EDUCATION NEWS

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The National Practitioner Data Bank: What CRNAs Need to Know

As a nationwide flagging system, the National Practitioner Data Bank (NPDB) allows state licensing boards, hospitals, and other registered healthcare entities the ability to monitor practitioners through reporting and inquiry about the qualifications and competency of healthcare practitioners seeking clinical privileges where incompetence or unprofessional conduct could adversely affect a patient's welfare. Certified Registered Nurse Anesthetists are not exempt from being reported on or queried by registered reporting and querying entities. The NPDB warehouses data pertaining to adverse actions or medical malpractice payments taken against a practitioner. Based on the updated federal ruling published in the Federal Register regarding the NPDB and Section 1921 of the Social Security Act, the NPDB has expanded the definition of healthcare practitioners to include all healthcare practitioners as a means of protecting beneficiaries of the Social Security Act's healthcare programs. As such, nurse anesthetists should be aware of the additional reportable information that may be collected or disseminated based on the updated ruling pertaining to the NPDB.

Keywords: Adverse action, anesthesia-related medical malpractice, medical malpractice, National Practitioner Data Bank, reportable information.

The healthcare environment has made remarkable changes over the years. An increased awareness and accountability for healthcare providers' actions are essential in ensuring safe environments. According to the Institute of Medicine's seminal report, *Crossing the Quality Chasm*, safety as a system property must be infused into healthcare delivery.[1] As such, the report suggests that greater attention should be placed on systems that prevent or mitigate potential errors. The *National Practitioner Data Bank* (NPDB) and the *Healthcare Integrity and Protection Data Bank* (HIPDB) are one of the first system-based federal initiatives developed to protect patients and improve transparency of potentially harmful providers by authorizing the collection of information on healthcare practitioners and providing a feedback system for healthcare entities that hire and manage healthcare practitioners. The aim of this article is to discuss data banks, in particular the NPDB. The NPDB will be reviewed in detail, as well as recent changes that have occurred since its inception.

In 1986, Congress passed the *Health Care Quality Improvement Act* (HCQIA) with the intention to improve the quality of healthcare and protect the public by monitoring medical malpractice, preventing incompetent, unsafe practitioners (ie, mainly physicians and dentists) from practicing from state to state without a systematic method to uncover documented incompetent practice. In accordance with the mission of the HCQIA of 1986 under *Title IV of Public Law 99-660*,[2] the NPDB was formed to collect information about medical malpractice payments, adverse licensing and clinical privileging actions related to competence and conduct, professional society membership actions, Drug Enforcement Administration (DEA) actions, and Medicare/Medicaid exclusions. In 1989 the *Federal Register* published the final rule leading to the full implementation of the NPDB by September 1, 1990. Overall, as a healthcare quality initiative, the NPDB was created as a nationwide flagging system that allows state licensing boards, hospitals, and healthcare entities the ability to report and inquire about the qualifications and competency of healthcare practitioners seeking clinical privileges.[3]

In 1996 the *Health Insurance Portability and Accountability Act* (HIPAA) was enacted, which in

part required the US Department of Health and Human Services (DHHS) to create a national healthcare fraud and abuse program. As such, legislation referred to as *Section 1128E of the Social Security Act* allowed for the creation of the HIPDB.[4] Specifically, HIPDB was formed to combat health insurance fraud and abuse in healthcare delivery by collecting information on adverse actions and judgment or conviction reports taken against a practitioner, provider, or supplier. The HIPDB gives government agencies and health plans the ability to better identify poor performance of a potentially problematic practitioner, provider, or supplier; however, it should not be used as a source to verify credentials or qualifications of any of these entities. Practitioners may query the HIPDB at any time.

By 1997 the federal agency known as the Health Resources and Services Administration (HRSA) under the DHHS was mandated by law to coordinate the operations of both the NPDB and HIPDB. Together, the purpose of the NPDB and HIPDB, currently known as "the Data Bank," is to improve healthcare quality, protect the public, and reduce healthcare fraud and abuse in the United States. Some entities are required to report and/or query both data banks; however, not all entities have equal access to the information in either data bank. As such, the Integrated Querying and Reporting System (IQRS) was developed to sort information into the appropriate data bank to alleviate multiple report submissions of duplicate data.[4] A proposed rule has been published requesting the consolidation of the HIPDB into the NPDB so there is only one reporting system and data warehouse instead of 2, to comply with *Section 6403* of the *Patient Protection and Affordable Care Act of 2010*. Consolidating the 2 databases is an attempt to eliminate the current system's duplicative data reporting and access requirements by authorized submitters.[5] The replacement name for the single reporting system has been proposed as "the NPDB."[6] The migration of licensing action information collected from 1996 to the present in the HIPDB to the NPDB is currently under way.[6] For the purpose of this article, the use of the term *Data Bank* refers to an entity's requirement to report and/or query using the IQRS. When referring to the NPDB, the article reflects the information gathered to comply with Title IV and *Section 1921* and not *Section 1128* of the HIPDB.

Definition of Healthcare Practitioner

The NPDB serves 2 functions: (1) defines entities that are required to report adverse actions or malpractice payments against a defined practitioner and (2) defines entities that can query the database to identify incompetent practitioners and ultimately protect healthcare consumers. Since the inception of the NPDB, information about physicians and dentists has always been subject to reporting and querying. Until recently, the NPDB previously did *not* require queries or reports on other healthcare practitioners who were *not* licensed or authorized by a state to provide medical services (eg, professional registered nurses, allied health professionals).[3] In particular, those who did not meet the requirements to be on medical staff or hold clinical privileges were not mandated to be queried by a healthcare entity. However, based on the clinical privileging caveat, Certified Registered Nurse Anesthetists (CRNAs) had met the definition of a distinct healthcare practitioner group subject to querying and reporting. A CRNA could be queried by a hospital only if the CRNA met the requirement to be on the medical staff or hold clinical privileges to provide healthcare services (ie, anesthesia) as individually credentialed by a hospital, thereby reflecting state authorization.

As of March 1, 2010, with the advent of the final rule published in the *Federal Register* regarding the NPDB and *Section 1921* of the *Social Security Act*, the NPDB has expanded the definition of healthcare practitioners to include all healthcare practitioners, as a means of protecting beneficiaries of the *Social Security Act's* healthcare programs.[6] That definition is "an individual other than a physician or dentist (1) who is licensed or otherwise authorized by a State to provide healthcare services, or (2) who, without State authority, holds him or herself out to be authorized to provide health care services."[7] In addition to the information collected from reports under Title IV of the NPDB, *Section 1921* allows eligible querying entities access to adverse licensure actions on all healthcare practitioners not limited to only competence and conduct, but also any negative action found or submitted by a state licensing or certification authority, peer review organization or private accreditation.[8] Licensing reports since 1996 that were previously reported in the HIPDB have now been migrated to the NPDB. In addition, other healthcare entities other than hospitals are eligible but not required to query on physicians, dentists, and other healthcare practitioners; however, reporting requirements under the HCQIA of adverse actions and malpractice have not changed for eligible entities.[9]

Reporting Entities to the Data Bank

According to the NPDB, as described in Table 1, several entities are required to report adverse licensing actions, clinical privileging changes, or malpractice payments of any healthcare practitioner. Only authorized submitters by a registered entity certified to provide information may query or report to the Data Bank.[3] Often the autho-

Must report	May report	Prohibited
• State medical, dental, and all other healthcare practitioners' licensing boards • Hospitals • Other healthcare entities/organizations • Professional societies that follow a formal peer review process • Medical malpractice payers • Peer review organizations • Private accreditation organizations • State agencies that license healthcare entities • DEA and DHHS Office of Inspector General	• Quality improvement organizations (QIOs) • State Medicaid Fraud Control Units and law enforcement agencies • Agencies administering federal healthcare programs and their contractors • State agencies administering state healthcare programs • US Comptroller General	• Healthcare practitioners • Plaintiff's attorneys

Table 1. NPDB Reporting Entities for Adverse Actions or Malpractice Payments of Healthcare Practitioners[9]
Abbreviations: NPDB, National Practitioner Data Bank; DEA, Drug Enforcement Administration; DHHS, Department of Health and Human Services.

rized submitter is an individual designated by the registered eligible entity or an authorized agent (ie, independent contractor) to submit reports or query. Registered reporting entities are responsible for the accuracy of the information. Individual practitioners are not allowed to submit reports to the Data Bank on their personal behalf. When a report has been filed to the Data Bank, a Notification of Report to the NPDB-HIPDB is mailed to the practitioner.

Reportable Information

Reportable information must be filled out using the electronic Medical Malpractice Payment Report or Adverse Action Report format as directed by the Data Bank. Table 2 shows reportable information under both Title IV and *Section 1921*. Reporting entities may make corrections to initial reports; however, corrections can be done only by an authorized submitter or agent of the reporting entity and cannot be submitted by the individual.[3] The authorized submitter or agent may correct or update a report's inaccurate information by voiding, revising, or modifying an adverse action or claim previously reported to the Data Bank. The authorized submitter may also decline to change the report. If so, the practitioner may initiate a dispute process and/or add a statement to the report at any time; however, the dispute or statement should pertain to the factual accuracy of the report and must be submitted on a Subject Statement and Dispute Initiation Form.

If the practitioner wishes to initiate a dispute, the request will undergo a review by the Secretary of Health and Human Services and will be reviewed for factual accuracy only with accompanying documentation. For Secretarial review, a statement clearly outlining what is in dispute, documentation supporting inaccuracy, and proof that the practitioner attempted to resolve the issue with the reporting entity must be included in the review submission. Practitioners may not use the dispute process as a platform to protest the merits of an adverse action or malpractice claim. *Practitioners may not make changes to reports*. If any information in a report is inaccurate, the subject must request that the reporting entity file a correction to the report.

Adverse Actions Reporting

Adverse actions can be taken against a practitioner's clinical privileges (ie, permission to furnish medical care by a healthcare entity), licensure, medical staff membership, and provider participation in Medicare/Medicaid.[10] Reportable adverse action information is collected from entities that monitor or distribute state and federal licensure, clinical privileging, health plans, exclusions or debarments from participation in a federal or state government health plan, professional societies, peer review organizations, accreditation bodies, and government administrative sources.[11] These sources collect and report information including, but not limited to, a practitioner's suspension, revocation, denial, probation, exclusion, or reduction of privileging or licensing. Currently, there are more than 360 reportable adverse action classification codes that qualify as adverse action items.[11] The adverse action items taken against a practitioner can range anywhere from substance abuse and impairment to fraud or unprofessional conduct.

Healthcare entities must report to the Data Bank within 15 days from the date that a privileging adverse action was taken against a practitioner for a period of 30 days or more or if the practitioner is being investigated and clinical privileges have been surrendered or restricted.[3] The healthcare entity must also relay a printed submitted report to the state licensing board. If a state licensing board takes corrective action against the practitioner, the state must

NPDB *Title IV*[a] reportable information	New *Section 1921*[b] reportable information
• Medical malpractice payments of all healthcare practitioners	• Adverse licensure actions (practitioners or entities—not limited to competence and conduct)
• Adverse licensure actions related to competence and conduct	• Any negative action or finding by state licensing or certification authority
• Adverse clinical privilege actions	• Peer review organization's negative actions or findings against a healthcare practitioner
• Adverse professional society membership actions	• Private accreditation organization's negative actions or findings against a healthcare entity
• DEA actions	
• Medicare/Medicaid exclusions	

Table 2. NPDB Reportable Information[8]
Abbreviations: NPDB, National Practitioner Data Bank; DEA, Drug Enforcement Administration.
[a] *Title IV* of *Public Law 99-660*.
[b] *Section 1921* of the *Social Security Act*.

report the adverse licensure action within 30 days to the Data Bank. Similar expectations are required for other entities (eg, professional societies) that are required to report.

Medical Malpractice Payment Reporting

Malpractice claims are reported to the Data Bank if a monetary exchange based on a settlement or judgment due to written complaint or claim was paid out for damages.[10] Any indemnity payment made on behalf of the practitioner by a medical malpractice payer must submit a report to the Data Bank. To be reported, a claim must be made against the practitioner; however, if a payment is made on behalf of a healthcare corporation or business entity (eg, hospital, group practice, and clinic) where no individual practitioner is named, then the claim is not considered reportable. If a single settlement for more than one practitioner was made, the insurer must report on each practitioner. In addition, if an individual practitioner is also a corporation or business and is the sole provider of that corporation or business, then a report must be made even if payment was made on behalf of the corporation or business.

A practitioner who pays a claim out of pocket with personal funds is exempt from reporting. Within 30 days of the date that the malpractice payment check was made, a report must be submitted to the Data Bank and, if indicated, to the state licensing board. Not all malpractice claims warrant a licensing or credentialing investigation.

Medical malpractice payments are based on the nature of the allegation. There are 11 general categories used to broadly describe an allegation: anesthesia related, behavioral health related, diagnosis related, equipment/product related, IV (intravenous) & blood products related, medication related, monitoring related, obstetrics related, surgery related, treatment related, and other miscellaneous.[11] In addition, there are currently more than 90 specific codes that may be used to further describe the malpractice allegation.

Anesthesia-Related Medical Malpractice Payment Reporting

All practitioners may have claims on a variety of issues such as medication-related claims (eg, wrong medication and/or dosage administration) or other miscellaneous claims (eg, failure to maintain appropriate infection control or aseptic technique); however, there are also specific anesthesia-related codes. The specific anesthesia-related action or omission malpractice codes are as follows:[11]

- Failure to complete a patient assessment
- Failure to monitor
- Failure to test equipment
- Improper (anesthesia) technique/induction
- Improper equipment use
- Improper intubation
- Improper positioning
- Failure to obtain consent/lack of informed consent
- Not otherwise classified

In all cases when an authorized submitter reports malpractice, a required narrative descriptive section outlining patient information such as age, sex, patient type, procedure performed, patient's initial medical condition, claimant's allegation, outcome, and associated legal issues must be reported.[3]

Querying the Data Bank

The purpose of the Data Bank electronic repository allows eligible querying entities including their human resources department and nurse recruitment offices to assist in hiring, privileging, and credentialing processes.[9] Entities that query must be registered with the Data Bank and must indicate the purpose for a query, such as querying for privileging or employment, professional review, mandatory 2-year review, licensing, fraud and abuse investigation, certification to participate in a government program, and claims processing.[11] Now, regardless of whether one is on medical staff or holds clinical privileges, all healthcare practitioners are subject to NPDB querying, and any healthcare entity (eg, hospital, ambulatory surgery center, long-term care facility) "which is licensed or otherwise authorized by the State to provide healthcare services" may query the NPDB to identify incompetent or unethical practitioner performance

Must query	May query	May query[a]	Prohibited
• Hospitals	• State medical and dental boards • State licensing boards for all other healthcare practitioners • Other healthcare entities/organizations • Professional societies that follow a formal peer review process • Healthcare practitioners (self-query) • Plaintiff's attorney only when a hospital failed to query and an action or claim was filed in the NPDB	• Quality improvement organizations (QIOs) • State Medicaid Fraud Control Units and law enforcement agencies • Agencies administering federal healthcare programs and their contractors • State agencies administering state healthcare programs • State agencies that license healthcare entities • US Comptroller General	• Medical malpractice payers • Peer review organizations

Table 3. Entities That Have Access to Information[9]
Abbreviations: NPDB, National Practitioner Data Bank.
[a] These entities may receive *Section 1921* reportable information only. All other entities, except for those that are prohibited to query, may receive information that is reportable under *Title IV* of *Public Law 99-660* and *Section 1921* of the *Social Security Act*. See Table 2 for a list of reportable information.

for the screening of hires or clinical privileges.[7]

Table 3 represents the entities that may query NPDB information from the Data Bank. Only hospitals are mandated to query the system about a practitioner upon hire and every 2 years for review.[3] However, other institutions such as ambulatory surgery centers and offices may query the Data Bank based on their own policies. For a nominal fee, any individual practitioner may self-query to obtain information about oneself at any time by submitting a self-query application to the Data Bank website.[12] All mandatory fields on the electronic form must be filled out to submit a query. In addition, the self-query must be printed, signed, notarized, and mailed back to the Data Bank for retrieval of information.

Conclusion

The NPDB is designed to improve the quality of healthcare and to protect the public by monitoring medical malpractice and preventing incompetent and unsafe healthcare practitioners from practicing. This national data system provides a systematic method to uncover documented incompetent practitioners. Certified Registered Nurse Anesthetists will be notified of a submitted report to the Data Bank. Previously, malpractice payments made on behalf of the CRNA were reportable in addition to hospital clinical privileging changes; however, with the federal expansion of the NPDB, nursing state licensing boards must also report licensing issues if they arise. Only authorized submitters by a registered entity certified to provide information may query or report to the Data Bank; however, CRNAs may self-query at any time. A CRNA may request that an authorized submitter or agent correct a report by voiding, revising, or modifying an adverse action or claim previously reported to the Data Bank. If the CRNA is not satisfied with a correction or a correction has been declined, the CRNA may submit a statement or initiate a dispute for Secretarial review.

It is not unusual that an entity such as an ambulatory surgery center or office request the CRNA to conduct a self-query and submit the results of the self-query as part of their application for employment and/or privileges to the entity. Medical malpractice insurers and peer review organizations are prohibited from accessing this information but may request the individual to submit a copy of the self-query. Aggregate nonidentifiable data may be requested for research purposes. Although reporting entities are responsible for the accuracy of information submitted to the Data Bank, limitations for its use in research include incomplete data and/or reporting inaccuracies.

Nurse anesthetists need to be aware of the NPDB and the impact of reporting malpractice payments and adverse licensing actions. The NPDB, which is intended to protect patients, is one tool that may be used to evaluate a CRNA's practice. Although medical malpractice payments are not always equivalent to incompetent practice, employers may use the NPDB as a form of assessing a CRNA's past practices and/or risk to their organization. Use of the NPDB report is only one mechanism of feedback for assessing a CRNA's competency, albeit one that carries a substantial amount of weight and has an impact on the CRNA's future.

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