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E-Flash Update

NPDB Guidance Re-Affirms Breadth of Hospital Reporting Obligations

National Practitioner Data Bank (NPDB) reporting obligations are generally unpopular with hospitals because they are associated with increased litigation risk from adversely impacted physicians, thereby raising the stakes associated with intra-hospital "policing" of physician competence and conduct. NPDB reporting of adverse credentialing actions is required by the Health Care Quality Improvement Act (HCQIA), enacted to limit the ability of incompetent physicians to move from state to state without disclosure or discovery of their previous damaging or incompetent performance. One of HCQIA's unintended consequences is that it makes it more difficult, and riskier, for hospitals to remove problem physicians from their medical staffs. Some hospitals and health care attorneys have therefore been eager to construe the reporting obligations narrowly so as to avoid the reporting requirements. The NPDB recently rejected one such attempt, and re-affirmed the breadth of Databank reportability.

HCQIA requires hospitals to report to the NPDB and state licensing authorities various types of "professional review actions" that impact physician privileges. 42 U.S.C. § 11133. The law defines a "professional review action" for purposes of NPDB reporting as a peer review action "which is based on the competence or professional conduct of an individual physician (which conduct **affects or could affect adversely the health or welfare of a patient or patients**)." 42 U.S.C. § 11151(9). While Post & Schell has always counseled clients that denial, suspension, or revocation of a physician's medical staff privileges based on a material misrepresentation or omission in the physician's appointment or reappointment application would be reportable, advocates for a narrow view of Databank reportability have argued that it would not ordinarily be reportable because there is no direct link to patient health or welfare.

On July 30, 2009, the NPDB issued guidance that squarely rejects the narrower approach and re-affirms the broad scope of Databank reportability under HCQIA. The NPDB's guidance addressed the hypothetical question of whether a hospital had to report that a physician misrepresented and failed to disclose quality-related information on his reappointment application, where the physician had had no specific quality of care problems at the hospital to which he was seeking reappointment. The NPDB initially cautioned that whether a physician's competence or conduct could potentially adversely affect patients is a fact-intensive determination "which the healthcare entity taking the action is in the best position to determine." However, the NPDB then stated unequivocally its view that a physician's intentional misrepresentation during the credentialing process triggers almost a *per se* reporting obligation, because of its potential to adversely affect the health or welfare of patients. The NPDB pointed out that the very premise of the credentialing process is the protection of patient health and welfare.

In elaborating on its position, the NPDB went even further and indicated that a 31-day suspension of a physician for failure to complete medical records would also likely be reportable, because "a failure to complete medical records . . . almost always has the potential to adversely affect a patient's health or welfare." Many hospitals have presumed previously that medical records violations are generally not reportable. The NPDB's position on medical records violations has already generated much discussion and concern among health care attorneys in terms of its impact on automatic suspension/revocation policies. If a physician's privileges were suspended for more than 31 days or revoked under such a policy, the hospital may well have to report the suspension under the NPDB's broad interpretation of hospitals' reporting obligations; however, reporting could expose the hospital to liability **without** the protection of HCQIA immunity if the HCQIA-mandated hearing rights are not afforded. Therefore, the NPDB's position on medical records violations could require hospitals to re-evaluate their NPDB reporting policies as well as automatic suspension policies. The NPDB has promised further guidance in this area, but it is unclear when such guidance will be forthcoming.

The NPDB's July 30 letter serves as an important reminder to hospitals that determining whether a particular situation is reportable is not always a straightforward inquiry, and that there are many situations that are not directly tied to specific adverse patient events or other quality of care concerns which nonetheless give rise to reporting obligations

because of the potential for an adverse effect on patient care.

Moreover, failure to make a required report can result in loss of HCQIA immunity for a period of three years, thus leaving hospitals exposed to the possibility of expensive, high stakes physician litigation for defamation, tortious interference, and breach of contract arising out of peer review activity. It is therefore critical that hospitals take steps to ensure that they reach well-considered, defensible decisions regarding physician discipline and NPDB reporting, and seek counsel knowledgeable in such matters.

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