization that represents consumer interests published a report titled, "Hospitals Drop the Ball on Physician Oversight - Failure of Hospitals to Discipline and Report Doctors Endangers Patients" (the "Report"). The Report examines multiple studies which suggest widespread under-reporting by hospitals to the National Practitioner Data Bank ("NPDB") for unprofessional or incompetent behavior by physicians. The Report suggests that under-reporting to the NPDB raises serious questions about the effectiveness of hospitals' peer review processes. The Report also offers recommendations for making hospital peer review, reporting, and oversight activities more accountable to the public. Individuals reviewing the Report should keep in mind that the hospital peer review process is multifaceted and often results in many non-reportable activities and actions, as well. The following is a summary of Public Citizen's Report.

The National Practitioner Data Bank and Physician Reporting

The NPDB, established by the Health Care Quality Improvement Act of 1986 (the "Act"), was established, in part, to protect patients from questionable physicians since groups such as state licensing boards, hospitals, and medical societies were not taking action deemed necessary to protect the public. The Act requires hospitals to report (1) professional review actions that adversely affect the clinical privileges of a physician for a period of longer than thirty days and (2) the acceptance of a physician's surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct or in return for not conducting such an investigation.

Most states also have mandatory reporting laws governing hospitals' clinical privilege actions. Many states require hospitals to report any action to the state licensing board, regardless of the time period that the sanction covers, while others states impose monetary penalties as high as \$10,000 for not reporting adverse privilege actions. Hospitals in states with monetary penalties for not reporting adverse privilege actions to the state licensing board appear to have significantly higher numbers of reports to the NPDB than hospitals in states with no monetary penalty.

An Analysis of Hospital Reporting Compliance

Since the NPDB was initiated in 1990, forty-nine percent of hospitals in the United States have never submitted a clinical privilege sanction report regarding a physician to the NPDB. Prior to the opening on the NPDB, the Public Health Service ("PHS"), a subsection of the Department of Health and Human Services ("HHS"), estimated that hospitals would report 5,000

hospital adverse actions per year to the NPDB. The American Medical Association ("AMA") estimated that hospitals would file 10,000 reports per year. Since the NPDB opened, the average number of reports filed by hospitals each year is approximately 650, which is 1/8th of the PHS estimate and 1/16th of the AMA estimate. There is also evidence suggesting that the average number of reports filed by hospitals is declining. The Report notes that the total number of adverse hospital privileges reports filed with the NPDB has ranged from a high of 830 in 1991 to a low of 532 in 2006. In addition, the Report notes that clinical privileging reporting seems to be concentrated in a few facilities, even in states with comparatively high overall reporting levels.

The Report also notes that reporting statistics vary greatly from state to state. For example, seventy-five percent of the hospitals in South Dakota have never reported while only twenty-four percent of the hospitals in New Hampshire have never reported. There also appears to be significant regional differences in reporting with hospitals in the east south central region of the United States, such as Alabama, Kentucky, Mississippi, and Tennessee, having the lowest reporting rates. Urban hospitals, and hospitals accredited by the Joint Commission, were more likely to have reported one or more privileges actions and have higher rates of reported actions per 100,000 admissions than their counterparts for nearly all bed size categories. State and local hospitals were the least likely to have reported.

The Report also examines the relationship between hospital reports and state licensure actions. 25,136 physicians were reported to the NPDB by a state licensure board while only 9,877 physicians had been reported by a hospital. 3,566 physicians in the database had been reported by both a state licensure board and a hospital. Of the 9,877 physicians who had been reported at least once by a hospital, 5,359 have at least one adverse hospital clinical privileges action that was not followed by a state licensure action. Thirty-one of those physicians had five or more adverse hospital clinical privilege reports but no subsequent state licensure action, raising concern that state licensing boards may not be taking the disciplinary actions necessary to protect the public.

Additionally, the Report focuses on the interplay between NPDB reporting and the Act. To encourage effective peer review, the Act provides immunity for peer review activities, provided they are conducted in a certain way. To qualify for immunity, the peer review action must be taken in the reasonable belief that the action was in the furtherance of quality health care, after a reasonable effort to obtain the facts of the matter, after adequate notice and hearing procedures are afforded to the physician, and in the reasonable belief that the action was warranted by the facts. Hospitals that fail to report reportable actions to the NPDB risk losing the liability protection afforded to their professional review activities.

Failing to report disciplinary actions to the NPDB not only violates the Act but deprives health care organizations of potentially useful information for credentialing and regulatory activities. One survey found that a wide variety of committees and individuals use NPDB reports for credentialing and disciplinary decision-making. Credentialing committees are most likely to use the report but other groups or individuals that frequently review NPDB reports include medical staff committees, department chairs, and the chief executive officers. An average of four to five different individuals or committees review each NPDB report.

Under the Act, the Secretary of HHS is required to investigate hospitals that appear to be substantially failing to comply with reporting requirements, provide them with an opportunity to correct their practices if they are found to be non-compliant, and remove the liability protections for three years if they are found non-compliant. However, while the Health Resources and Services Administration ("HRSA") has conducted investigations of non-compliance, as of November 2008, the Report notes that no hospital has ever been penalized through the loss of peer review immunity. For a hospital to lose its immunity, the hospital has to "substantially" violate the reporting requirement, meaning there has to be a pattern of non-compliance. According to HRSA staff, after identifying hospitals, usually through medical reports or public court records, and contacting these hospitals, HRSA has always received a report or a satisfactory explanation of why no report was required.

Report Recommendations

The Report concluded with several recommendations including:

- HRSA and the Centers for Medicare and Medicaid Services ("CMS") should work together to achieve a regulatory and statutory change so that the Medicare Conditions of Participation specifies hospitals' reporting responsibilities under the Act.
- Congress should provide CMS with the authority to impose sanctions on hospitals and physicians for failure to perform peer review.
- Congress should amend the Act to impose a civil money penalty for failure to report.
- The Office of Inspector General should review hospital practices relating to granting and renewing privileges.
- HRSA should initiate educational and compliance activities involving hospitals that have not reported.
- Hospital compliance officers should monitor hospital peer review and reporting to the NPDB.


Hospital peer review is considered to be one of the pillars of quality assurance and hospital under-reporting certainly may raise serious questions about the effectiveness of hospital peer review. Nevertheless, it is also important to keep in mind that effective peer review may or may not result in reporting of adverse action to the NPDB. In fact, peer review activities often result in actions that are not reportable to the NPDB. These activities and actions also play a critical role in improving patient care.

The entire text of the Report is available at:

<http://www.citizen.org/documents/1873.pdf>.

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