

National Practitioner Data Bank

2012 Annual Report

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EXECUTIVE SUMMARY

The National Practitioner Data Bank (NPDB) was created by Title IV of the Health Care Quality Improvement Act of 1986, Public Law 99-660 (HCQIA), as amended, and was implemented in 1990. The NPDB is overseen by the Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr), Division of Practitioner Data Banks (DPDB).

The NPDB's initial purposes were to (1) collect and disseminate information about physicians and dentists to prevent incompetent or unprofessional practitioners from moving from one jurisdiction to another without disclosure or discovery of previously damaging or incompetent performance, and (2) promote professional peer review activities. The overarching intent was to improve patient safety and quality of care. Therefore, Title IV requires medical malpractice payers, hospitals, medical and dental licensing boards, and certain other health care entities to report to the NPDB adverse actions taken against physicians and dentists. The implementation of Section 1921 of the Social Security Act on March 1, 2010, expanded state licensure reporting requirements to include all health care practitioners, not just physicians and dentists.

This Annual Report describes HRSA's increased efforts during 2012 to educate NPDB reporters about new reporting requirements. The report also highlights data for 2012, and it provides trend data covering the past 10 years.

In 2012, the NPDB expanded its research offerings to include a new [Data Analysis Tool](#) that resides on the NPDB's website. This statistical application permits users to perform specific data analyses and create customized data tables. The website also was updated to include 10 years of statistical data in tabular and graphical form.

The NPDB continued to implement system enhancements throughout 2012. During this time, several Federal Register notices were released. [One notice](#) announced changes to the Privacy Act exemption for the NPDB, [another](#) invited comments regarding the merger of the Health Integrity and Protection Data Bank (HIPDB) with the NPDB, and a [third](#) requested comments on the proposed Survey of Eligible Users of the NPDB, a project launched that same year.

As part of a strategic planning effort, the NPDB began several key initiatives to identify specific high-value opportunities for technology enhancements. The NPDB also launched feasibility studies of new technologies that have the potential to generate significant efficiencies for customers and internal staff.

Also in 2012, the NPDB released the National Practitioner Data Bank 2010 Annual Report, which is available on the NPDB website. HRSA will sunset the NPDB Annual Report, in its current format in 2012. All information contained in the NPDB Annual Report can be found at <http://www.npdb.hrsa.gov>.

PART I

CHAPTER 1: NATIONAL PRACTITIONER DATA BANK DESCRIPTION

Purpose of the National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) was established by the Health Care Quality Improvement Act of 1986 (HCQIA) to protect the public by restricting the ability of practitioners to move from State to State or hospital to hospital without disclosing medical malpractice payments or adverse action histories at the time of credentialing, employment, licensing, or monitoring. Implemented in September 1990, the NPDB serves as an electronic repository to collect and release information related to the professional competence and conduct of physicians, dentists, and other health care practitioners. Establishing the NPDB represented an important step by the Department of Health and Human Services (HHS) to promote patient safety and improve the quality of health care for all Americans.

State licensing boards, hospitals, health care entities, and professional societies are expected to identify, discipline, and report on those who engage in unprofessional behavior. The NPDB plays an important role in ensuring quality health care and a skilled health care workforce by providing critical information to health care entities about practitioners. The NPDB serves as an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. The information contained in the NPDB directs discrete inquiry into, and scrutiny of, a practitioner's licensure, clinical privileges, professional society memberships, and medical malpractice payment history.

Annual Reporting

This edition of the NPDB Annual Report is available on the [NPDB website](#). Previous editions are also accessible on the website.

Aggregated data gleaned from the NPDB are depicted in graphic and tabular forms. Information covering calendar years 2003 through 2012 is presented.

Additional detailed information about the NPDB is provided in the NPDB Guidebook. The Guidebook is available on the [NPDB website](#).

CHAPTER 2: NATIONAL PRACTITIONER DATA BANK STATUTES AND REGULATIONS

Health Care Quality Improvement Act

Title IV of Public Law 99-660 (42 USC § 11101 et seq.), the Health Care Quality Improvement Act of 1986 (HCQIA), created the NPDB. Issues that led to the adoption of HCQIA included:

- ◆ An increasing occurrence of medical malpractice and the need to improve the quality of medical care;
- ◆ A need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance;
- ◆ A need for effective professional peer review to protect the public;
- ◆ The threat of private monetary damages liability discouraging physicians from participating in effective professional peer review; and
- ◆ The need to provide incentives and protection for physicians engaging in effective professional peer review.

The NPDB, implemented in 1990, serves as an electronic repository to collect and release information related to the professional competence and conduct of physicians, dentists, and, in some cases, other health care practitioners. The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. The information contained in the NPDB is intended to direct discrete inquiry into, and scrutiny of, a practitioner's licensure, clinical privileges, professional society memberships, and medical malpractice payment history.

Section 1921 of the Social Security Act

Initially, the NPDB collected and released information only under HCQIA. However, in 1987, Section 5(b) of the Medicare and Medicaid Patient and Program Protection Act (Section 1921 of the Social Security Act), Public Law 100-93, was enacted. It authorized the Federal Government to collect information concerning sanctions taken by State licensing authorities against all health care practitioners and entities.

On March 1, 2010, regulations went into effect that implemented Section 1921, which expanded the information the NPDB collects and disseminates. The intent of this expansion is to protect the public from any and all unfit health care practitioners and to improve the antifraud provisions of the Social Security Act's health care programs.

Reports

HCQIA Reporting

HCQIA requires NPDB reporters to report medical malpractice payments and adverse actions taken on or after September 1, 1990. With the exception of reports on Medicare or Medicaid exclusions, the NPDB cannot accept any report with a date of payment or a date of action prior to September 1, 1990. State licensing boards, hospitals, other health care entities, and professional societies are expected to identify, discipline, and report on those who engage in

unprofessional behavior. With the addition of Section 1921, HCQIA reporting requirements did not change for hospitals, other health care entities, medical malpractice payers and insurers, professional societies with formal peer review processes, the Drug Enforcement Administration (DEA), or the HHS Office of Inspector General (OIG) (See below).

Exclusions from certain Federal Government health care programs are also part of the NPDB. In 1997, an interagency agreement between HHS' Health Resources and Services Administration (HRSA), the Centers for Medicare & Medicaid Services (CMS), and the HHS OIG included Medicaid and Medicare exclusions in the NPDB. Later that same year, the NPDB made CMS reinstatement reports available to registered users. Thus, Adverse Action Reports submitted to the NPDB expanded to include practitioner exclusions from Medicare and Medicaid in addition to adverse licensure and professional review actions related to clinical privileges and professional society memberships.

Section 1921 Reporting

Section 1921 added State licensure actions taken against all types of health care practitioners, not just physicians and dentists, to the NPDB. The section also expanded NPDB reporting requirements to include negative actions or findings by State licensing agencies, peer review organizations, and private accreditation organizations against all health care practitioners and organizations. The following is a description of the reporting requirements under Section 1921.

NPDB Reporters with New Responsibilities under Section 1921

- ◆ Boards of medical or dental examiners report:
 - Adverse licensure actions against a health care practitioner (not just actions related to competence or conduct against physicians and dentists).
 - Any negative action or finding by a State licensing authority against a health care practitioner or entity.¹

New NPDB Reporters under Section 1921

- ◆ Other State practitioner licensing boards report:
 - Adverse licensure actions against a health care practitioner. Any negative action or finding by a State licensing authority against a health care practitioner.
- ◆ State health care entity licensing authorities report:
 - Adverse licensure actions against a health care entity. Any negative action or finding by a State licensing authority against a health care entity.
- ◆ Private accreditation organizations report:
 - Certain final actions taken by the private accreditation organization against a health care entity.
- ◆ Peer review organizations report:
 - Recommendations by the peer review organization to sanction a health care practitioner.

¹ The term "entity" refers to an organization that is licensed or otherwise authorized by a State to provide health care services. This includes, but is not limited to, skilled nursing facilities, ambulatory surgical centers, pharmacies, residential treatment facilities, mental health centers, and ambulance services.

Combined HCQIA and Section 1921 Reporting

In summary, the following entities are required to report to the NPDB:

- ◆ State medical and dental boards;
- ◆ State licensing boards for all other health care practitioners;
- ◆ State agencies that license health care entities;
- ◆ Hospitals;
- ◆ Other health care entities or organizations;
- ◆ Professional societies that follow a formal peer review process;
- ◆ Medical malpractice payers;
- ◆ Private accreditation organizations; and
- ◆ Peer review organizations.

Government Reporting

Reports are collected from private and government entities, including the Armed Services, located in the 50 states and U.S. territories.² To obtain information from government entities, the Secretary of HHS entered into memorandums of agreement (MOA) with all relevant Federal agencies and departments. Section 432(b) of the Social Security Act required the Secretary to establish an MOA with the Secretaries of Defense and Veterans Affairs to apply provisions of the SSA to hospitals, other facilities, and health care providers under their jurisdictions. Section 432(c) stipulated that the Secretary also enter into an MOA with the administrator of the Department of Justice, Drug Enforcement Administration (DEA) to ensure the reporting of practitioners whose registrations to dispense controlled substances are suspended or revoked under section 304 of the Controlled Substances Act.

The Secretary of HHS has government agreements in place with the following agencies to ensure compliance with all NPDB-related laws.

- ◆ Centers for Medicare & Medicaid Services (Interagency Agreement);
- ◆ Department of Defense (MOA);
- ◆ Department of Justice, which includes the Bureau of Prisons and the DEA (MOA);
- ◆ Department of Veterans Affairs (MOA); and
- ◆ Public Health Service contractors and employees (HHS Policy Directive).

Queries

HCQIA requires NPDB reports to be available to hospitals, health care entities with formal peer review, professional societies with formal peer review, state licensing authorities, health care practitioners (self-query only), researchers (non-identifiable data for statistical purposes only), and, in limited circumstances, plaintiff's attorneys. However, this same information must not be disclosed to the general public. NPDB information should be considered together with other relevant data in evaluating a practitioner's credentials. The NPDB does not collect full records of reported incidents or actions and is not designed to be the sole source of information about a practitioner or entity. For example, an NPDB medical malpractice payment report does not

²In addition to the 50 States, the District of Columbia, and Armed Forces installations throughout the world, entities eligible to report and query are located in Puerto Rico, the Virgin Islands, American Samoa, Palau, Guam, the Northern Mariana Islands, the Federated States of Micronesia, and the Marshall Islands.

necessarily indicate negligence on the part of a practitioner because a medical malpractice payment may be made for reasons other than negligence.

Access to NPDB information is available to entities that meet the eligibility requirements defined in the provisions of HCQIA, Section 1921, and [NPDB regulations](#). Medical malpractice insurers cannot query the NPDB.³ In order to access NPDB data about practitioners, entities that meet the eligibility requirements must first register with the NPDB.

Queriers under HCQIA also receive Section 1921 information. Hospitals, including their human resources departments and nurse recruitment offices, have access to Section 1921 licensure actions to assist with hiring, privileging, and re-credentialing decisions.

NPDB information is available to the following queriers under HCQIA and Section 1921:

- ◆ Hospitals (required to query);
- ◆ Other health care entities (optional query);
- ◆ State medical and dental boards (optional query);
- ◆ State licensing boards for other health care practitioners (optional query);
- ◆ Professional societies that follow a formal peer review process (optional query);
- ◆ Health care practitioners (self-query only);
- ◆ Plaintiff's attorneys (under certain circumstances); and
- ◆ Researchers requesting aggregated information that does not identify any particular entity or practitioner (non-identifiable data).

The following queriers have access to information reported to the NPDB under Section 1921 only:

- ◆ Agencies administering Federal health care programs, including private sector entities administering such programs under contract;
- ◆ State agencies administering or supervising the administration of State health care 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; and
- ◆ Utilization and quality control peer review organizations (now known as quality improvement organizations).

Health care practitioners may self-query the NPDB at any time. A plaintiff or an attorney for a plaintiff in a civil action against a hospital may query the NPDB about a specific practitioner in limited circumstances. This is possible only when independently obtained evidence, submitted to HHS, discloses that the hospital did not make a required query on the practitioner. If this is proven, the attorney or plaintiff is provided with information that the hospital would have received if it had queried the practitioner as mandated. This information may be used only against the hospital, not against the practitioner.

³Self-insured health care entities may query for peer review but not for "insurance" purposes.

Fees

As mandated by law, user fees, not congressionally appropriated funds, are used to pay for all costs of NPDB operations. The query fee in 2012 was \$4.75 for each One-Time Query. The Continuous Query fee was \$3.25 per practitioner for an enrollment in the service for one year. The Self-Query fee was \$8.00. Queries must be paid for by credit card or via automatic electronic funds transfer.

Confidentiality of NPDB Information

Under HCQIA, information reported to the NPDB is considered confidential and cannot be disclosed except as specified in the NPDB regulations. The Privacy Act of 1974 protects from disclosure the contents of Federal records, such as those contained in the NPDB. Authorized queriers must use NPDB information solely for the purposes for which it was provided. The HHS OIG can impose civil monetary penalties on those who violate the confidentiality provisions. Persons, organizations, or entities that receive NPDB information either directly or indirectly are subject to the confidentiality provisions and the imposition of a civil monetary penalty of up to \$11,000 for each offense if they violate these provisions. In this Annual Report, data from the records are aggregated and do not disclose the identity of the practitioners or entities in the NPDB.

Civil Liability Protection

To encourage and support professional review activity of physicians and dentists, Part A of HCQIA provides that the professional review bodies of hospitals and other health care entities, and persons serving on or otherwise assisting such bodies, are offered immunity from private damages in civil suits under Federal or State law. Immunity provisions apply when professional review responsibilities are conducted with the reasonable belief that they are furthering the quality of health care and with proper regard for due process.

PART II

CHAPTER 3: ADMINISTERING THE NATIONAL PRACTITIONER DATA BANK

The NPDB is administered by staff members of the Division of Practitioner Data Banks (DPDB). The DPDB resides in HRSA's Bureau of Health Professions (BHPPr), within HHS. Descriptions of HRSA, BHPPr, and DPDB are provided below.

Health Resources and Services Administration

[HRSA](#), an agency of HHS, is the primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.

Comprising six bureaus and ten offices, HRSA provides leadership and financial support to health care providers in every State and U.S. territory. HRSA grantees provide health care to uninsured people, people living with HIV/AIDS, pregnant women, mothers, and children. Additionally, HRSA grantees train health professionals and improve systems of care in rural communities.

HRSA oversees organ, bone marrow, and cord blood donation. It supports programs that prepare against bioterrorism, compensates individuals harmed by vaccination, and maintains the NPDB and the Health Integrity and Protection Data Bank (HIPDB), collectively known as the Data Bank.

Since 1943, the agencies that were HRSA precursors have worked to improve the health of needy people. HRSA was [created in 1982](#), when the Health Resources Administration and the Health Services Administration were merged.

Bureau of Health Professions

The Bureau of Health Professions increases the Nation's access to quality health care, especially for underserved people, by developing, distributing and retaining a diverse, culturally competent health workforce that can adapt to the population's changing health care needs and provide the highest quality of care for all.

Division of Practitioner Data Banks

DPDB, a component of BHPPr, operates the NPDB and the HIPDB. DPDB is committed to developing and operating cost-effective and efficient systems that offer accurate, reliable, and timely information on practitioners, providers, and suppliers to credentialing, privileging, and government authorities.

DPDB actively addresses its mission by working closely with stakeholders – such as State licensing boards and health care entities – to ensure that all disciplinary actions are reported to the Data Bank, by monitoring data entry accuracy and completeness, and by making presentations to a variety of audiences representing State licensing boards and professionals in the health care and private sector industries.

In 2012, DPDB presented information about the Data Bank to stakeholders and constituents across the country (Figure 1).

Figure 1: Presentations by DPDB



- Anchorage, AK
- Tuscaloosa, AL
- Sacramento, San Diego, and San Francisco, CA
- Denver, CO
- Washington, DC
- Orlando and Seminole, FL
- Des Moines, IA
- Chicago, IL
- New Orleans, LA
- Boston, MA
- Annapolis, MD
- Bangor, ME
- Jackson, MS
- Las Vegas, NV
- Bend, OR
- Nashville, TN
- Fort Worth, TX
- Charlottesville and Hot Springs, VA
- Green Bay, WI

Contractor

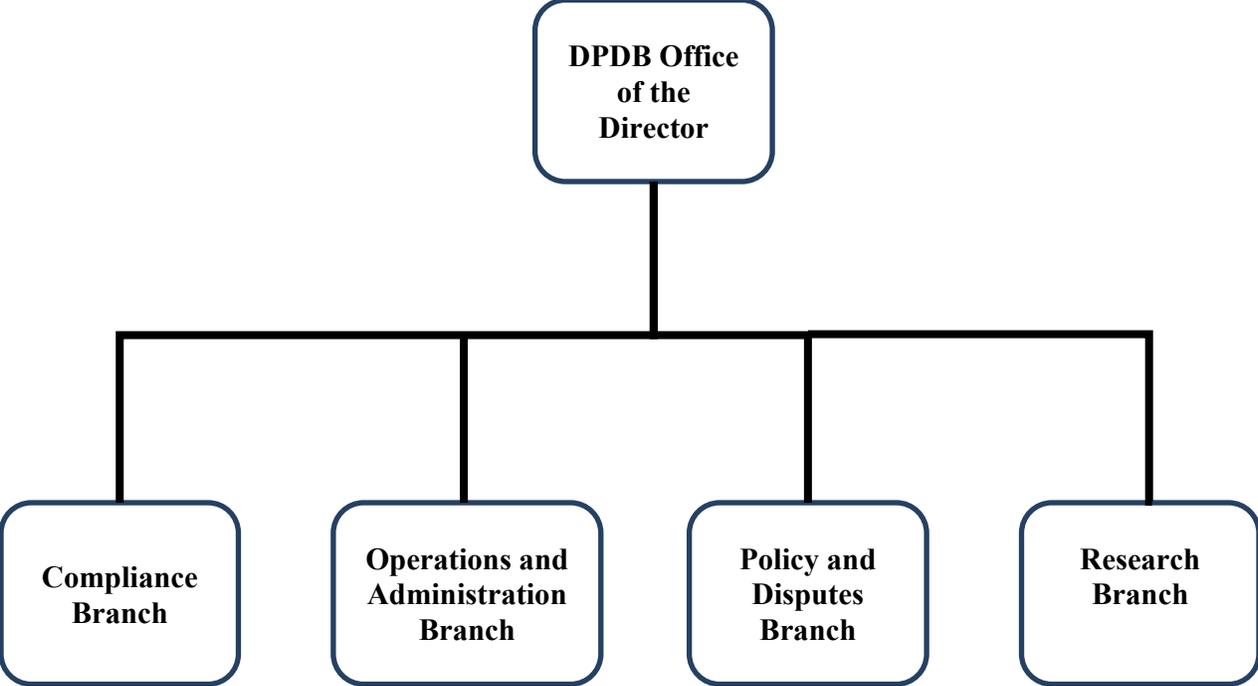
The NPDB information technology system is operated by a contractor, SRA International, Inc. (SRA), which began doing so in June 1995. SRA replaced Unisys Corp., which operated the NPDB from its opening on September 1, 1990. SRA created the Integrated Querying and Reporting Service (IQRS), an Internet reporting and querying system for the NPDB and the HIPDB.

Executive Committee

The NPDB Executive Committee was established in February 1989 to provide from individual members guidance, recommendations for improvement, and health care expertise to the NPDB contractor on NPDB operations. No consensus advice or recommendations from group deliberation are provided. However, the committee, through its work with DPDB, provides valued, individual feedback on NPDB processes.

The committee is composed of 32 organizational representatives from HRSA and other Federal agencies, various health professions, national health organizations, State professional licensing agencies, medical malpractice insurers, and public advocacy organizations. The committee serves as a forum for these organizations that share a stake in the NPDB to discuss NPDB operations and policy. A chair and vice chair of the committee are elected for 2-year terms by Executive Committee members. Committee members from private organizations have 3-year renewable, staggered terms. Federal agencies, such as the Department of Defense and the HHS OIG, participate on the committee without term limits. The Executive Committee meets periodically with the contractor and DPDB. A webinar was held with the Executive Committee on May 2, 2012. The committee met in person on November 8, 2012, in Washington, DC, where an election of officers took place. The new incoming chair is Ralph W. Hale, M.D., F.A.C.O.G., of the American College of Obstetricians and Gynecologists, and the new incoming vice chair is Lisa A. Robin, M.L.A., of the Federation of State Medical Boards.

Figure 2: Organizational Structure of the DPDB



Branch Highlights and Activities

The DPDB is composed of four branches – Operations and Administration, Policy and Disputes, Research, and Compliance. Major branch activities in 2012 are listed below.

Operations and Administration Branch

The Operations and Administration Branch is primarily responsible for managing the technological, financial, administrative, and contractual functions that support DPDB's mission. The branch is also responsible for formulating and maintaining DPDB's budget, and for other administrative functions. To support the needs of the Data Bank user base, the branch oversees operational aspects of the Data Bank, including a customer service center, system maintenance and enhancements, query fee processing, document management, and the publication of newsletters. Branch employees plan and manage system enhancements to make the Data Bank system more user-friendly, to improve data quality, and to ensure reliability. Additionally, the branch completed the selection process for the fifth generation Data Bank contract.

The Operations and Administration Branch provided oversight of the following:

- ◆ Streamlined the entity registration process, allowing users to correctly choose their statutory authorities using a wizard-like tool.
- ◆ Enabled online registration renewal, allowing entities to bypass the 2-week paper process and renew online instantly.
- ◆ Eliminated mailing paper reports, thereby reducing paper consumption by 200,000 sheets annually and boosting data security.
- ◆ Created an electronic process to automatically forward reports directly to licensing boards, to facilitate improved information sharing.
- ◆ Improved overall system performance for reports, reducing response time from between 2 hours and 4 hours down to a few seconds.
- ◆ Reduced the risk of downtime and improved overall system responsiveness, especially during periods of peak use.
- ◆ Introduced enhancements to boost data integrity and compliance.
- ◆ Enabled a new approach that helps users see connections between different reports, helping to tell the story of an incident or action.
- ◆ Prepared the behind-the-scenes database changes needed to merge the HIPDB with the NPDB, expected during 2013.
- ◆ Improved Data Bank Customer Service Center operations by leveraging new cloud-based customer relationship management software.

In addition, the Data Bank newsletter was converted from a traditional printed version to an electronic-only format. This effort is saving the Federal Government more than \$50,000 in printing and postage costs and reducing paper consumption by 256,000 pages annually. The electronic newsletter is now delivered monthly, rather than quarterly, giving Data Bank users information in a more timely manner.

Policy and Disputes Branch

The Policy and Disputes Branch writes policy guidelines for the Data Bank; answers policy questions from health care entities, attorneys, government officials, and practitioners; educates

users about Data Bank programs; makes presentations at health care conferences and meetings; ensures compliance with reporting and querying requirements; and creates fact sheets, articles, and other texts for the Data Bank's website and other locations. The branch also facilitates a Dispute Resolution process, which results from practitioners disputing reports in the Data Bank. If a reporting entity does not resolve a practitioner's concerns, the practitioner may ask for Dispute Resolution. A final determination is then made on whether a report should remain unchanged, be modified, or be voided.

Branch highlights for 2012 included the following:

- ◆ DPDB staff coordinated and conducted 37 professional presentations or exhibits for Data Bank users and stakeholders across the country, including five webinars.
- ◆ The DPDB hosted two educational forums in the United States – Nashville, September 26-27, and Denver, October 10-11. The purpose of these forums was to help attendees understand their Data Bank reporting and querying requirements and to inform them about the latest Data Bank initiatives. Forums included educational briefings on the following: overview of the Data Bank, Data Bank reporting and querying requirements, Data Bank system enhancements and security, and new and upcoming Data Bank features.
- ◆ A [Notice of Proposed Rulemaking](#) was published in the Federal Register on February 15, 2012, announcing the merger of the HIPDB with the NPDB.
- ◆ The [System of Records Notice](#) for the NPDB was updated to reflect changes in the Privacy Act exemptions for the NPDB. A final notice was published in the Federal Register on March 30, 2012.
- ◆ Policy staff worked with the Department of Veterans Affairs, CMS, and the HHS OIG to ensure that Federal partners were prepared for changes that will go into effect after the merger of the NPDB and the HIPDB.
- ◆ In 2012, a total of 103 reports were elevated to Dispute Resolution and 113 cases were closed. Both the elevations and closures were the highest in Data Bank history. Several reports closed in 2012 were elevated prior to 2012.
- ◆ The Disputes staff continued to build and use an electronic Disputes Tracker system to rely less on paper files, including developing an electronic workflow, secure messaging, and a repository of cases.
- ◆ Weekly disputes reports were eliminated due to automatically generated data tables from the Disputes Tracker.
- ◆ Innovative training materials were developed by Dispute team members, including a video on how to put together dispute case materials and a PowerPoint tutorial on how to use the Disputes Tracker.
- ◆ Practitioners who elevated their reports to Dispute Resolution now have a more user-friendly Report Response Service, developed in 2012, allowing them to see where they are in the process.
- ◆ An article for the National Council of State Boards of Examiners for Speech-Language Pathology and Audiology (NCSB) was written and published in the NCSB newsletter. It included information on the Data Bank and Section 1921, and tables showing the reporting of speech-language pathologists and audiologists. The NCSB called it “just what NCSB needs to get out to member boards and licensees.”
- ◆ Several Data Bank fact sheets for allied professions were created in 2012. Fact sheets have been developed for nurses, chiropractors, and pharmacists. Each fact sheet contains

information on who can be reported to the Data Bank for what actions, as well as instructions on how to dispute a report. Completed fact sheets were posted on the Data Bank website.

- ◆ The Policy team responded to inquiries elevated from the Data Bank Customer Service Center, correspondence from the White House, and policy-related emails and phone calls. Types of inquiries and correspondence included complaints against practitioners, attorney access, State and Federal subpoenas, State board issues, and policy clarifications.

Research Branch

The Research Branch is responsible for creating in-house research files and Public Use Files by selecting, merging, and recoding variables from the NPDB and the HIPDB. The Research Branch also creates and updates web-based statistics and produces the NPDB Annual Report. Other functions of the Research Branch include providing aggregated data to internal and external stakeholders and performing quality control checks for data accuracy. The Research Branch also provides information to other DPDB branches to support their work.

Branch highlights for 2012 include the following:

- ◆ A web-based [Data Analysis Tool](#) was developed and implemented to facilitate independent analysis of information relating to medical malpractice payments and adverse actions. The new tool allows a wide range of users to perform unique analyses that can be customized by State or region, making it possible for stakeholders to identify trends of interest and to target their resources on areas of concern. The Research Branch was recognized with an Outstanding Performance Award at the HRSA level for this effort.
- ◆ The Research Branch also developed NPDB [statistics by State](#) that are available in table and trend plot formats that can be accessed using an interactive map of the United States.
- ◆ The Research Branch used NPDB administrative data and information from an external data source to begin the process of validating existing NPDB system information. Combining the NPDB data with information from an outside data source is also providing answers to more research questions than would have been possible using NPDB data alone.
- ◆ The Research Branch examined information residing in the Data Bank that is collected in non-mandatory fields by the reporting system.
- ◆ The Research Branch procured a contract to administer a survey of eligible Data Bank users to obtain a comprehensive view of the usability and customer satisfaction with Data Bank products and services. Work on this contract began in the fall of 2012 and is expected to continue for 2 years.
- ◆ The Public Use File was downloaded an average of three to four times per day.
- ◆ Data Requests
 - The Research Branch responded to 70 data requests and inquiries from external users and more than 25 requests from other DPDB branches and other HHS staff.
 - The Research Branch completed 23 reports for 20 medical boards and boards of osteopathic medicine from 19 states (Alabama, Arkansas, California, Delaware, Florida, Hawaii, Kansas, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Utah, Washington, and Wisconsin). For this project, the Research staff verified the number of physicians with one or more clinical privilege action in the Data Bank but no licensure action in those states.

- ◆ The Research Branch conducted a session that was open to all HRSA employees to introduce research that combined NPBD data with physician specialty information from an external data source.

Compliance Branch

The Compliance Branch acts to improve the completeness and accuracy of data reported to the HIPDB and the NPDB. The Compliance Branch works actively with State agencies on an Adverse Action Comparison Project and a Never Reported Professions Compliance Effort. The web-based technologies supporting these State agency compliance efforts were significantly improved, reducing the number of manual steps in various compliance processes. In addition, the results of these efforts can now be viewed on a [U.S. map of compliance statistics by State](#).

Specific compliance efforts in 2012 included:

- ◆ Never Reported Professions: Compliance staff continued to work with licensing boards that never reported disciplinary actions to the Data Bank. For this effort, staff identified specific professions and contacted the State licensing boards for those professions. Data Bank staff continued to work closely with these agencies to ensure they (1) understood the Data Bank reporting requirements, (2) registered with the Data Bank (if they were previously unregistered), (3) reported all reportable disciplinary actions they had taken, and (4) attested that they would continue to report in the future. At the end of 2012, 88 percent of the professions reviewed were compliant with reporting requirements. Table 1 details the compliant professions through the 2011 and 2012 public postings, as well as new reports to the Data Bank and the number of disclosures of these new reports from the Data Bank as a direct result of this effort.
- ◆ Adverse Licensure Action Comparison Project: For this effort, Data Bank staff compared publicly available disciplinary action data against reports contained in the Data Bank to verify that the disciplinary actions were reported as required by law. When data were not publicly available, staff requested data from State licensing boards. Staff continued efforts to verify, by a one-to-one match, that all licensure actions taken by State licensing boards had been reported to the Data Bank when required by law. In 2012, staff continued working with the State licensing boards that regulate nurses, pharmacists, physician assistants, podiatrists, psychologists, social workers, physicians, dentists, chiropractors, optometrists, and physical therapists, and it added behavioral health professions to the effort. By the end of 2012, 96 percent of all professions in the effort were compliant with Data Bank reporting requirements. Table 1 details the compliant professions by public posting and profession.
- ◆ Compliance efforts resulted in 3,919 new reports added to the Data Bank that may not have been submitted otherwise. In addition, there were 6,331 disclosures of these new reports.
- ◆ Communications: To assist States in their efforts to comply with Data Bank reporting requirements, staff conducted or participated in a variety of outreach education activities, including webinars, teleconferences, and presentations to State and national organizations. Staff provided a webinar for State licensing boards focusing on a new 2-year cycle of compliance activities for the 12 most-queried professions: physicians, dentists, nurses, pharmacists, physician assistants, podiatrists, psychologists, social workers, chiropractors, optometrists, physical therapists, and the behavioral health professions. The first compliance status posting (approximately one-quarter of the boards in this review) for this new effort will be April 1, 2013. The webinar also demonstrated new web-based technology available to all

State licensing boards when involved in a Data Bank compliance activity. Staff used the Data Bank Customer Service Center, email, telephone, and secure messaging to provide ongoing technical assistance to various stakeholder groups.

- ◆ Technological Improvements: In November 2012, DPDB released a web-based technology solution for compliance, directly linked to the Data Bank database. This system introduced innovative applications, allowing staff and users to manage, organize, and communicate about missing licensure action data. The new system consolidates information into one location for users, and it improves the efficiency, accuracy, retention, and security of compliance-related data.
- ◆ The Data Bank began a hospital compliance initiative in 2012 to better understand and improve querying activity and the completeness and accuracy of reports submitted to the Data Bank. This effort included:
 - Convening a variety of Data Bank stakeholder groups with the intent to obtain the viewpoints from individual attendees to better understand the role the Data Bank plays relative to individual users and health care organizations. The results of the group discussions concerning individual experiences will serve to inform the development of the Data Bank hospital compliance framework.
 - Beginning a comparative analysis to identify eligible hospitals and health care entities that may not be registered with the Data Bank and to determine reporting and querying activity trends.

**Table 1: Adverse Licensure Action Comparison Project Compliance Status by Profession
Compliance Status Public Posting**

Number of Compliant Professions

Profession	July 1 2010	Oct 1 2010	Apr 1 2011	July 1 2011	Oct 1 2011	Dec 1 2011	July 1 2012	New Reports	Disclosures
Nurse	7	22	46	49	50	50	51	476	185
Pharmacist	0	19	39	41	41	41	48	1,039	283
Physician Assistant	5	43	46	48	48	48	48	31	125
Podiatrist	3	38	43	45	45	45	45	14	84
Psychologist	1	33	44	46	47	48	50	78	107
Social Worker	0	29	45	46	46	48	50	226	134
Physician	-	-	68	87	95	99	102	776	3,397
Dentist	-	-	41	47	48	49	50	467	1,474
Chiropractor	-	-	-	-	50	51	51	288	270
Optometrist	-	-	-	-	50	51	51	41	91
Physical Therapist	-	-	-	-	82	83	85	83	22
Behavioral Health	-	-	-	-	-	-	286	400	159
Never Reported Professions	261	415	493	490	494	494	413	16,349	753
Adverse Licensure Total								3,919	6,331
Grand Total								20,258	7,084

Percent Compliant

Profession	July 1 2010	Oct 1 2010	Apr 1 2011	July 1 2011	Oct 1 2011	Dec 1 2011	July 1 2012	New Reports	Disclosures
Nurse	13%	43%	90%	96%	98%	98%	98%		
Pharmacist	0	40	83	87	87	87	94		
Physician Assistant	10	90	96	100	100	100	100		
Podiatrist	7	83	93	98	98	98	98		
Psychologist	2	65	86	90	92	94	98		
Social Worker	0	59	92	94	94	98	98		
Physician	-	-	67	86	94	98	100		
Dentist	-	-	80	92	94	96	98		
Chiropractor	-	-	-	-	98	100	100		
Optometrist	-	-	-	-	98	100	100		
Physical Therapist	-	-	-	-	82	83	85		
Behavioral Health	-	-	-	-	-	-	89		
Never Reported Professions	39	63	74	74	77	77	88		

Note: Grand Total includes Never Reported.

Behavioral Health includes professions related to mental or behavioral health other than those listed separately; includes various types of counselors, therapists, and addiction professionals. For some professions, DPDB separated out groupings for the public posting.

New Reports are the number of new reports in the Data Bank as a result of the compliance effort.

Disclosures are the total number of times the New Reports were viewed by a registered Data Bank entity or seen as a result of a self-query. A search on a practitioner that does not result in a matched Data Bank report is not counted as a disclosure. One report may account for more than one disclosure – i.e., a report that is disclosed to five different queriers is counted as five disclosures.

PART III

CHAPTER 4: REPORTING AND QUERYING

Reporting to the NPDB

The statutes and regulations governing the information and types of entities (Table 2) that are required to submit reports to the NPDB were described in Chapter 1.

Table 2: Entities that Report to the NPDB

Entity	Report
State Medical and Dental Boards	Required to report on licensure disciplinary actions, e.g., revocation, suspension, voluntary surrender while under investigation, license restriction, and any negative action or finding.
State Licensing Boards for Other Health Care Practitioners	Required to report in generally the same manner as State medical and dental boards.
Hospitals	Required to report on adverse professional review actions related to professional competence or conduct that impact physician or dentist privileges or panel memberships for more than 30 days. Required to report a physician's or dentist's voluntary surrender or restriction of clinical privileges or panel memberships while being investigated for possible professional incompetence or improper professional conduct or in return for an entity not conducting an investigation or taking a reportable professional review action.
Health Care Entities*	Required to report in the same manner as hospitals.
Professional Societies that Follow a Formal Peer Review Process	Required to report on adverse professional review actions based on reasons related to professional competence or professional conduct that adversely affects a physician's or a dentist's membership.
Medical Malpractice Payers	Required to report all medical malpractice payments when an entity makes a payment for the benefit of a health care practitioner in settlement or in satisfaction, in whole or in part, of a claim or judgment against that practitioner.
Peer Review Organizations	Required to report recommendations to sanction a health care practitioner.
Private Accreditation Organizations	Required to report certain final actions taken by the private accreditation organization against a health care entity that is licensed or otherwise authorized by a State to provide health care services.
State Agencies that License Health Care Entities	Required to report in the same manner as State medical and dental boards.

*Health care entities or organizations must provide health care services, directly or indirectly, and follow a formal peer review process for the purpose of furthering quality health care.

Querying the NPDB

The statutes and regulations authorizing entities to query the NPDB were described in Chapter 2 (See Table 3 for details).

The NPDB can be queried using a One-Time Query or Continuous Query. When using the One-Time Query method, entities submit individual queries on a practitioner or entity and receive a copy of reports stored on the practitioner or entity at the time of the query.

To use Continuous Query, entities must first enroll their practitioners in this service. Entities with enrolled practitioners receive copies of reports stored on their practitioner(s) and

automatically receive notice of new and updated reports in real time. Entities enroll practitioners for one year and may renew that enrollment annually.

Queries submitted by either method may or may not receive a matched report. Matched reports are generated when the information on the query matches information on an active report stored in the Data Bank.

Table 3: Entities that Query the National Practitioner Data Bank

Entity	Query
State Medical and Dental Boards	Optional.
State Licensing Boards for Other Health Care Practitioners	Optional.
Hospitals	Required to query on all applicants for medical staff appointments or when granting, adding to, or expanding clinical privileges, and every two years to review clinical privileges, and as needed.
Health Care Entities*	Optional.
Professional Societies that Follow a Formal Peer Review Process	Optional.
Health Care Practitioners	May self-query.
Medical Malpractice Payers	Prohibited.
Peer Review Organizations	Prohibited.
Quality Improvement Organizations	Optional.**
Private Accreditation Organizations	Prohibited.
State Medicaid Fraud Control Units and Law Enforcement Agencies	Optional.**
Agencies Administering Federal Health Care Programs and their Contractors	Optional.**
State Agencies Administering State Health Care Programs	Optional.**
State Agencies that License Health Care Entities	Optional.**
U.S. Comptroller General	Optional.**
Plaintiff's Attorneys	May query when a hospital failed to make a mandatory query of a practitioner and both the hospital and practitioner are named in a medical malpractice action.

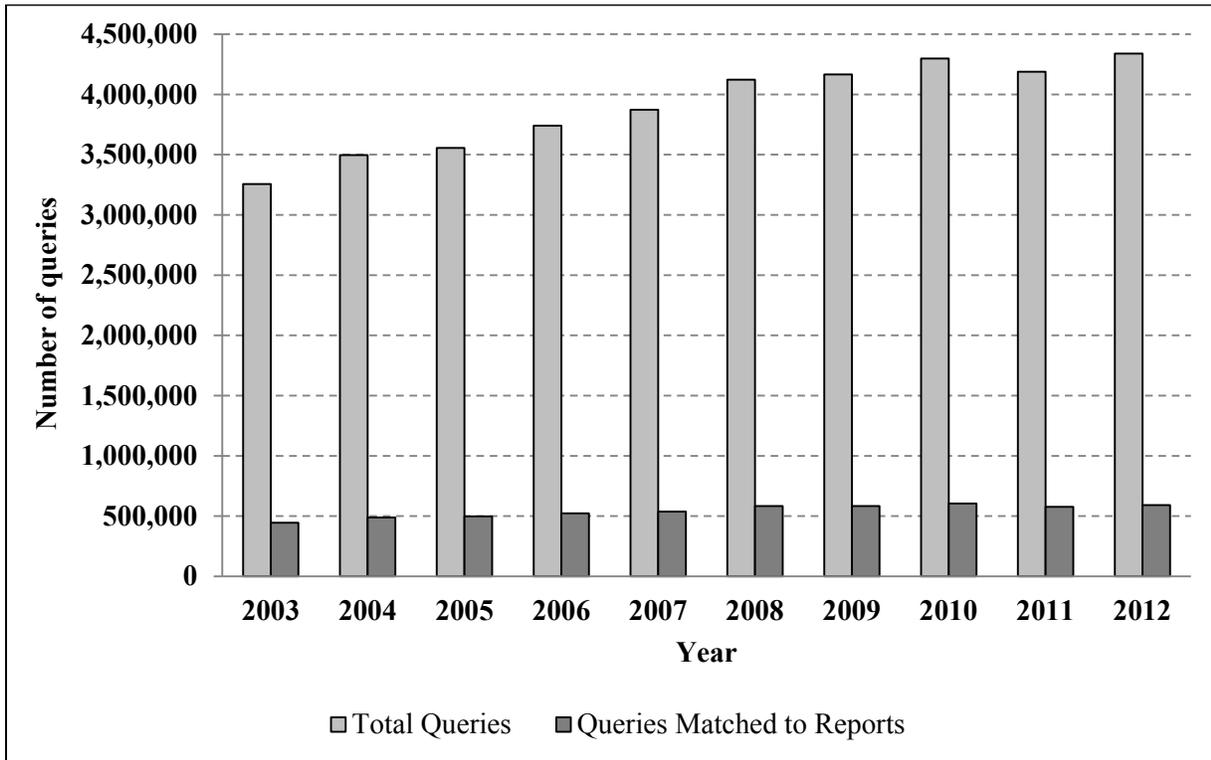
*Health care entities or organizations must provide health care services, directly or indirectly, and follow a formal peer review process for the purpose of furthering quality health care.

**These organizations and agencies may receive only information reported to the NPDB under Section 1921.

One Time Queries

Between 2003 and 2012, the number of One-Time Queries increased from 3.3 million to 4.3 million (Figure 3). The number of One-Time Queries that matched to reports increased from 445,004 in 2003 to 604,889 in 2010; the number declined in 2011 and then increased in 2012 (577,565 and 592,230 respectively).

Figure 3: One-Time Queries, 2003 - 2012



Continuous Query

The Data Bank introduced Continuous Query in May 2007 in response to growing interest from the health care community for ongoing practitioner monitoring. Organizations that enroll their practitioners in Continuous Query receive an initial query response, followed by continuous, around-the-clock monitoring on their practitioners. Continuous Query is popular with users for its prompt and automatic notices of new information, its ease of use, and the time it saves by effectively automating querying. As a result, Continuous Query usage among all types of organizations, big and small, has grown substantially since 2007.

Between 2008 and 2012, the number of Continuous Query enrollees increased dramatically from 206,128 to 1,202,472 (Figure 4). At the same time, the number of enrollees that matched to reports increased from 22,695 to 165,743 for the same time period.

Figure 4: Continuous Query Enrollees, 2008 - 2012

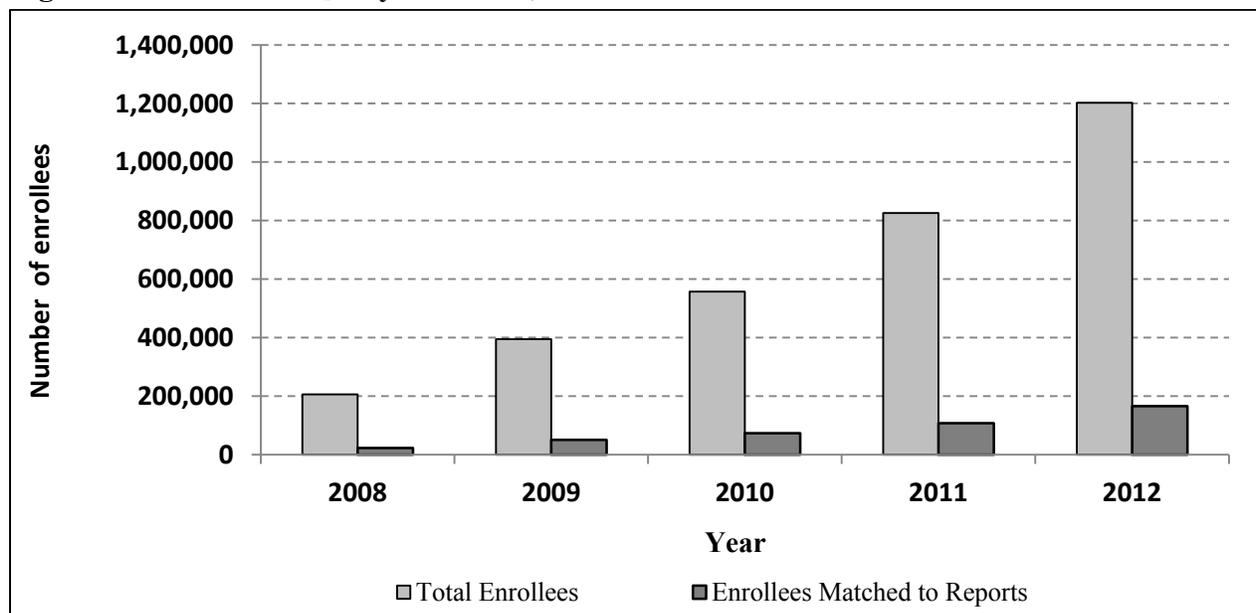
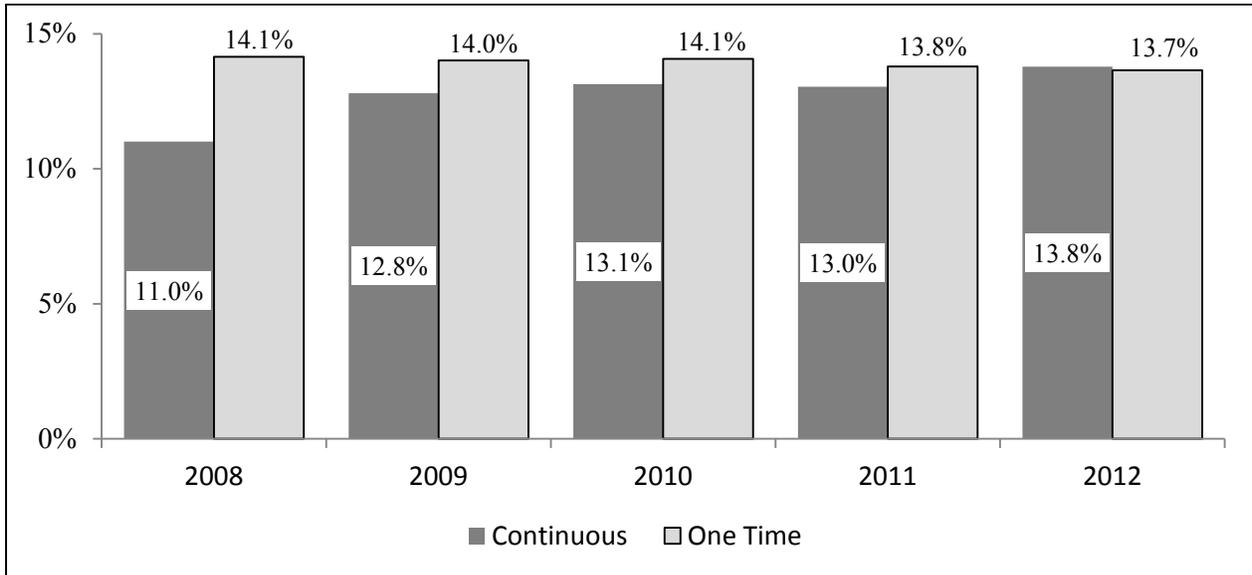


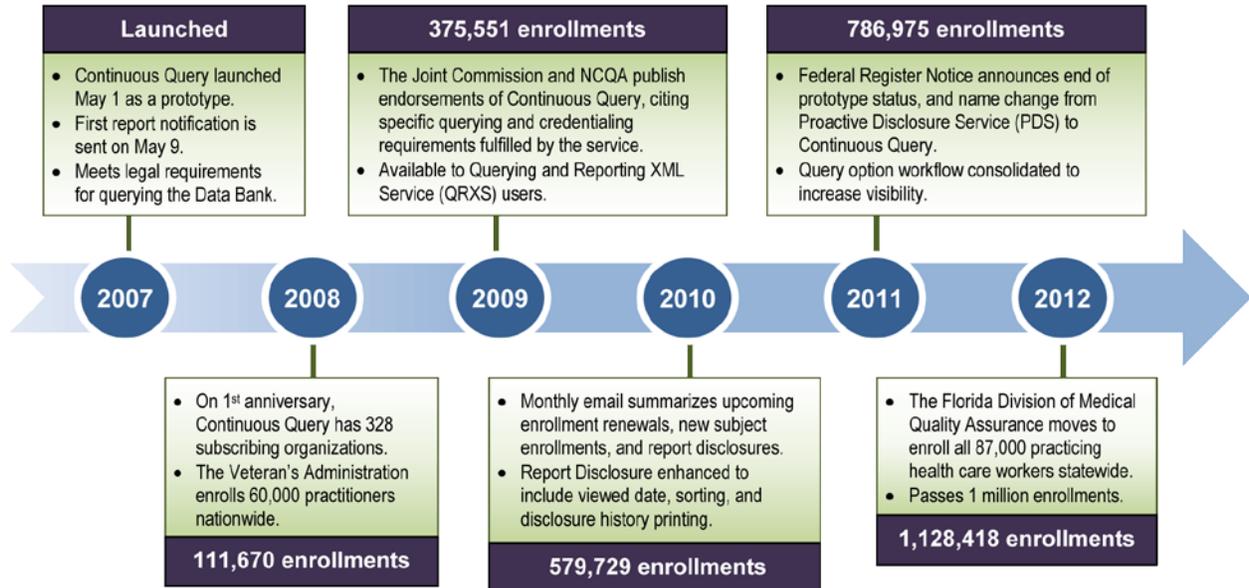
Figure 5: Queries Matched to Data Bank Reports by Query Type, 2008 - 2012



Between 2008 and 2012, the trend in the match rates for One-Time Queries and Continuous Queries did not differ substantially (Figure 5). The match rate for One-Time Queries showed a slow decline from 14.1 percent to 13.7 percent. For the same time period, match rates for Continuous Queries increased slightly from 11 percent to 13.8 percent.

Figure 6: Continuous Query Timeline

A History of Continuous Query



Below are some of the most often cited benefits of using Continuous Query:

- ◆ The *timeliness* of report disclosures enables organizations to respond proactively to adverse actions as they occur, instead of waiting until re-credentialing time.
- ◆ *No need to submit One-Time Queries* on enrolled practitioners. Organizations are automatically notified of new or changed reports within one business day of the Data Bank's receipt.
- ◆ *Flexible enrollment and renewal options* include automatic renewals, the ability to schedule enrollment termination dates, and a variety of sorting and filtering capabilities to simplify tracking of enrolled practitioners.
- ◆ Provides organizations with *cost-effective savings in staff time spent on querying* while keeping them systematically informed about reportable incidents on their enrolled practitioners – including adverse licensure and privileging actions, Medicare and Medicaid exclusions, civil judgments, criminal convictions, and medical malpractice payments.
- ◆ Can *enhance the hiring practices* of health care organizations and fulfill certain [legal and accreditation requirements](#).

These features help to explain the increase in Continuous Query enrollments since its 2007 introduction.

CHAPTER 5: WHO AND WHAT IS REPORTED

The types of practitioners reported to the NPDB include, but are not limited to, the following:

- ◆ Physicians (MDs and DOs)
- ◆ Dentists
- ◆ Professional nurses (RNs and APRNs)
- ◆ Para-professionals
- ◆ Assisted devices services practitioners
- ◆ Chiropractors
- ◆ Complementary medicine practitioners
- ◆ Counselors and marriage or family therapists
- ◆ Dental assistants and hygienists
- ◆ Dietitians and nutritionists
- ◆ Emergency medical technicians
- ◆ Medical assistants
- ◆ Occupational therapists and assistants
- ◆ Optometrists
- ◆ Pharmacists and assistants
- ◆ Physical therapists and assistants
- ◆ Physician assistants
- ◆ Podiatrists and assistants
- ◆ Psychologists and assistants and associates
- ◆ Respiratory therapists and technologists
- ◆ Speech and language pathologists and audiologists
- ◆ Social workers
- ◆ Other technologists and technicians
- ◆ Other rehab or restorative service practitioners
- ◆ Lay midwives (non-nurse)
- ◆ Health care facility administrators

Over the years, the number of reports processed annually by the NPDB has increased substantially. Between 2009 and 2010, the number of reports submitted annually to the NPDB more than doubled (Table 4). This dramatic increase may, in part, represent the impact of implementing Section 1921 as well as the submission of several multi-year report files. The implementation of Section 1921 coupled with the increased efforts on the part of the DPDB's Compliance Branch produced large numbers of Adverse Action Reports processed in 2010.

Table 4: NPDB Reports by Type and Processed Year, 1990 - 2012

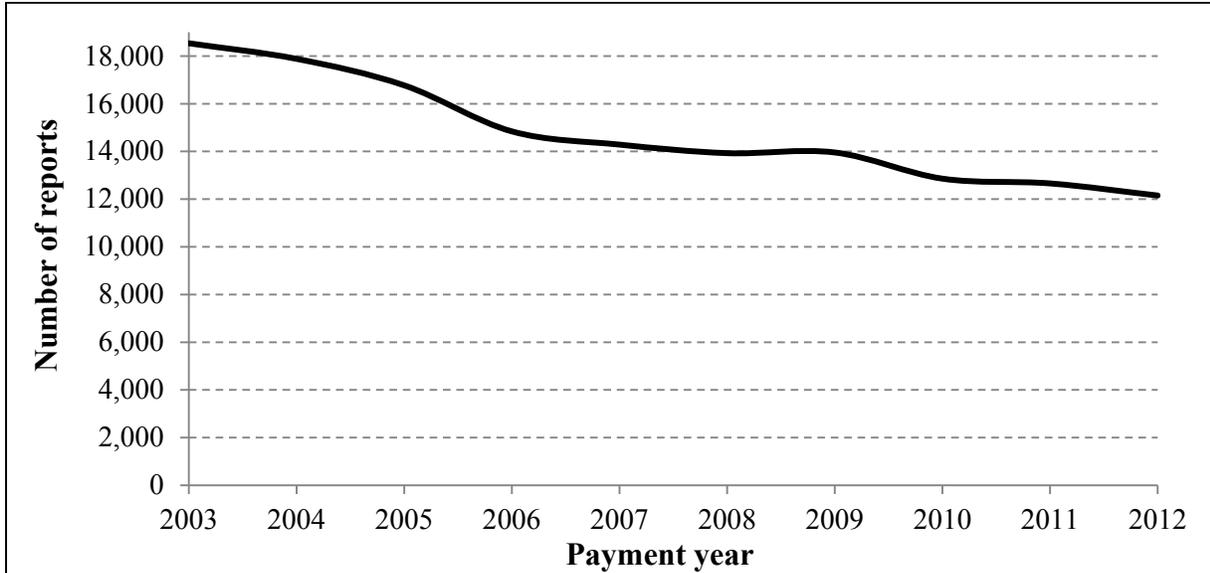
Processed Year	Number of Reports			Percent of All Reports	
	All	Malpractice	Adverse Action	Malpractice	Adverse Action
1990	2,320	2,108	212	90.9%	9.1%
1991	21,086	17,772	3,314	84.3	15.7
1992	23,498	19,751	3,747	84.1	15.9
1993	23,284	19,242	4,042	82.6	17.4
1994	24,295	19,647	4,648	80.9	19.1
1995	22,197	17,677	4,520	79.6	20.4
1996	23,940	18,897	5,043	78.9	21.1
1997	23,126	18,264	4,862	79.0	21.0
1998	22,348	17,296	5,052	77.4	22.6
1999	24,787	18,677	6,110	75.3	24.7
2000	61,832	19,131	42,701	30.9	69.1
2001	36,784	20,353	16,431	55.3	44.7
2002	39,319	18,817	20,502	47.9	52.1
2003	42,173	18,683	23,490	44.3	55.7
2004	38,627	17,549	21,078	45.4	54.6
2005	39,395	17,150	22,245	43.5	56.5
2006	40,041	15,703	24,338	39.2	60.8
2007	39,953	14,457	25,496	36.2	63.8
2008	52,746	14,095	38,651	26.7	73.3
2009	43,344	14,590	28,754	33.7	66.3
2010	115,521	14,399	101,122	12.5	87.5
2011	85,554	13,308	72,246	15.6	84.4
2012	76,839	12,598	64,241	16.4	83.6
Total	923,009	380,164	542,845	41.2%	58.8%

Note: Processed Year is the year the report was submitted to the NPDB. 1990 is a partial year, September – December.

Totals include reports from the 50 States, the District of Columbia, Armed Forces installations, and the territories.

For nearly every year in the past 10 years, the number of medical malpractice payments reported to the NPDB for all practitioners has decreased (Figure 7). Between 2003 and 2012, the number of medical malpractice reports decreased 34 percent, declining steadily from 18,535 to 12,152.

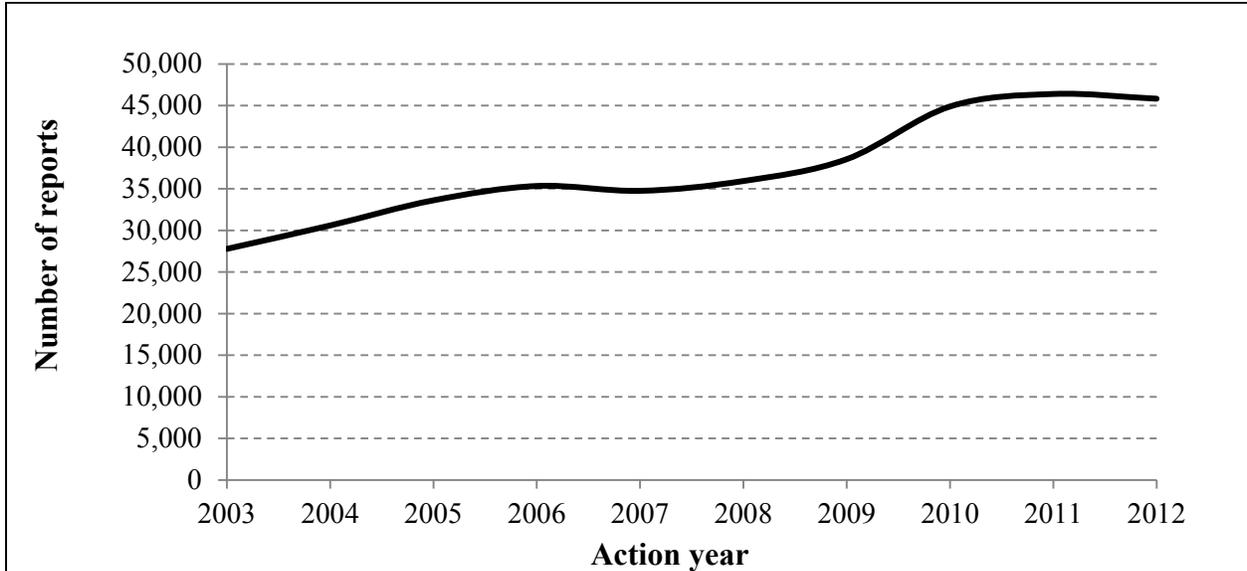
Figure 7: All Practitioners Medical Malpractice Payment Reports, 2003 - 2012



Note: Includes disclosable reports in the NPDB as of the end of the calendar year 2012.

In contrast to medical malpractice payment reporting, the number of Adverse Action Reports for all practitioners has increased nearly every year in the past 10 years (Figure 8). Between 2003 and 2012, the number of Adverse Action Reports increased 65 percent, from 27,780 to 45,830.

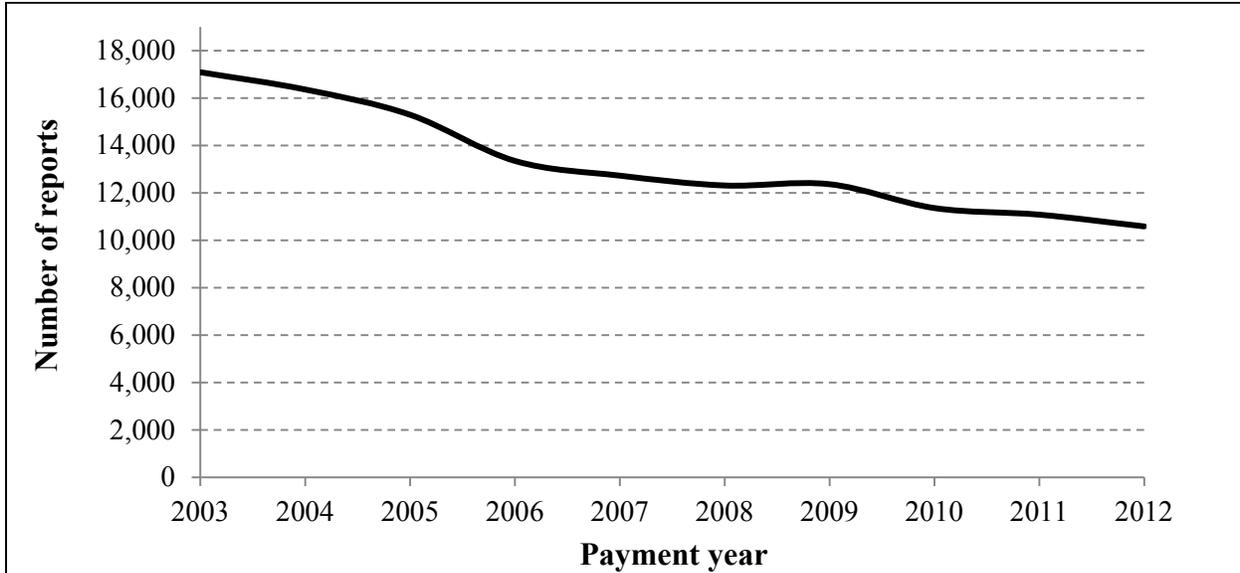
Figure 8: All Practitioner Adverse Action Reports, 2003 - 2012



Note: Includes disclosable reports in the NPDB as of the end of calendar year 2012; voided reports have been excluded. Adverse Action Reports include reinstatements, restorations, state licensure, clinical privilege, and professional society membership actions, Medicare and Medicaid exclusions, and DEA actions. Since the implementation of Section 1921 in September 2010, state licensure reports include reports for both practitioners and organizations.

In the past 10 years, the number of medical malpractice payments reported to the NPDB attributed to physicians and dentists has decreased steadily from 17,088 to 10,585, representing a 38 percent decline (Figure 9).

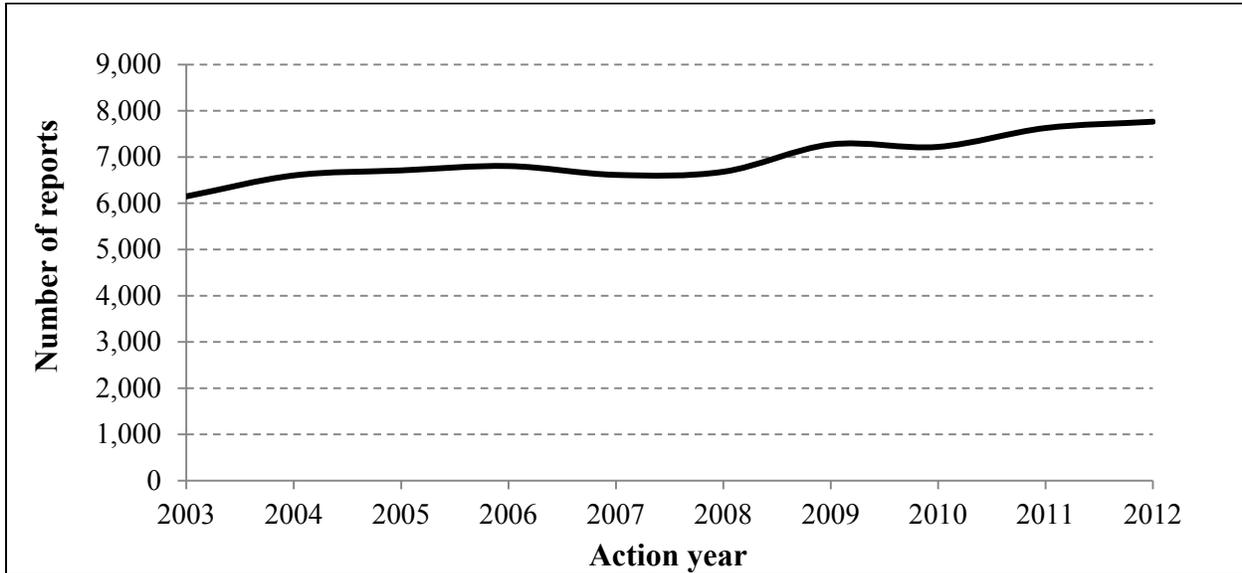
Figure 9: Physician and Dentist Medical Malpractice Payment Reports, 2003 - 2012



Note: Includes disclosable reports in the NPDB as of the end of calendar year 2012; voided reports have been excluded.

In the past 10 years, the number of Adverse Action Reports attributed to physicians and dentists presented a different trend from that of medical malpractice payments. Between 2003 and 2012, the number of adverse actions reported to the NPDB related to physicians and dentists increased from 6,149 to 7,765, representing a 26 percent increase (Figure 10).

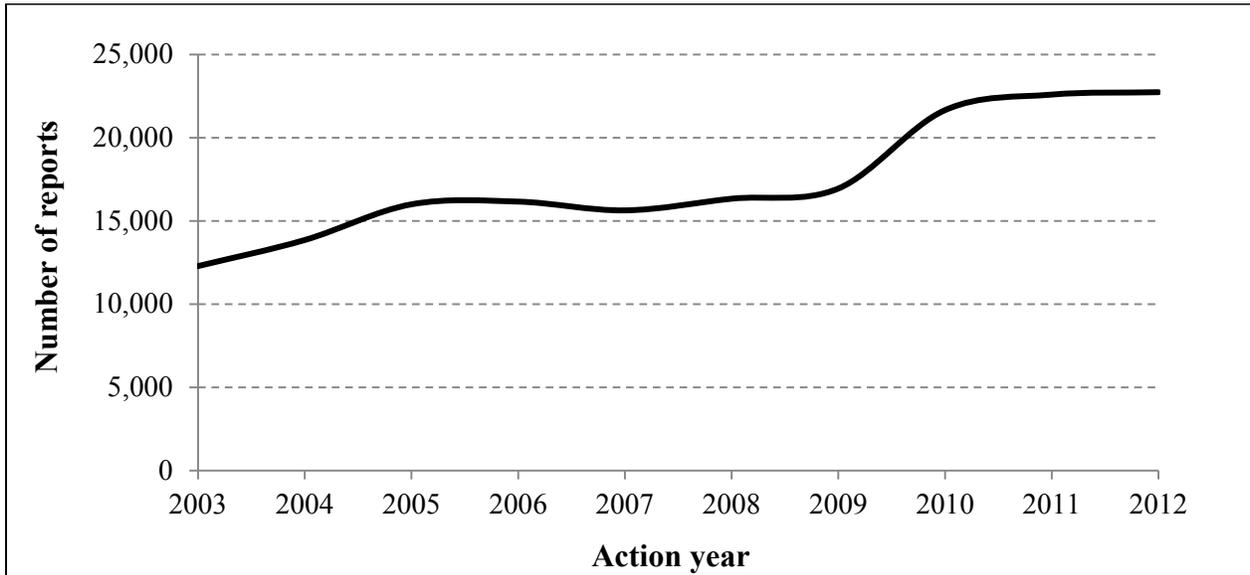
Figure 10: Physician and Dentist Adverse Action Reports, 2003 - 2012



Note: Includes disclosable reports in the NPDB as of the end of calendar year 2012; voided reports have been excluded. Adverse Action Reports include reinstatements, restorations, state licensure, clinical privilege, and professional society membership actions, Medicare and Medicaid exclusions, and DEA actions.

The number of adverse actions reported to NPDB related to nurses in 2012 was nearly double that for 2003 (22,741 and 12,289 respectively). The number of reports increased steadily between 2003 and 2005 and then remained relatively stable through 2009 (Figure 11). Between 2009 and 2011, the number of adverse actions reported to NPDB related to nurses increased 25 percent (from 16,951 to 22,597) reflecting the implementation of Section 1921.

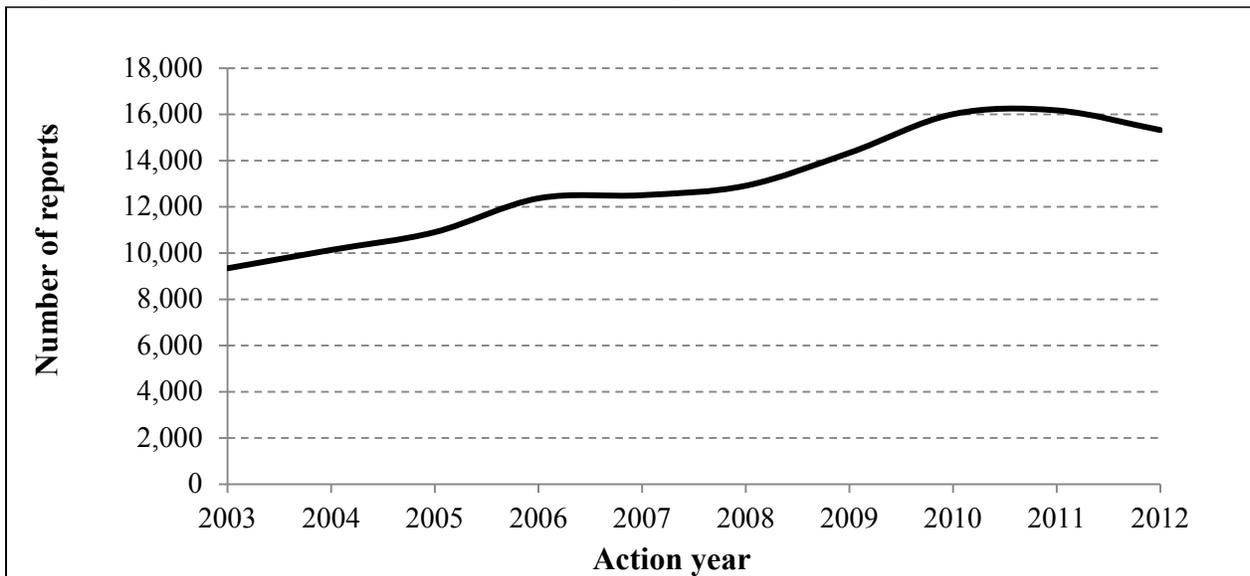
Figure 11: Nurses Adverse Action Reports 2003 - 2012



Note: Includes disclosable reports in the NPDB as of the end of calendar year 2012; voided reports have been excluded. Adverse Action Reports include reinstatements, restorations, state licensure, clinical privilege, and professional society membership actions, Medicare and Medicaid exclusions, and DEA actions.

Between 2003 and 2012, the number of adverse actions reported to NPDB related to practitioners other than physicians, dentists, and nurses increased 64 percent (Figure 12). After increasing steadily between 2003 and 2011 (from 9,342 to 16,175), the number of adverse actions reported to NPDB related to practitioners other than physicians, dentists, and nurses declined in 2012 (15,324).

Figure 12: Other Practitioner Adverse Action Reports 2003 - 2012



Note: Includes disclosable reports in the NPDB as of the end of calendar year 2012; voided reports have been excluded. Adverse Action Reports include reinstatements, restorations, state licensure, clinical privilege, and professional society membership actions, Medicare and Medicaid exclusions, and DEA actions.

Practitioners on whom reports were filed have the right to dispute the accuracy and the validity of the reports filed on them. Information about the process of disputing reports submitted to the NPDB is available on [NPDB's website](#). The number of disputed Adverse Action Reports and Medical Malpractice Payment Reports is provided in Appendix E.

PART IV

CHAPTER 6: FUTURE ENDEAVORS AND PROJECTS

This Annual Report concludes with projects and activities planned for 2013.

Policy and Law

- ◆ Affordable Care Act: Section 6403 of the Patient Protection and Affordable Care Act requires the Secretary of HHS to establish a transition period to transfer all data in the HIPDB to the NPDB and, once completed, to cease HIPDB operations. Information previously collected and disclosed through the HIPDB will then be collected and disclosed through the NPDB. The statute's intent is to transition HIPDB operations to the NPDB while maintaining reporting and querying requirements, to eliminate duplicative data reporting and access requirements between the NPDB and the HIPDB, and to streamline Data Bank operations.
- ◆ Final Rule: In 2013, HRSA will publish a Final Rule in the Federal Register to implement Section 6403.
- ◆ Privacy Act: In 2013, the Data Bank will publish a technical Final Rule revising a cross-reference cited in the Privacy Act to reflect changes made by the Final Rule merging the HIPDB and the NPDB.
- ◆ Disputes Tracker: Disputes activities for 2013 include building features into the Disputes Tracker to cut down on paper files and reduce turnaround time. One such feature will be secure messaging, which will allow practitioners, entities, their respective representatives, and Dispute team members to communicate electronically, including sending and receiving supporting documentation. Team members also will be able to communicate electronically with each other in a secure Disputes system because a workflow feature will be established. Additionally, data reports will be generated electronically and in real time, with accompanying graphs and charts for use in presentations. A repository of closed cases with keyword search functionality will be built to group similar cases. The use of paper and postal mail will be reduced, as will time spent on cases, while increasing efficiency in the Dispute Resolution process.
- ◆ Presentations: DPDB staff will conduct professional presentations, educational forums, and exhibits for Data Bank users and stakeholders across the country.
- ◆ NPDB Guidebook: The Data Bank staff is developing an updated NPDB Guidebook, which will reflect the policy outlined in the statute and regulations that merged the NPDB and the HIPDB. The Guidebook is expected to be completed in 2013. This online version of the Guidebook will be primarily a policy document with hyperlinks to operations information on the NPDB website. This approach will facilitate periodic updates of information.

Compliance, Outreach, and Information Dissemination

- ◆ Compliance Portal: Following the successful launch of a compliance website feature in 2012, the implementation of the new compliance framework will continue in 2013. The 12 most-queried professions will continue to be part of a one to one adverse licensure action matching process, whereby reportable licensure actions taken by an entity are compared to actual Data Bank reports. The reporting entities are divided by State into 4 semesters that are reviewed every 6 months. Half of the States will undergo a compliance review each year. This schedule results in each entity participating in compliance review activities for the 12 most-queried

professions every 2 years. The compliance status for each reporting entity will be posted on the Data Bank public website each April and October.

- ◆ State Licensing Board Attestation: Professions outside the 12 most-queried professions will be transitioned to a new attestation process that asks State licensing and certification boards to attest that they have submitted all reportable actions to the Data Bank as part of the entities' registration renewal process. The new process will be done electronically through a compliance attestation website feature, available when the entity signs in to the nonpublic Data Bank website. The entity may attest that it has met the reporting requirements; not attest that it has met the reporting requirements; or fail to attest, if the entity does not complete the new attestation process. The entity status will be posted on the Data Bank public website as received.
- ◆ Hospital Compliance Initiative: The hospital compliance initiative will continue: Staff will complete the analysis of hospital data and conduct the necessary outreach to reach the goal of 100 percent compliance with hospital registration. Staff will develop an attestation process to use with hospitals to monitor compliance with querying and reporting requirements. Staff will develop a robust plan to conduct educational outreach activities targeted at specific audiences associated with hospital compliance involving querying and reporting to the Data Bank.
- ◆ Medicaid Fraud Control Unit Compliance Outreach: A Medicaid Fraud Control Unit (MFCU) compliance initiative is being developed in coordination with the HHS OIG in the OIG's effort to conduct onsite performance reviews of MFCUs. Staff will develop a plan to conduct educational outreach activities targeted at MFCUs reporting to the Data Bank.
- ◆ Criminal Convictions Compliance Framework: A health care-related criminal convictions compliance initiative is being developed to evaluate the completeness and accuracy of criminal convictions reported to the Data Bank by Federal, State, and local prosecutors.
- ◆ Data Integrity: DPDB staff will continue to identify and address data integrity issues as they relate to information reported to and accessed from the Data Bank. Specific efforts will streamline various processes to promote accurate and complete data entry.

System-Level Enhancements

- ◆ As part of DPDB's strategic planning effort, several key initiatives will be started in 2013, including usability studies and business process modeling analyses. These efforts will identify specific high-value opportunities for technology enhancements. Feasibility studies will be conducted on new technologies, such as business intelligence and dashboard software, geographic information system mapping software, document management tools, and cloud-based services. In 2013, internal process changes and software enhancements will be explored. Examples include streamlining the Dispute Resolution process, adding new point-of-entry data validation rules to improve data integrity, and improving screen design to help agents perform transactions faster and easier. These leading-edge solutions have the potential to generate significant efficiencies for customers and internal staff.

Research Efforts

- ◆ Data Validation Project: The Research Branch is currently writing the statement of objectives to procure contracting services to examine the accuracy of information submitted to the NPDB. The project will evaluate the accuracy, completeness, and timeliness of NPDB data and assess DPDB's efforts to address potential underreporting to the Data Bank. The

Research Branch is interested in using existing NPDB transactional administrative data in conjunction with outside data sources to obtain national estimates of potential transactions that would reside in the Data Bank in the absence of underreporting, non-reporting, and the use of practices such as corporate shield to avoid reporting medical malpractice payments to the NPDB. Given that unreported data are disproportionately distributed relative to State, report type, and reporter type, the branch is particularly interested in identifying innovative approaches (including statistical methodologies and modeling) to validate the completeness of the DPDB transactional administrative data, calculating national estimates of potential transactions that would reside in the Data Bank in the absence of loopholes, and computing national point estimates and their confidence intervals while controlling for the differences in State policies and regulations that affect both current and potential reporting of adverse actions and medical malpractice payments.

- ◆ FSMB Data Project: The Research Branch has entered into an agreement with the Federation of State Medical Boards (FSMB) to receive data to use for research purposes. Merging these data with the NPDB administrative data will provide a robust data file that will be used to answer many research questions that cannot be answered using NPDB data alone. While the American Medical Association file that DPDB is using already contains physician-specific information, the FSMB data contains information on a wider range of topics – specifically, information about adverse actions against physicians.
- ◆ New Coding Schemes for Adverse Action and Malpractice Payment Reports: The purpose of this study is to examine how reporting to the NPDB can be improved, particularly as it relates to coding of the reason (i.e., allegation code) for a malpractice payment or the type of and reason for (i.e., basis of action) an adverse action was taken. Entities submitting reports to the NPDB must provide a narrative description of the acts or omissions and injuries or illnesses for malpractice payments and the basis for the action when filing Adverse Action Reports. In addition to the descriptions, reporters must use a specified set of codes to classify the reason for a malpractice payment and the types of and reasons for a licensure or clinical privilege adverse action. Presently, a significant portion of reports of malpractice payments and adverse actions are classified as “Not otherwise classified (NOC).” This study will examine how the use of NOC and similar categories without specific reasons can be reduced.
- ◆ Matching Algorithm: This project will improve data integrity of the NPDB by enhancing the algorithm used to match reports to reports, and queries to reports, on health care practitioners. Hospitals are required to query the NPDB when credentialing physicians and other practitioners. The NPDB uses an algorithm to score queries based on how closely the practitioner’s name, date of birth, license number, and other data match existing NPDB records. For 97 percent of queries, the algorithm matches successfully. However, manually resolving the unmatched 3 percent (139,000 annually) is labor intensive and expensive. The Research Branch (in conjunction with the NPDB contractor) will develop a more sophisticated and precise algorithm based on prior data, using Bayesian statistics. The objective is to increase the match rate to 99.8 percent or higher, strengthen NPDB’s confidence in the data, and lower contract costs.

APPENDICES

Appendix A: Milestones

Table 5: NPDB Milestones

YEAR	MILESTONES
1994	<p>Practitioner Statement Added to Reports</p> <ul style="list-style-type: none"> ◆ A practitioner with a report in the NPDB could add his or her own statement, which is available to queriers, to the report. ◆ NPDB implemented automated fee collection through electronic funds transfer. Individuals and entities that query could preauthorize the NPDB to debit their bank accounts directly for query fees. ◆ QPRAC version 2.0 was introduced, allowing the NPDB to respond electronically to queries. ◆ HRSA contracted with its second contractor to develop and operate the second-generation NPDB. ◆ More than 1.5 million queries were processed, an average of 30,000 per week. More than half of all queries became electronic. ◆ Average query response time was 2 to 3 days.
1995	<p>NPDB Collected Its 100,000th Report</p> <ul style="list-style-type: none"> ◆ Since its implementation in 1990, the NPDB collected its 100,000th report. ◆ All paper queries, except practitioner self-queries, were eliminated. ◆ Voluntary queries, submitted by entities not mandated by law, outnumbered mandated queries for the first time. ◆ Responses to queries became more comprehensive. If the subject of a report requested a Secretarial Review (now called Dispute Review), the response for each query included this information as well as the status of the Secretarial Review.
1996	<p>Health Insurance Portability and Accountability Act Enacted</p> <ul style="list-style-type: none"> ◆ The Secretary of HHS, acting through the OIG, was directed by the Health Insurance Portability and Accountability Act of 1996 to create the HIPDB to combat fraud and abuse in health insurance and health care delivery. ◆ NPDB users could submit reports and update registration information electronically using QPRAC version 3.0. ◆ A blizzard blanketed the Washington, DC, area with 20 inches of snow. Although employees of DPDB's forerunner, the Division of Quality Assurance, were not able to get to work, the NPDB received and processed more than 20,000 queries during the blizzard. ◆ More than 2.7 million queries were processed, an average of 52,000 per week. ◆ Average query response time was 6 hours or less.
1997	<p>HRSA Coordinated NPDB with HIPDB</p> <ul style="list-style-type: none"> ◆ Because of the NPDB's success, the HHS OIG asked BHP's Division of Quality Assurance to design, develop, and operate the new HIPDB. By law, the operations of the NPDB and HIPDB were required to be coordinated. ◆ NPDB queries generated information about Medicare and Medicaid exclusions.
1998	<p>Health Care Entities Queried More than 15 Million Times</p> <ul style="list-style-type: none"> ◆ State licensing boards, hospitals, and other health care entities queried the NPDB more than 15 million times since 1990. ◆ The NPDB collected its 200,000th report.

YEAR	MILESTONES
1999	<p>NPDB and HIPDB Became Web Based</p> <ul style="list-style-type: none"> ◆ Final regulations governing the HIPDB were codified as 45 CFR Part 61. ◆ For the first time, the NPDB and the HIPDB began accepting reports and single-name queries using a secure Internet site. This was made possible with the Integrated Querying and Reporting Service (IQRS). ◆ More than 3.2 million NPDB queries were processed during the year, an average of 6 queries a minute, 24 hours a day, 365 days a year, or a query every 10 seconds.
2000	<p>NPDB Turned 10 Years Old</p> <ul style="list-style-type: none"> ◆ NPDB celebrated 10 years of successful operations. ◆ NPDB entered the new millennium Y2K-trouble free. ◆ HIPDB opened for querying. ◆ Average query response time was 4 hours. ◆ The Data Bank introduced the Interface Control Document Transfer Program, an alternative to the IQRS for large-volume users. This change allowed interoperability between the computer systems of those that query and report and the Data Bank.
2001	<p>Web-Based Self-Query Service Began</p> <ul style="list-style-type: none"> ◆ Improvements were made to the self-query service so that practitioners were able to submit self-query data electronically through the Data Bank's secure website. After transmitting a self-query, the process was completed by printing and mailing a notarized self-query application to the Data Bank. Self-queries were processed within 48 hours and self-query status could be tracked online. ◆ BHPPr's Division of Quality Assurance was renamed the Division of Practitioner Data Banks.
2002	<p>NPDB Received Recognition</p> <ul style="list-style-type: none"> ◆ The DPDB received an Electronic Government Trailblazer Award for the Data Bank. This award highlighted Federal, State, local, and international government programs that had successfully implemented the most innovative information systems in e-Government. ◆ The Data Bank introduced the online Report Response Service for efficient processing of self-queries, while maintaining strict security standards. The Report Response Service allowed report subjects to electronically maintain current address information with the Data Bank; add, modify, or remove Subject Statements; initiate or withdraw disputes; and elevate or withdraw requests for Secretarial Review online. Previously, subjects performed these functions via paper correspondence.
2003	<p>IQRS Introduced Web-Based Entity and Agent Registration</p> <ul style="list-style-type: none"> ◆ The Data Bank introduced online entity and authorized agent registration, replacing the paper registration forms and paper-based registration process. On-screen instructions and help file information provided immediate assistance, enabling simplified online registration. ◆ The number of registered users of the Data Bank reached 16,000.

YEAR	MILESTONES
2004	<p>Data Bank Won Excellence.Gov Award</p> <ul style="list-style-type: none"> ◆ The Data Bank program was awarded the 2004 Excellence.Gov Award. In addition, the Data Bank also was recognized as one of the "Top Five" Federal E-Government Programs of 2004. The awards were bestowed on Federal organizations with outstanding information technology achievements in the public service arena. The Excellence.Gov Award focused on governance models used in e-Government projects that cross organizations. ◆ The Data Bank made IQRS report and query histories available to users, enabling them to obtain a summary of subjects queried or reported on over the previous 4 years.
2005	<p>Querying and Reporting XML Service Introduced</p> <ul style="list-style-type: none"> ◆ The Data Bank introduced the Querying and Reporting XML Service (QRXS), an alternative to the IQRS and the ITP for users who want their computer systems to interface directly with the Data Bank. ◆ Average query response time was less than 2 hours. ◆ The NPDB processed more than 36 million queries since 1991 and maintained more than 375,000 reports.
2006	<p>IQRS Query Workflow Streamlined</p> <ul style="list-style-type: none"> ◆ The IQRS query workflow was streamlined, making submitting queries easier and more intuitive. ◆ Average query response time was less than 1 hour. ◆ An improved registration renewal process was completed. More than 16,500 entities and agents updated their registrations with the Data Bank using the new procedure.
2007	<p>Proactive Disclosure Service Prototype Launched</p> <ul style="list-style-type: none"> ◆ The Proactive Disclosure Service (PDS) (now called Continuous Query) was implemented on April 30. ◆ PDS subscribers received notification of new reports within one business day.
2008	<p>PDS Became a Permanent Service</p> <ul style="list-style-type: none"> ◆ The PDS became a permanent service for automatic and continuous querying of enrolled practitioners in the NPDB and the HIPDB. ◆ The PDS successfully completed a full monitoring cycle, including the opportunity for entities to renew their PDS registration. The renewal rate after the first year was 97 percent.
2009	<p>Interface Control Document Transfer Program Phased Out for Querying and Reporting XML Service</p> <ul style="list-style-type: none"> ◆ The QRXS, the next generation interface for high-volume users, started replacing and phasing out the Interface Control Document Transfer Program (ICD ITP). ◆ The QRXS uses an industry standard XML format that improves the exchange of data between users and the Data Bank, providing real-time data validation.

YEAR	MILESTONES
2010	<p>Section 1921 of the Social Security Act</p> <ul style="list-style-type: none"> ◆ NPDB began accepting reports and queries required by Section 1921 on March 1. Section 1921 expanded the information collected and disseminated through the NPDB to include reports on all licensure actions taken against all health care practitioners, not just physicians and dentists. ◆ The Compliance Branch initiated a rigorous review of adverse or disciplinary actions reporting by State licensing boards and agencies. ◆ The Secretary of HHS published for the first time a list of State agencies that failed to meet Data Bank reporting requirements. She also took the unprecedented step of calling on State governors to do their part to assure that State reports to the Data Bank are complete and accurate. ◆ DPDB continued to provide State boards with technical assistance to ensure compliance.
2011	<p>PDS Becomes Continuous Query</p> <ul style="list-style-type: none"> ◆ The prototype status for PDS was removed and the name formally changed from PDS to Continuous Query to better capture the true nature of the service, which is the continuous monitoring of enrolled practitioners. ◆ By the end of 2011, more than 94 percent of all professions reviewed in the Adverse Licensure Comparison Project were compliant with Data Bank reporting requirements for years 2006 thru 2009. The reviewed professions were nurses, pharmacists, physicians, dentists, physician assistants, podiatrists, psychologists, social workers, chiropractors, optometrists, and physical therapists. ◆ DPDB established a dedicated email account for receiving data requests and inquiries, resulting in a more streamlined process for handling inquiries from users and shortening the time for staff to respond. ◆ A data use agreement policy was instituted to protect the anonymity of practitioners on whom reports were filed and to establish guidelines regarding how the Public Use File is to be used.
2012	<p>Preparation Activities for Merger</p> <ul style="list-style-type: none"> ◆ Several preparation activities took place in 2012 to get ready for the publication of a Final Rule in 2013 concerning the merger of the HIPDB with the NPDB. These activities included outreach to Federal partners and other users of the Data Bank, technical assistance, revising Privacy Act notices, and updating systems and forms. <p>Began Providing Web-based Statistical Information</p> <ul style="list-style-type: none"> ◆ A web-based Data Analysis Tool was developed and implemented to facilitate independent analysis of information relating to medical malpractice payments and adverse actions. The tool allows a wide range of users to perform unique analyses that can be customized by State or region, making it possible for stakeholders to identify trends of interest and to target their resources on areas of concern. ◆ The Research Branch developed NPDB statistics by State that are available in table and trend plot formats that can be accessed using an interactive map of the United States.

Appendix B: Queries and Reports by Entity Type and Year

Table 6: Querying Entities by Type, 2003 - 2012

Entity Type	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Required Queriers										
Hospital	5,934	6,020	6,035	6,080	6,075	6,040	5,908	5,913	5,746	5,363
Voluntary Queriers										
State Licensing Board	77	83	89	86	85	82	79	96	90	92
Managed Care Organization	860	820	813	780	744	724	702	681	664	635
Professional Society	61	63	62	58	52	52	51	49	45	43
Other Health Care Entity	4,501	5,286	5,849	6,383	6,681	6,972	7,265	7,496	7,680	7,327
Total Voluntary Queriers	5,499	6,252	6,813	7,307	7,562	7,830	8,097	8,322	8,479	8,097
Total Queriers	11,433	12,272	12,848	13,387	13,637	13,870	14,005	14,235	14,225	13,460

Note: Entity type is based on registration as of December 31, 2012. An entity may have more than one registration.

Table 7: Queries by Entity Type, 2003 - 2012

Entity Type	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
<u>Number</u>										
Required Queries										
Hospital	1,148,202	1,194,888	1,224,436	1,288,694	1,291,420	1,296,473	1,214,600	1,199,310	1,121,401	1,027,303
Voluntary Queries										
State Licensing Board	19,431	23,421	23,584	56,072	68,878	72,837	56,038	69,469	60,138	32,454
Managed Care Organization	1,375,293	1,472,191	1,449,788	1,412,282	1,448,328	1,604,983	1,635,812	1,648,250	1,640,079	1,743,803
Professional Society	4,886	4,280	6,277	4,444	4,400	4,809	4,991	5,222	5,887	6,399
Other Health Care Entity	666,245	753,723	799,831	925,775	1,000,096	1,078,310	1,191,896	1,313,508	1,296,513	1,449,178
Voluntary Queries Total	2,065,855	2,253,615	2,279,480	2,398,573	2,521,702	2,760,939	2,888,737	3,036,449	3,002,617	3,231,834
Total Queries	3,214,057	3,448,503	3,503,916	3,687,267	3,813,122	4,057,412	4,103,337	4,235,759	4,124,018	4,259,137
<u>Percent</u>										
Required Queries										
Hospital	35.7%	34.6%	34.9%	34.9%	33.9%	32.0%	29.6%	28.3%	27.2%	24.1%
Voluntary Queries										
State Licensing Board	0.6%	0.7%	0.7%	1.5%	1.8%	1.8%	1.4%	1.6%	1.5%	0.8%
Managed Care Organization	42.8	42.7	41.4	38.3	38.0	39.6	39.9	38.9	39.8	40.9
Professional Society	0.2	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Other Health Care Entity	20.7	21.9	22.8	25.1	26.2	26.6	29.0	31.0	31.4	34.0
Voluntary Queries Total	64.3	65.4	65.1	65.1	66.1	68.0	70.4	71.7	72.8	75.9
Total Queries	100.0									

Note: Entity type is based on registration as of December 31, 2012. An entity may have more than one registration.

Table 8: Reports by Entity Type, 2003 - 2012

Entity Type	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
	<u>Number</u>									
Hospital	1,128	1,157	1,125	1,008	1,031	1,099	1,185	1,193	1,082	905
State Licensing Board	23,783	26,458	29,487	31,351	30,874	32,091	34,712	40,770	42,382	41,864
Managed Care Organization	173	166	140	136	129	145	169	146	187	183
Professional Society	54	42	62	32	48	84	69	88	61	58
Malpractice Payer Organization	15,123	14,769	13,859	12,192	12,076	11,590	11,409	10,627	10,543	9,976
Other Health Care Entity	6,054	5,885	5,717	5,462	4,885	4,856	4,974	4,929	4,804	4,996
Total	46,315	48,477	50,390	50,181	49,043	49,865	52,518	57,753	59,059	57,982
	<u>Percent</u>									
Hospital	2.4%	2.4%	2.2%	2.0%	2.1%	2.2%	2.3%	2.1%	1.8%	1.6%
State Licensing Board	51.4	54.6	58.5	62.5	63.0	64.4	66.1	70.6	71.8	72.2
Managed Care Organization	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Professional Society	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.2	0.1	0.1
Malpractice Payer Organization	32.7	30.5	27.5	24.3	24.6	23.2	21.7	18.4	17.9	17.2
Other Health Care Entity	13.1	12.1	11.3	10.9	10.0	9.7	9.5	8.5	8.1	8.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Entity type is based on registration as of December 31, 2012. An entity may have more than one registration.

Table 9: Continuous Query Subscribers by Entity Type, 2008 - 2012

Entity Type	2008	2009	2010	2011	2012
	<u>Number</u>				
Required Queriers					
Hospital	408	800	980	1,513	1,819
Voluntary Queriers					
Managed Care Organizations	7	29	48	86	108
Other Health Care Entities	121	462	518	1,099	1,505
Professional Societies	0	0	2	7	6
State Licensing Boards	1	3	5	9	10
Total Voluntary Queriers	129	494	573	1,201	1,629
Total Queriers	537	1,294	1,553	2,714	3,448

Table 10: Continuous Query Enrollments by Entity Type, 2007 - 2012

Entity Type	2007	2008	2009	2010	2011	2012
<u>Number</u>						
Required Queriers						
Hospital	71,054	172,445	291,520	391,909	519,387	675,807
Voluntary Queriers						
Managed Care Organizations	3,016	6,305	26,895	61,473	142,481	201,384
Other Health Care Entities	7,957	27,322	75,854	101,685	152,430	237,125
Professional Societies	38	35	47	1,471	1,762	1,361
State Licensing Boards	35	21	77	784	9,341	86,795
Total Voluntary Queriers	11,046	33,683	102,873	165,413	306,014	526,665
Total	82,100	206,128	394,393	557,322	825,401	1,202,472
<u>Percent</u>						
Required Queriers						
Hospital	86.5%	83.7%	73.9%	70.3%	62.9%	56.2%
Voluntary Queriers						
Managed Care Organizations	3.7%	3.1%	6.8%	11.0%	17.3%	16.7%
Other Health Care Entities	9.7	13.3	19.2	18.2	18.5	19.7
Professional Societies	0.0	0.0	0.0	0.3	0.2	0.1
State Licensing Boards	0.0	0.0	0.0	0.1	1.1	7.2
Total Voluntary Queriers	13.5%	16.3%	26.1%	29.7%	37.1%	43.8%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Appendix C: Practitioner Reports by Type, State, and Year

Table 11: Medical Malpractice Payment Reports by Practitioner Type, 2003 - 2012

Practitioner Type	Payment Year										Total
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	
	<u>Number</u>										
Physicians and Dentists	17,088	16,359	15,293	13,347	12,726	12,311	12,365	11,359	11,080	10,585	132,513
Professional Nurse	483	531	596	586	625	687	680	609	659	711	6,167
All Other Practitioners	964	992	882	908	935	930	912	891	920	856	9,190
Total	18,535	17,882	16,771	14,841	14,286	13,928	13,957	12,859	12,659	12,152	147,870
	<u>Percent</u>										
Physicians and Dentists	92.2%	91.5%	91.2%	89.9%	89.1%	88.4%	88.6%	88.3%	87.5%	87.1%	89.6%
Professional Nurse	2.6	3.0	3.6	3.9	4.4	4.9	4.9	4.7	5.2	5.9	4.2
All Other Practitioners	5.2	5.5	5.3	6.1	6.5	6.7	6.5	6.9	7.3	7.0	6.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Includes reports for the 50 U.S. States, the District of Columbia, American Samoa, Guam, Federated States of Micronesia, Northern Mariana Islands, Palau, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas. Includes disclosable reports in the NPDB as of December 31, 2012; voided reports are excluded.

“Physicians and Dentists” includes allopathic (M.D.) physicians, interns, and residents; osteopathic (D.O.) physicians, interns, and residents; and dentists and dental residents.

“Professional Nurses” includes registered nurses, licensed practical nurses, licensed vocational nurses, nurse practitioners, nurse anesthetists, nurse midwives, clinical nurse specialists, advanced nurse practitioners, and doctors of nursing practice.

“All Other Practitioners” includes all other health care practitioners, non-health care professionals, and nonspecified professionals.

Table 12: Adverse Action Reports by Practitioner Type, 2003 - 2012

Practitioner Type	Action Year										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
	<u>Number</u>										
Physicians and Dentists	5,441	5,812	5,792	5,948	5,675	5,631	6,282	6,312	6,757	6,949	60,599
Professional Nurse	10,430	11,682	13,779	13,740	13,402	14,240	15,085	18,628	19,404	19,115	149,505
All Other Practitioners	8,780	9,538	10,144	11,485	11,611	11,986	13,402	14,879	14,961	13,892	120,678
Total	24,651	27,032	29,715	31,173	30,688	31,857	34,769	39,819	41,122	39,956	330,782
	<u>Percent</u>										
Physicians and Dentists	22.1%	21.5%	19.5%	19.1%	18.5%	17.7%	18.1%	15.9%	16.4%	17.4%	18.3%
Professional Nurse	42.3	43.2	46.4	44.1	43.7	44.7	43.4	46.8	47.2	47.8	45.2
All Other Practitioners	35.6	35.3	34.1	36.8	37.8	37.6	38.5	37.4	36.4	34.8	36.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Includes reports for the 50 U.S. States, the District of Columbia, American Samoa, Guam, Federated States of Micronesia, Northern Mariana Islands, Palau, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas. Includes disclosable reports in the NPDB as of December 31, 2012; voided reports are excluded.

“Physicians and Dentists” includes allopathic (M.D.) physicians, interns, and residents; osteopathic (D.O.) physicians, interns, and residents; and dentists and dental residents.

“Professional Nurse” includes registered nurses, licensed practical nurses, licensed vocational nurses, nurse practitioners, nurse anesthetists, nurse midwives, clinical nurse specialists, advanced nurse practitioners, and doctors of nursing practice.

“All Other Practitioners” includes all other health care practitioners, non-health care professionals, and nonspecified professionals.

Table 13: Reinstatement and Restoration Reports by Practitioner Type, 2003 - 2012

Practitioner Type	Action Year										Total
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	
	<u>Number</u>										
Physicians and Dentists	708	790	919	857	939	1,051	991	908	871	816	8,850
Professional Nurse	1,859	2,175	2,223	2,425	2,236	2,100	1,866	3,035	3,193	3,626	24,738
All Other Practitioners	562	598	762	885	894	929	935	1,132	1,214	1,432	9,343
Total	3,129	3,563	3,904	4,167	4,069	4,080	3,792	5,075	5,278	5,874	42,931
	<u>Percent</u>										
Physicians and Dentists	22.6%	22.2%	23.5%	20.6%	23.1%	25.8%	26.1%	17.9%	16.5%	13.9%	20.6%
Professional Nurse	59.4	61.0	56.9	58.2	55.0	51.5	49.2	59.8	60.5	61.7	57.6
All Other Practitioners	18.0	16.8	19.5	21.2	22.0	22.8	24.7	22.3	23.0	24.4	21.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Includes reports for the 50 U.S. States, the District of Columbia, American Samoa, Guam, Federated States of Micronesia, Northern Mariana Islands, Palau, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas. Includes disclosable reports in the NPDB as of December 31, 2012; voided reports are excluded.

“Physicians and Dentists” includes allopathic (M.D.) physicians, interns, and residents; osteopathic (D.O.) physicians, interns, and residents; and dentists and dental residents.

“Professional Nurse” includes registered nurses, licensed practical nurses, licensed vocational nurses, nurse practitioners, nurse anesthetists, nurse midwives, clinical nurse specialists, advanced nurse practitioners, and doctors of nursing practice.

“All Other Practitioners” includes all other health care practitioners, non-health care professionals, and nonspecified professionals.

Table 14: All Reports by Type, 2003 - 2012

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
	<u>Number</u>										
Malpractice Payment Reports	18,535	17,882	16,771	14,841	14,286	13,928	13,957	12,859	12,659	12,152	147,870
All Adverse Action Reports	27,780	30,595	33,619	35,340	34,757	35,937	38,561	44,894	46,400	45,830	373,713
State Licensure Action	23,879	26,537	29,597	31,408	30,966	32,205	34,825	41,122	42,743	41,956	335,238
Clinical Priv./Panel Membership Action	1,005	993	867	806	822	802	868	878	821	778	8,640
Prof. Society Membership Action	54	42	62	32	48	84	70	91	62	60	605
Drug Enforcement Admin. Action	37	48	26	18	12	19	382	139	102	280	1,063
HHS OIG Exclusion	2,805	2,975	3,067	3,076	2,909	2,827	2,416	2,664	2,667	2,752	28,158
Accreditation Action	0	0	0	0	0	0	0	0	5	4	9
All Reports	46,315	48,477	50,390	50,181	49,043	49,865	52,518	57,753	59,059	57,982	521,583
	<u>Percent</u>										
Malpractice Payment Reports	40.0%	36.9%	33.3%	29.6%	29.1%	27.9%	26.6%	22.3%	21.4%	21.0%	28.4%
All Adverse Action Reports	60.0	63.1	66.7	70.4	70.9	72.1	73.4	77.7	78.6	79.0	71.6
State Licensure Action	51.6	54.7	58.7	62.6	63.1	64.6	66.3	71.2	72.4	72.4	64.3
Clinical Priv./Panel Membership Action	2.2	2.0	1.7	1.6	1.7	1.6	1.7	1.5	1.4	1.3	1.7
Prof. Society Membership Action	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.2	0.1	0.1	0.1
Drug Enforcement Admin. Action	0.1	0.1	0.1	0.0	0.0	0.0	0.7	0.2	0.2	0.5	0.2
HHS OIG Exclusion	6.1	6.1	6.1	6.1	5.9	5.7	4.6	4.6	4.5	4.7	5.4
Accreditation Action	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
All Reports	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Includes reports for the 50 U.S. States, the District of Columbia, American Samoa, Guam, Federated States of Micronesia, Northern Mariana Islands, Palau, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas.

Payment year is used for Medical Malpractice Payment Reports; action year is used for Adverse Action Reports.

Adverse Action Reports include reinstatements, restorations, state licensure actions, clinical privilege actions, professional society membership actions, Medicare and Medicaid exclusions, and DEA actions.

Table 15: Reports for Physicians, 2003 - 2012

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
	<u>Number</u>										
Malpractice Payment Reports	15,124	14,525	13,626	11,739	11,246	10,851	10,761	9,795	9,615	9,194	116,476
All Adverse Action Reports	4,941	5,340	5,350	5,400	5,244	5,265	5,911	5,733	6,215	6,306	55,705
State Licensure Action	3,687	4,094	4,192	4,357	4,195	4,231	4,546	4,534	5,102	5,093	44,031
Clinical Priv./Panel Membership Action	891	905	797	692	720	672	723	757	683	649	7,489
Prof. Society Membership Action	48	37	47	26	41	79	60	65	41	33	477
Drug Enforcement Admin. Action	30	40	23	14	12	12	302	110	88	227	858
HHS OIG Exclusion	285	264	291	311	276	271	280	267	301	304	2,850
All Reports	20,065	19,865	18,976	17,139	16,490	16,116	16,672	15,528	15,830	15,500	172,181
	<u>Percent</u>										
Malpractice Payment Reports	75.4%	73.1%	71.8%	68.5%	68.2%	67.3%	64.5%	63.1%	60.7%	59.3%	67.6%
All Adverse Action Reports	24.6	26.9	28.2	31.5	31.8	32.7	35.5	36.9	39.3	40.7	32.4
State Licensure Action	18.4	20.6	22.1	25.4	25.4	26.3	27.3	29.2	32.2	32.9	25.6
Clinical Priv./Panel Membership Action	4.4	4.6	4.2	4.0	4.4	4.2	4.3	4.9	4.3	4.2	4.3
Prof. Society Membership Action	0.2	0.2	0.2	0.2	0.2	0.5	0.4	0.4	0.3	0.2	0.3
Drug Enforcement Admin. Action	0.1	0.2	0.1	0.1	0.1	0.1	1.8	0.7	0.6	1.5	0.5
HHS OIG Exclusion	1.4	1.3	1.5	1.8	1.7	1.7	1.7	1.7	1.9	2.0	1.7
All Reports	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Includes reports for the 50 U.S. States, the District of Columbia, American Samoa, Guam, Federated States of Micronesia, Northern Mariana Islands, Palau, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas.

Payment year is used for Medical Malpractice Payment Reports; action year is used for Adverse Action Reports.

Adverse Action Reports include reinstatements, restorations, state licensure actions, clinical privilege actions, professional society membership actions, Medicare and Medicaid exclusions, and DEA actions.

Table 16: Reports for Nurses, 2003 - 2012

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
	<u>Number</u>										
Malpractice Payment Reports	483	531	596	586	625	687	680	609	659	711	6,167
All Adverse Action Reports	12,289	13,857	16,002	16,165	15,638	16,340	16,951	21,663	22,597	22,741	174,243
State Licensure Action	12,272	13,827	15,984	16,149	15,627	16,321	16,924	21,636	22,582	22,709	174,031
Clinical Priv./Panel Membership Action	15	27	18	16	11	18	16	20	11	19	171
Prof. Society Membership Action	0	0	0	0	0	0	0	1	0	0	1
Drug Enforcement Admin. Action	0	1	0	0	0	1	11	6	4	13	36
HHS OIG Exclusion	2	2	0	0	0	0	0	0	0	0	4
All Reports	12,772	14,388	16,598	16,751	16,263	17,027	17,631	22,272	23,256	23,452	180,410
	<u>Percent</u>										
Malpractice Payment Reports	3.8%	3.7%	3.6%	3.5%	3.8%	4.0%	3.9%	2.7%	2.8%	3.0%	3.4%
All Adverse Action Reports	96.2	96.3	96.4	96.5	96.2	96.0	96.1	97.3	97.2	97.0	96.6
State Licensure Action	96.1	96.1	96.3	96.4	96.1	95.9	96.0	97.1	97.1	96.8	96.5
Clinical Priv./Panel Membership Action	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.1
Prof. Society Membership Action	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Drug Enforcement Admin. Action	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.0
HHS OIG Exclusion	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
All Reports	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Includes reports for the 50 U.S. States, the District of Columbia, American Samoa, Guam, Federated States of Micronesia, Northern Mariana Islands, Palau, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas.

Payment year is used for Medical Malpractice Payment Reports; action year is used for Adverse Action Reports.

Adverse Action Reports include reinstatements, restorations, state licensure actions, clinical privilege actions, professional society membership actions, Medicare and Medicaid exclusions, and DEA actions.

Table 17: Number of Reports by Practitioner Type, September 1990 - December 2012

Number of Reports	Physicians		Dentists		Professional Nurses	
	N	%	N	%	N	%
1	116,222	57.8%	25,805	64.5%	69,129	53.0%
2	42,365	21.1	7,634	19.1	39,209	21.1
3	18,011	9.0	3,063	7.7	12,112	9.0
4	9,411	4.7	1,485	3.7	5,549	4.7
5	5,343	2.7	764	1.9	2,369	2.7
6	3,161	1.6	435	1.1	1,085	1.6
7	2,001	1.0	259	0.6	496	1.0
8	1,316	0.7	164	0.4	269	0.7
9	871	0.4	88	0.2	111	0.4
10	604	0.3	78	0.2	67	0.3
>10	1,728	0.9	217	0.5	91	0.9

“Physicians” includes allopathic (M.D.) physicians, interns, and residents and osteopathic (D.O.) physicians, interns, and residents.

“Dentists” includes dentists and dental residents.

“Professional Nurses” includes registered nurses, licensed practical nurses, licensed vocational nurses, nurse practitioners, nurse anesthetists, nurse midwives, clinical nurse specialists, advanced nurse practitioners, and doctors of nursing practice.

Table 18: Reports by Jurisdiction, 2003 - 2012

Jurisdiction	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Alabama	918	1,075	1,168	1,169	1,218	1,040	1,128	1,244	1,183	1,257
Alaska	156	161	163	144	166	160	161	192	195	122
American Samoa	2	1	1	2	0	1	1	1	1	0
Arizona	2,163	2,178	2,205	2,364	2,093	2,012	2,019	1,896	1,793	1,584
Arkansas	453	807	767	655	600	683	702	756	729	754
Armed Forces - Americas	0	0	1	0	1	0	0	0	0	0
Armed Forces - Europe	5	6	1	5	3	5	1	2	7	1
Armed Forces - Pacific	1	3	6	2	3	0	4	3	2	2
California	3,687	3,906	3,798	3,699	3,822	3,775	3,839	4,804	5,364	4,495
Colorado	826	850	893	1,045	1,193	1,223	1,341	1,312	1,167	1,148
Connecticut	637	545	511	596	501	535	523	451	512	428
Delaware	106	91	100	109	76	89	101	147	149	187
District of Columbia	93	101	154	133	121	107	102	123	117	130
Federated States of Micronesia	0	0	0	0	2	0	0	0	0	0
Florida	2,816	2,887	3,381	3,123	3,088	3,370	3,059	3,336	3,679	3,770
Georgia	833	825	772	676	755	710	731	594	659	636
Guam	3	1	1	1	1	5	1	0	1	2
Hawaii	78	77	64	82	71	97	109	86	66	88
Idaho	123	137	143	139	158	159	163	147	224	178
Illinois	1,588	1,417	1,597	1,301	1,376	1,381	1,645	2,201	1,926	1,744
Indiana	724	707	860	935	825	864	1,039	1,072	1,215	1,612
Iowa	428	539	513	424	472	583	627	661	646	614
Kansas	381	429	383	380	406	493	496	622	587	448
Kentucky	626	706	746	711	748	762	798	757	829	762
Louisiana	1,038	1,212	1,278	1,258	1,273	1,253	1,268	1,730	1,568	1,546
Maine	226	214	233	313	282	338	316	326	337	327

Jurisdiction	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Maryland	665	665	629	676	735	676	768	824	918	953
Massachusetts	930	1,031	1,001	1,029	941	1,009	1,073	1,093	1,057	1,025
Michigan	1,494	1,526	1,426	1,457	1,380	1,381	1,558	1,480	1,639	1,701
Minnesota	599	621	600	610	713	561	628	905	740	857
Mississippi	866	851	801	891	650	795	663	778	718	757
Missouri	838	1,069	1,501	938	1,091	949	1,262	2,021	1,407	1,412
Montana	186	152	187	172	238	251	176	242	218	194
Nebraska	284	371	499	352	378	433	352	569	543	669
Nevada	532	537	450	473	548	590	592	530	567	559
New Hampshire	225	289	219	235	206	195	192	223	216	251
New Jersey	1,387	1,419	1,726	1,447	1,340	1,428	1,636	1,640	1,988	1,568
New Mexico	277	311	286	307	335	318	388	431	408	427
New York	3,307	3,306	3,173	3,217	2,866	2,721	2,759	2,731	2,855	2,730
North Carolina	904	1,030	1,009	1,027	1,143	1,307	1,296	1,425	1,454	1,406
North Dakota	117	108	126	115	143	126	136	159	146	186
Northern Marianas	0	0	0	1	0	0	0	0	0	0
Ohio	1,790	2,041	2,304	2,127	2,000	2,435	2,428	2,377	2,497	2,282
Oklahoma	1,592	1,458	1,504	1,300	1,105	1,319	1,177	1,554	1,779	1,696
Oregon	581	544	597	643	773	1,011	1,266	1,247	1,041	1,070
Pennsylvania	2,342	2,432	21,33	2,515	2,312	2,106	2,204	2,292	2,301	2,279
Puerto Rico	198	240	265	209	251	299	282	308	297	318
Rhode Island	182	151	168	184	177	192	196	174	194	153
South Carolina	613	584	541	598	604	637	659	836	646	763
South Dakota	83	85	105	92	109	146	99	145	130	171
Tennessee	452	610	742	755	715	786	997	1,094	1,069	1,129
Texas	3,794	4,112	4,527	5,012	4,465	3,684	4,402	4,985	5,315	5,870
Utah	389	376	399	398	360	373	370	398	379	458
Vermont	190	240	252	251	213	203	251	233	213	209

Jurisdiction	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Virgin Islands	3	2	3	2	5	1	5	1	0	5
Virginia	1,148	1,251	1,299	1,161	1,194	1,619	1,675	1,630	1,927	1,958
Washington	1,433	1,243	1,170	1,720	1,719	1,635	1,812	1,733	1,965	1938
West Virginia	383	373	405	364	411	365	402	445	485	348
Wisconsin	520	502	522	553	597	581	530	616	788	659
Wyoming	98	71	80	82	71	86	110	170	200	145

**Appendix D: Medical Malpractice Payment Adjustments
by State, Amount, and Delay**

Table 19: Medical Malpractice and Adjusted Payment Reports, by State, 2003 - 2012

State	<u>Physicians</u>		<u>Dentists</u>		<u>Ratios</u>	
	Total	Adjusted	Total	Adjusted	Physician/ Dentist	Dentist/ Physician
Florida	9,455	9,401	941	941	10.0	0.10
Indiana	2,190	1,630	150	146	11.2	0.09
Kansas	1,472	936	104	103	9.1	0.11
Louisiana	3,012	1,756	170	145	12.1	0.08
Nebraska	733	512	58	58	8.8	0.11
New Mexico	991	798	124	124	6.4	0.16
Pennsylvania	9,341	6,644	843	843	7.9	0.13
South Carolina	1,586	1,204	105	101	11.9	0.08
Wisconsin	712	657	187	187	3.5	0.28

Note: Includes States that provide additional patient compensation. Adjusted columns exclude reports from State funds that make payments in addition to primary malpractice carrier payments for the same case. State funds occasionally make payments on behalf of a practitioner practicing in another State.

Table 20: Medical Malpractice Payment and Adjusted Reports for Physicians and Dentists, by State, 2003 - 2012

State	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total	
						<u>Reports</u>						
Florida	1,415	1,326	1,157	916	927	1,047	1,023	920	858	807	10,396	
Indiana	323	265	209	240	234	226	293	182	182	186	2,340	
Kansas	165	183	194	161	160	146	128	160	142	137	1,576	
Louisiana	314	332	294	378	334	360	312	313	281	264	3,182	
Nebraska	97	120	181	69	69	57	57	44	50	47	791	
New Mexico	113	111	120	126	104	83	100	107	101	150	1,115	
Pennsylvania	1,384	1,334	1,145	1,011	901	935	933	863	859	819	10,184	
South Carolina	190	178	195	216	210	165	134	131	134	138	1,691	
Wisconsin	150	123	100	79	79	85	92	58	77	56	899	
						<u>Adjusted</u>						
Florida	1,407	1,316	1,154	913	919	1,040	1,018	916	855	804	10,342	
Indiana	209	165	135	162	182	171	220	164	182	186	1,776	
Kansas	110	116	138	105	115	95	80	107	94	79	1,039	
Louisiana	202	221	201	212	187	212	167	178	158	163	1,901	
Nebraska	72	93	103	44	52	42	46	37	43	38	570	
New Mexico	97	92	95	96	84	66	79	87	85	141	922	
Pennsylvania	938	933	843	749	675	714	686	691	655	603	7,487	
South Carolina	143	127	139	164	160	133	113	103	106	117	1,305	
Wisconsin	141	119	94	71	74	80	82	53	75	55	844	

Note: Includes States that provide additional patient compensation. Adjusted columns exclude reports from State funds that make payments in addition to primary malpractice carrier payments for the same case. State funds occasionally make payments on behalf of a practitioner practicing in another State.

Table 21: Medical Malpractice Payment and Adjusted Reports for Physicians, by State, 2003 - 2012

State	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total	
						<u>Reports</u>						
Florida	1,325	1,244	1,069	841	851	963	921	803	735	703	9,455	
Indiana	309	246	191	229	219	210	272	172	169	173	2,190	
Kansas	155	167	181	149	146	137	122	157	129	129	1,472	
Louisiana	288	308	279	355	317	343	298	302	275	247	3,012	
Nebraska	89	112	171	66	62	54	53	42	45	39	733	
New Mexico	103	101	104	109	94	73	88	96	85	138	991	
Pennsylvania	1,290	1,252	1,060	899	827	848	853	778	784	750	9,341	
South Carolina	180	164	186	210	202	155	126	121	120	122	1,586	
Wisconsin	122	86	86	72	63	71	74	39	58	41	712	
						<u>Adjusted</u>						
Florida	1,317	1,234	1,066	838	843	956	916	799	732	700	9,401	
Indiana	195	146	121	151	167	155	199	154	169	173	1,630	
Kansas	100	100	125	93	102	86	74	104	81	71	936	
Louisiana	181	200	187	193	171	196	156	169	154	149	1,756	
Nebraska	64	85	93	41	45	39	42	35	38	30	512	
New Mexico	87	82	79	79	74	56	67	76	69	129	798	
Pennsylvania	844	851	758	637	601	627	606	606	580	534	6,644	
South Carolina	133	113	131	158	153	124	106	93	92	101	1,204	
Wisconsin	113	82	80	64	58	66	64	34	56	40	657	

Note: Includes States that provide additional patient compensation. Adjusted columns exclude reports from State funds that make payments in addition to primary malpractice carrier payments for the same case. State funds occasionally make payments on behalf of a practitioner practicing in another State.

Table 22: Medical Malpractice Payment and Adjusted Reports for Dentists, by State, 2003 - 2012

State	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
	<u>Reports</u>										
Florida	90	82	88	75	76	84	102	117	123	104	941
Indiana	14	19	18	11	15	16	21	10	13	13	150
Kansas	10	16	13	12	14	9	6	3	13	8	104
Louisiana	26	24	15	23	17	17	14	11	6	17	170
Nebraska	8	8	10	3	7	3	4	2	5	8	58
New Mexico	10	10	16	17	10	10	12	11	16	12	124
Pennsylvania	94	82	85	112	74	87	80	85	75	69	843
South Carolina	10	14	9	6	8	10	8	10	14	16	105
Wisconsin	28	37	14	7	16	14	18	19	19	15	187
	<u>Adjusted</u>										
Florida	90	82	88	75	76	84	102	117	123	104	941
Indiana	14	19	14	11	15	16	21	10	13	13	146
Kansas	10	16	13	12	13	9	6	3	13	8	103
Louisiana	21	21	14	19	16	16	11	9	4	14	145
Nebraska	8	8	10	3	7	3	4	2	5	8	58
New Mexico	10	10	16	17	10	10	12	11	16	12	124
Pennsylvania	94	82	85	112	74	87	80	85	75	69	843
South Carolina	10	14	8	6	7	9	7	10	14	16	101
Wisconsin	28	37	14	7	16	14	18	19	19	15	187

Note: Includes States that provide additional patient compensation. Adjusted columns exclude reports from State funds that make payments in addition to primary malpractice carrier payments for the same case. State funds occasionally make payments on behalf of a practitioner practicing in another State.

Table 23: Median Malpractice Payments and Rank by Jurisdiction, Physicians 2003 - 2012

State	Payment Ranks		Median Payment 2012
	2012	2003-2012	
Alabama	32	24	\$150,000
Alaska	12	39	\$250,000
Arizona	18	14	\$229,101
Arkansas	35	22	\$137,500
California	47	51	\$85,000
Colorado	41	30	\$115,000
Connecticut	4	3	\$400,000
Delaware	8	6	\$319,000
District of Columbia	42	10	\$110,000
Florida	22	19	\$200,000
Georgia	12	12	\$250,000
Hawaii	1	14	\$555,000
Idaho	29	27	\$185,000
Illinois	3	1	\$418,440
Indiana	45	43	\$93,501
Iowa	22	40	\$200,000
Kansas	22	27	\$200,000
Kentucky	30	37	\$176,750
Louisiana	46	44	\$90,000
Maine	12	7	\$250,000
Maryland	20	13	\$205,000
Massachusetts	2	2	\$424,736
Michigan	38	44	\$120,000
Minnesota	6	14	\$375,000
Mississippi	50	40	\$70,000
Missouri	22	14	\$200,000
Montana	12	14	\$250,000
Nebraska	11	38	\$275,000
Nevada	31	24	\$157,500
New Hampshire	9	7	\$312,500
New Jersey	10	7	\$300,000
New Mexico	51	30	\$56,250
New York	7	5	\$344,625
North Carolina	37	24	\$125,000
North Dakota	36	30	\$130,000

State	Payment Ranks		Median Payment
	2012	2003-2012	2012
Ohio	22	20	\$200,000
Oklahoma	32	30	\$150,000
Oregon	43	30	\$100,000
Pennsylvania	4	3	\$400,000
Rhode Island	21	23	\$202,500
South Carolina	40	44	\$115,903
South Dakota	12	44	\$250,000
Tennessee	38	30	\$120,000
Texas	44	40	\$99,000
Utah	48	44	\$80,000
Vermont	49	44	\$71,250
Virginia	12	11	\$250,000
Washington	22	30	\$200,000
West Virginia	32	50	\$150,000
Wisconsin	19	21	\$225,000
Wyoming	22	29	\$200,000

Note: Year is malpractice payment year.

Table 24: Median and Mean Medical Malpractice Payment Delay, in Years, Between Incident and Payment, by Jurisdiction, 2003 - 2012

State	Median Rank		Median Delay		Mean Delay	
	2012	2003-2012	2012	2003-2012	2012	2003-2012
Alabama	17	17	4.1	4.1	5.0	4.5
Alaska	14	36	4.4	3.6	4.4	5.3
Arizona	25	33	3.9	3.7	4.0	4.0
Arkansas	23	35	4.0	3.7	5.4	4.2
California	50	51	2.8	2.7	3.3	3.2
Colorado	49	50	3.2	3.1	3.3	3.5
Connecticut	8	7	5.5	5.1	5.9	5.4
Delaware	45	26	3.3	3.8	3.5	4.3
District of Columbia	20	23	4.0	3.9	5.5	4.5
Florida	47	32	3.2	3.7	3.7	4.1
Georgia	33	28	3.7	3.8	4.0	4.3
Hawaii	3	15	5.9	4.2	5.6	4.3
Idaho	43	31	3.3	3.7	3.8	4.2
Illinois	7	5	5.6	5.3	6.0	5.8
Indiana	5	1	5.8	6.0	6.0	6.3
Iowa	39	45	3.4	3.4	3.6	3.8
Kansas	32	40	3.7	3.5	4.6	3.9
Kentucky	44	24	3.3	3.9	4.1	4.5
Louisiana	2	4	5.9	5.3	7.0	6.0
Maine	37	13	3.6	4.2	4.0	4.8
Maryland	16	18	4.1	4.1	4.3	4.3
Massachusetts	6	2	5.7	6.0	6.0	6.1

State	Median Rank		Median Delay		Mean Delay	
	2012	2003-2012	2012	2003-2012	2012	2003-2012
Michigan	31	25	3.7	3.9	4.3	4.3
Minnesota	24	47	4.0	3.4	4.1	3.8
Mississippi	1	12	6.1	4.3	7.6	5.2
Missouri	34	22	3.7	3.9	5.0	4.4
Montana	42	38	3.3	3.6	6.2	4.1
Nebraska	21	19	4.0	4.0	3.9	4.3
Nevada	22	10	4.0	4.5	4.3	4.7
New Hampshire	36	16	3.7	4.1	3.8	4.4
New Jersey	10	8	5.0	5.1	5.5	5.9
New Mexico	12	21	4.5	3.9	4.4	4.0
New York	9	6	5.4	5.2	6.0	5.8
North Carolina	18	27	4.1	3.8	4.5	4.3
North Dakota	27	43	3.9	3.5	3.6	3.6
Ohio	46	37	3.2	3.6	4.1	4.4
Oklahoma	18	34	4.1	3.7	4.8	4.2
Oregon	47	49	3.2	3.2	3.9	3.5
Pennsylvania	11	9	4.7	4.8	5.4	5.6
Rhode Island	3	3	5.9	5.8	5.9	6.0
South Carolina	13	11	4.4	4.4	4.8	4.8
South Dakota	51	48	2.5	3.2	3.2	3.7
Tennessee	26	29	3.9	3.8	4.4	4.3
Texas	38	46	3.4	3.4	3.9	3.8
Utah	30	30	3.7	3.7	4.3	4.1
Vermont	29	20	3.8	4.0	3.5	4.5

State	Median Rank		Median Delay		Mean Delay	
	2012	2003-2012	2012	2003-2012	2012	2003-2012
Virginia	15	44	4.3	3.4	6.6	4.3
Washington	28	38	3.8	3.6	4.2	3.9
West Virginia	41	41	3.4	3.5	3.7	4.0
Wisconsin	40	14	3.4	4.2	3.9	4.5
Wyoming	35	42	3.7	3.5	4.2	3.7

Table 25: Mean and Median Physician Malpractice Payments, 2003 - 2012

Payment Reason	Median Payment		Number of Payments		Mean Payment	
	2012	2003-2012	2012	2003-2012	2012	2003-2012
Obstetrics Related	\$350,000	\$300,000	585	9,321	\$572,199	\$548,733
Anesthesia Related	\$239,980	\$200,000	2,872	37,836	\$373,476	\$340,667
Diagnosis Related	\$227,500	\$200,000	222	3,298	\$388,892	\$378,730
Monitoring Related	\$170,000	\$152,500	323	3,306	\$293,769	\$315,952
IV & Blood Products Related	\$169,400	\$150,000	2,559	30,782	\$319,332	\$271,443
Treatment Related	\$150,000	\$140,000	1,804	22,331	\$286,892	\$264,929
Surgery Related	\$140,000	\$150,000	21	247	\$205,203	\$241,172
Medication Related	\$125,000	\$125,000	511	5,942	\$246,756	\$241,885
Behavioral Health Related	\$75,000	\$75,000	222	2,407	\$278,249	\$211,332
Other Miscellaneous	\$65,625	\$100,000	26	379	\$282,567	\$236,656
Equipment/Product Related	\$30,000	\$55,000	49	627	\$160,323	\$145,413

Note: Year is malpractice payment year.

Table 26: Median and Mean Physician Medical Malpractice Delay, in Years, Between Incident and Payment, by Payment Reason, 2003 - 2012

Payment Reason	Number of Payments		Mean Delay		Median Delay	
	2012	2003-2012	2012	2003-2012	2012	2003-2012
Obstetrics Related	585	9,321	6.6	6.1	5.4	5.1
Diagnosis Related	2,872	37,836	5.2	5.0	4.5	4.4
Monitoring Related	323	3,306	4.7	4.6	4.2	4.1
IV & Blood Products Related	1,804	22,331	4.9	4.7	4.2	4.1
Treatment Related	21	247	4.6	4.5	4.1	3.6
Medication Related	511	5,942	4.6	4.4	3.8	3.8
Surgery Related	2,559	30,782	4.4	4.3	3.8	3.9
Anesthesia Related	26	379	5.2	5.5	3.5	4.6
Equipment/Product Related	222	3,298	4.0	4.0	3.5	3.6
Behavioral Health Related	49	627	4.2	3.8	3.4	3.2
Other Miscellaneous	222	2,407	3.7	4.3	3.0	3.5

Note: Year is malpractice payment year.

Appendix E: Summary Tables

Table 27: Adverse Action and Medical Malpractice Payment Reports in Dispute Resolution, 2003 - 2012

Report Type	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
	<u>Number</u>									
Adverse Action Reports	56	56	61	58	39	49	41	59	65	53
State Licensure Actions	18	14	20	17	8	13	10	23	32	26
Clinical Privileges Actions	36	41	39	40	30	36	30	35	33	25
Professional Society Actions	1	0	0	1	1	0	1	0	0	1
Medicare/Medicaid exclusions	1	1	2	0	0	0	0	1	0	1
Medical Malpractice Payment Reports	5	16	12	14	11	11	9	5	9	12
Total	61	72	73	72	50	60	50	64	74	65
	<u>Percent</u>									
Adverse Action Reports	91.8	77.8	83.6	80.6	78.0	81.7	82.0	92.2	87.8	81.5
State Licensure Actions	32.1	25.0	35.7	30.4	14.3	23.2	17.9	41.1	57.1	46.4
Clinical Privileges Actions	64.3	73.2	69.6	71.4	53.6	64.3	53.6	62.5	58.9	44.6
Professional Society Actions	1.8	0.0	0.0	1.8	1.8	0.0	1.8	0.0	0.0	1.8
Medicare/Medicaid exclusions	1.8	1.8	3.6	0.0	0.0	0.0	0.0	1.8	0.0	1.8
Medical malpractice payment reports	8.2	22.2	16.4	19.4	22.0	18.3	18.0	7.8	12.2	18.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Includes disclosable reports in the NPDB as of December 31, 2012.

Table 28: Outcomes of Dispute Resolution Adverse Action and Medical Malpractice Payment Reports, 2003 - 2012

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
	<u>Number</u>									
Total	61	72	73	72	50	60	50	64	74	65
Beyond Scope of Secretary	39	46	49	42	33	45	40	33	53	27
Voided by Secretary	1	2	3	3	0	0	0	3	1	0
Closed by Intervening Action	17	23	20	27	5	13	7	19	10	14
Closed by Practitioner	4	1	1	0	12	1	2	4	1	1
Unresolved as of December 31, 2012	0	0	0	0	0	1	1	5	9	23

Note: Includes disclosable reports in the NPDB as of December 31, 2012.