reported (three, four, or five). Leaders must report at least three measures within three measure groups to qualify for a star rating.

"Finally, hospitals are assigned to star ratings within each peer group using k-means clustering so that summary scores in one star rating category are more similar to each other and more different than summary scores in other star rating categories," CMS explains.[1] ■

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NPDB Reporting Protected by Law in Some Cases, Gray Areas Problematic

Hospitals enjoy substantial protection when reporting physicians to the National Practitioner Data Bank (NPDB) in many situations, with laws protecting against retaliatory lawsuits as long as the hospital was required to report and followed appropriate protocols.

However, there are situations in which reporting to the NPDB is not required but might still be the right thing to do when leaders are concerned about a clinician's threat to patient safety. In those circumstances, the protection against liability is not ironclad.

The NPDB requires facilities to report several pieces of information involving healthcare practitioners, healthcare entities, providers, and suppliers, including but not limited to: medical malpractice payments, federal and state licensure and certification actions, adverse clinical privileges actions, and adverse professional society membership actions.[1]

Protection for Required Reporting

A hospital or other healthcare organization reporting information that falls into those categories is protected by law as long as the reported information is accurate, says **Christopher J. Kutner**, JD, partner with Rivkin Radler in Uniondale, NY.

"In the matters in which I've been involved, the hospital or surgery center had no choice but to report. If they don't report something that is reportable, they could be subject to a civil fine by the OIG," Kutner says. "If someone is vindictive and reports something to the NPDB that they know is not true, they could be subject to a civil penalty. As long as the person reporting believes the information is true, there is immunity from liability. You can't be sued if you in good faith reported a doctor with information you reasonably believed to be accurate."

Healthcare organizations are only required to report actions taken against physicians and dentists, but they may report clinical privileges actions taken against other types of practitioners. The NPDB reports that the most commonly reported profession to the NPDB is actually

nurses, not physicians.[2] While there is substantial protection when reporting physicians to the NPDB, the situation is not as clear when reporting nurses, explains **Sarah E. Coyne**, JD, partner with Quarles & Brady in Madison, WI.

"It is not discretionary whether hospitals report to the data bank, although there are some circumstances where it is a complicated analysis whether the reporting obligation has been triggered," Coyne says. "A physician is unlikely to have a viable successful cause of action. This would not be the case for non-physician providers who are reported, as they are not a mandatory report, and there would not be associated immunity."

If it is clear reporting is required, the physician would not have a viable claim against the hospital for reporting, Coyne says. A report is mandatory when a hospital has taken adverse action on a physician's clinical privileges during a professional review of his or her competence or conduct. Specifically, when the health or welfare of a patient could have been affected, when clinical privileges are restricted for more than 30 days, or when a physician surrenders his or her privileges to avoid an investigation or the consequences of it.

"It is conceivable that a physician would have a viable suit for claiming that there was no basis to limit the privileges in the first place or in a complicated reporting situation for deciding that it is reportable. However, hospitals reporting in good faith, and limiting privileges in good faith, have immunity under the federal Health Care Quality Improvement Act [HCQIA]," Coyne says. "While the physician could bring the lawsuit, the hospital would have a very solid affirmative defense." Hospitals might hesitate to report to the NPDB if there is reason to doubt the mandatory reporting has been triggered. An NPDB report can affect a clinician for the rest of his or her career, and the threat of a lawsuit for a report that did not meet NPDB reporting requirements is a big deterrent.

Despite the protections that come with NPDB reporting, Kutner still advises caution. A lawsuit filed by a disgruntled clinician will require time and money, even if a court eventually dismissed the suit. Kutner advises obtaining an opinion from the NPDB before making the report. This opinion could discourage a clinician from claiming the report was improper.

"I worked with a surgery center that had to report a surgeon. We were very cautious and careful because we didn't want to be sued, even if the suit could be dismissed and [was] without merit," Kutner says. "We wanted to do it right. We contacted the NPDB, and the individual there could not have been more helpful and precise with her directions and assurance that we were doing the right thing. The NPDB will walk you through the response so that you have that additional defense for the reporter, showing that you did due diligence."

Kutner notes hospitals also are required to query the NPDB in some situations, aside from reporting.

Gray Areas Can Raise Questions

The situations involving a clear requirement to report (e.g., a malpractice settlement or a hospital investigation) are the easy ones to handle. But there are other scenarios that are not as clear.

"The gray areas include things like NPDB's category of 'adverse society membership action.' What does that entail?" Kutner asks. "Or 'negative actions against a provider within an institution?' Those are gray areas, and nobody wants to blackball a provider if you don't have to."

Typically, hospitals do all they can to allow the provider to move on without a report to the NPDB when there is room for doubt, Kutner says. That approach has been criticized in conjunction with high-profile cases in which a physician moved from one hospital and continued harming patients because the facilities allowed him or her to leave without reporting to the NPDB.

That was the case with Christopher Duntsch, MD, PhD, who practiced medicine in Dallas for two years and operated on 37 patients. Thirty-three were injured. At least two hospitals quietly ended Duntsch's privileges but did not report him to the NPDB. Duntsch became the first doctor in the United States to be sentenced to life in prison for his practice of medicine.[3] His case may be an extreme example of what happens when hospitals choose not to report to the NPDB.

"When it comes to issues of clinical competence, I think there is more of an inclination to report. The more common cases in which hospitals struggle and decide not to report is when the surgeon is just obnoxious or demeaning to staff," Kutner says. "They don't want to keep him around, but it doesn't impact his clinical abilities. But once there are questions of clinical competence and patient safety, I think you'll find that hospitals get on the phone with the NPDB, make sure they are on solid ground, and err on the side of reporting."

With physicians, it is a common misunderstanding to think the professional can leave while under

investigation and thereby avoid a NPDB report. Kutner recalls one case in which a surgeon was under investigation by a hospital and tried that.

"Unfortunately, he was not counseled well, and he left after he was under investigation, and he knew that. He resigned his privileges saying, 'I've had enough, and I'm out of here,'" Kutner recalls. "The hospital had no choice in the matter and had to report that this physician resigned while he was under an investigation."

Protocols for reporting to the NPDB and how investigations will be conducted should be included in the hospital's bylaws, says **Kathy H. Butler**, JD, officer with Greensfelder, Hemker & Gale in St. Louis. All processes leading up to an NPDB report should follow a prescribed process, including a time to allow the clinician to respond to allegations.

When a hospital is concerned but does not conduct a formal investigation that would trigger a report to the NPDB — and the physician resigns — there can be a question of whether the resignation itself is reportable. Butler says if the clinician clearly resigned to avoid an investigation, that is reportable. However, it can be hard to prove the intent of the resignation.

"It's subject to interpretation. If a physician resigns before an investigation is initiated, it can be argued that the resignation was not an attempt to avoid the investigation," Butler says. "But the data bank recently broadened its definition of an investigation. That makes those resignations harder to ignore if you're going to strictly follow the rules."

Another situation that raises questions is when a physician employment agreement ends and the privileges automatically terminate. This termination of privileges is not reportable to the NPDB because it is automatic, not the result of any affirmative action against the physician.

"Similarly, if you lose your privileges because you lost your insurance, and you're automatically terminated because that is specified in the bylaws, that is not reportable," Butler says.

Hospitals also find it difficult when deciding whether to report a non-physician for matters that would be required reporting with physicians.

According to Butler, in many of those situations, there will be state licensing board requirements to report the clinician.

How can administrators protect themselves when they need to take action with a clinician's performance?

"It sounds cliché, but the most important thing is to follow the process specified in the medical staff bylaws, or other related policy, to the letter. The issue is that very often, these situations are convoluted, and the bylaws do not contemplate the specific decisions facing medical staff leadership," Coyne says. "In these situations, it is vital to involve legal counsel to assist in crafting a strategy that will be consistent with and defensible under the bylaws."

Experienced legal counsel also can suggest how to manage the collateral consequences, such as division and conflict among the medical staff, disclosure of information, messaging regarding departures, or changes in privileging status. Counsel can recommend when to discuss these matters in a closed session and the appropriate level of documentation throughout the process.

Also, hospital medical staff always should act in the best interest of patients. That should be the driving force behind any actions. Regardless of whether there is an NPDB report should not drive the process or decisions.

"The NPDB is viewed as a hammer by many physicians, a potential threat to their careers. Certainly, there are significant concerns and consequences for any physician who is reported," Coyne says. "It is important, however, for hospital medical staff to remember that the NPDB is supposed to be about protecting patients, not targeting physicians."

Coyne recommends these best practices:

• If the corrective action section of the bylaws and fair hearing plan have not been updated recently, direct experienced legal counsel to review them.

• With employed physicians, evaluate at the outset whether this is an administrative process through employment vs. a medical staff professional review action under the bylaws.

• Resist the temptation to accept the facts at face value or as they first appear. A reasonable factual inquiry is one of the requirements for immunity. If at all in doubt, convene an investigative committee to carefully examine the facts.

• Be aware of the arc. In reviewing professional competence or conduct, there is a natural tendency to be outraged and aggressive initially. Then, over time, one might come to believe the entire thing is an overreaction, that leadership is making a mountain out of a molehill. "This is a very normal human response to the intensity of the proceedings, but it should not rule the day," Coyne says.

• Ensure the clinician knows the entire basis of the problem. Communication with the clinician is not only the right thing to do from a fairness perspective, it is essential to a proper and compliant process — and to immunity. Make sure the clinician receives appropriate information and can tell his or her side of the story. ■

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When Hospitals Must Query the NPDB

Hospitals might face quandaries over when they must report clinicians to the National Practitioner Data Bank (NPDB), but it is important to remember queries to the NPDB also are required.

Under Title IV of the Health Care Quality Improvement Act, the law that governs NPDB reporting and protections from liability, hospitals must query the NPDB when physicians, dentists, and other healthcare practitioners apply for medical staff appointment.[1] The same requirement applies when they seek clinical privileges. Additionally, hospitals must query the NPDB every two years on physicians, dentists, and other healthcare practitioners who are part of the medical staff or who hold privileges.

Failing to follow those requirements puts the hospital at risk of liability, says **Christopher J. Kutner**, JD, partner with Rivkin Radler in Uniondale, NY.

"One reason hospitals can be reluctant to report to the data bank is that they may be afraid to acknowledge that they hired or provided privileges to somebody who really shouldn't have had them," he says. "When someone applies for initial privileges at a hospital, the hospital must inquire with the data bank whether they have any history that would prevent granting them privileges. In addition, if a doctor already has privileges and wants to expand on those privileges and do something else, that also triggers the hospital to query the data bank and find out if there is anything in this person's past that would require us to decline this expansion on privileges."

Failure to query the NPDB when required can give a plaintiff attorney an opening to claim the hospital is responsible for a patient injury because the physician should not have been privileged.

"If a provider commits malpractice, there is a lawsuit, and the plaintiff's attorney finds out that this doctor had a history — and also finds out that that the hospital did not query the data bank before granting privileges — there's another pocket that can be picked for purposes of settlement," Kutner says. "Hospitals and surgery centers are very cautious about this, putting it on autopilot to check the data bank at the appropriate times. That is good practice." ■

REFERENCE

1. National Practitioner Data Bank. Title IV of public law 99-660. The Health Care Quality Improvement Act of 1986, as amended 42 USC Sec. 11101 01/26/98.