

NATIONAL PRACTITIONER DATA BANK REPORTS

1. **REASON FOR ISSUE:** This Veterans Health Administration (VHA) Handbook contains requirements for health care facilities on reporting information to the National Practitioner Data Bank (NPDB) regarding physicians, dentists and other licensed health care professionals.
2. **SUMMARY OF CONTENTS/MAJOR CHANGES:** Changes in this policy include:
 - a. Reflecting organizational designations resulting from the VHA Central Office reorganization, and
 - b. Incorporating changes made with the publication of regulations.
3. **RELATED DIRECTIVE:** VHA Directive 1100.17, to be published.
4. **RESPONSIBLE OFFICE:** Office of Quality and Performance (10Q), and the Office of Patient Care Services Forensic Medicine Strategic Healthcare Group (11F) are responsible for the contents of this handbook.
5. **RESCISSIONS:** VHA Handbook 1100.17, dated March 21, 2002, is rescinded.
6. **RECERTIFICATION:** This document is scheduled for recertification on or before the last working day of November 2007.

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Under Secretary for Health

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NATIONAL PRACTITIONER DATA BANK REPORTS

1. PURPOSE

The purpose of this Veterans Health Administration (VHA) Handbook is to provide required procedures for health care facilities on reporting information to the National Practitioner Data Bank (NPDB) regarding physicians, dentists and other licensed health care professionals.

NOTE: This handbook does not apply to individuals in training programs, other than licensed physician and dental residents(see subpars 5a(2) and 5a(3)).

2. BACKGROUND

a. Under the provisions of the Health Care Quality Improvement Act of 1986 (Public Law 99-660), which established the NPDB, and a Memorandum of Understanding (MOU) between the Department of Veterans Affairs (VA) and the Department of Health and Human Services (HHS), reports of certain malpractice payments and certain clinical privileges actions must be submitted to the NPDB and appropriate state licensing boards for VA practitioners. Regulations in 38 CFR Part 46 published in the Federal Register on April 23, 2002, set forth VA reporting requirements. These reporting requirements apply to all VHA physicians, dentists, and other licensed health care practitioners involved in patient care who are employed, appointed, or contracted for, under job titles listed in the NPDB document entitled "Field of Licensure Codes" on a full-time (FT), part-time (PT), intermittent, consultant, attending, without compensation (WOC), on-station fee-basis, on-station contract, on-station scarce medical specialty or mutual use and/or sharing agreement basis. Since the NPDB is unable to assure the identity of any individual in the absence of a license number, individuals who do not have a license will not be reported, except in special circumstances as outlined in subparagraph 5c(6).

b. A "Malpractice Payment" is a payment, by way of settlement or judgment, by the United States on a claim of medical malpractice as defined in Title 38 Code of Federal Regulations (CFR) Section 46.1(b).

3. AUTHORITY

VHA facilities must file a report with the NPDB in accordance with regulations in Title 45 CFR Part 60, Subpart B, as applicable, and 38 CFR Part 46 regarding:

a. Any payment for the benefit of a physician, dentist or other licensed health care practitioner which was made as the result of a settlement or judgment of a claim of medical malpractice (subsequent to review as outlined in subpar. 5b), and

b. Adverse clinical privileges actions (e.g., restriction, suspension, revocation, etc.) taken against physicians and dentists that are final and affect privileges for more than 30 days, as well as acceptance of the surrender of clinical privileges, or the restriction of clinical privileges of physicians and dentists, when the action is related to professional competence or professional conduct.

NOTE: Malpractice payment reporting applies to all licensed health care professionals. Adverse action reporting applies only to physicians and dentists.

4. RESPONSIBILITY

a. Facility Directors are responsible for ensuring that:

(1) Physicians, dentists, and other licensed health care practitioners are properly reported to the NPDB and appropriate state licensing boards in accordance with requirements outlined in this handbook. Actions taken under these procedures will be strictly followed and documented.

b. The requirements of this Handbook must be incorporated into appropriate medical center publications.

NOTE: Nothing in this Handbook relieves the facility Director of responsibility from any other VHA requirements for the review of Tort Claims.

c. Regional Counsel must provide malpractice payment information to the facility and to the Office of the Director, Medical-Legal Affairs.

d. Except as provided in following subparagraph 4d, the facility Director is the authorized representative who signs all submissions to the NPDB. Any delegation of that authority to other facility officials must be documented to include date of delegation and circumstances governing delegation. The authorized representative for purposes of making reports is limited to a formally designated Acting Director. Copies of reports to the NPDB and related documentation must be filed in the reported individual's Credentialing and Privileging Folder. **NOTE:** Paragraph 5 addresses the panel review process for, and NPDB reports related to, malpractice payments. Paragraph 6 addresses reports related to clinical privileges actions, and includes guidelines for formal review procedures to be followed prior to initiating such reports.

e. The Chief Patient Care Services Officer is authorized to submit the report concerning a medical malpractice payment reviewed pursuant to paragraph 5 to the NPDB and provide copies to the facility Director, the practitioner and State Licensing Boards (SLBs). This is done in cases where the Chief Patient Care Services Officer deems it appropriate to do so following the review panel's determination that a malpractice payment has been made for the benefit of a physician, dentist or other licensed health care practitioner.

f. The Director, Office of Medical-Legal Affairs, is responsible for coordinating the panel review process, including, but not limited to: the notification to the facility Director where the episode of care for which a payment has been made occurred; the request for all documentation pertinent to the episode of care under review; the selection and appointment of the members of the review panel and the administration of the review process; and the documentation of the findings of the review panel.

NOTE: VHA officials are expressly prohibited from entering into formal or implied agreements not to report an employee in return for a personnel action such as resignation, retirement,

accepting a reassignment, etc. VHA officials cannot enter into formal or implied agreements to restrict information that would otherwise be reported under the provisions of this handbook.

5. MALPRACTICE PAYMENTS

a. **Parameters for Reporting Malpractice Payments.** All licensed health care practitioners must be reported according to the requirements of this Handbook.

(1) Attending staff (including contract employees such as scarce medical specialists) are responsible for actions of interns and residents assigned under their supervision.

(a) Where the actions of a licensed trainee warrant reporting (for substandard care, professional incompetence or professional misconduct), but did not result from gross negligence or willful professional misconduct, the attending is to be reported without mention of an involved trainee, but with a notification that the attending is being reported in a supervisory capacity.

(b) In circumstances where the review panel concludes that the payment of a claim was related to substandard care, professional incompetence, or professional misconduct resulting from gross negligence or willful professional misconduct on the part of a licensed trainee in a training or residency program, the trainee must be reported to the NPDB. **NOTE:** *In this instance, the attending is not reported unless the review panel concludes there was substandard care, professional incompetence, or professional misconduct on the part of the attending in the supervisory role.*

(2) Physician residents who function outside the scope of their training program, i.e., who are appointed as the Admitting Officer of the Day (AOD), are to be considered and reported, if appropriate, as attending physicians.

(3) Unlicensed trainees are not be reported since the NPDB is unable to ensure the identity of any individual in the absence of a license number, except in special circumstances as outlined in subparagraph 5c(6).

NOTE: *See Appendix A for detailed description of the Review Process.*

b. **Malpractice Payments Review Process**

(1) At the time a malpractice payment is made, the Regional Counsel must notify the facility and the Director, Office of Medical-Legal Affairs.

(2) The facility Director must provide the documents pertinent to the care that lead to the claim to Director, Office of Medical-Legal Affairs.

(a) These documents include: medical records of the patient whose care lead to the claim, any reports of an administrative investigation appointed to investigate the care, and any other information associated with the care that lead to the claim.

(b) With the exception of the provider's written statement described in subparagraph 5(b)(3), this information must be forwarded to the Director, Office of Medical-Legal Affairs, within 30 days of Notice of Payment to the facility Director where the episode of care occurred.

(c) On a case-by-case basis, requests for extension of this time period may be granted. In order to be considered, requests must be received by the Director, Office of Medical-Legal Affairs, not later than 48 hours prior to the expiration of the submission period (See App. B for Sample Letter of Notification to the facility Director; See App. C for a sample facility review process).

NOTE: *Records that are confidential and privileged under the provisions of Title 38 United States Code(U.S.C.) 5705 may not be used as evidence for reporting individuals to the NPDB.*

(3) **Provider Notification.** Information from the individual practitioner(s) involved in the episode of care may be collected by facility officials prior to the appointment of the review panel. This information from the practitioner must be submitted in the form of written material.

(a) The facility Director must notify the practitioner(s) whose action is under review that VA is considering whether to report the practitioner(s) to the NPDB because of a specified malpractice payment made.

(1) This notification must be in writing and hand-delivered or sent to the practitioner's last known address. Written acknowledgment of receipt from the practitioner needs to be obtained. A signed Return Receipt Request fulfills this requirement.

(2) The practitioner must be informed in this notification of the opportunity to provide a written statement to the review panel concerning the care of the patient that led to the claim. The written statement must be submitted to the Director, Office of Medical-Legal Affairs, within 60 days of notice to the provider, either directly or through the facility Director.

(3) Inability to notify the practitioner(s) or non-response by the practitioner(s) does not preclude completion of the review and reporting process. At the time the facility Director forwards information to the Director, Office of Medical-Legal Affairs, the names of the practitioners notified must be documented.

NOTE: *See Appendix D for Sample Letter to Practitioners.*

(b) If a practitioner is deceased, this information must be forwarded to the Review Panel in place of a written statement.

(c) While the initial determination and notification of providers involved in the episode of care occurs at the facility level, the review panel may determine that additional or other practitioners were involved. In such cases, the panel's review of the episode of care is suspended. The Office of Medical-Legal Affairs contacts the facility Director, providing the names of these additional individuals, and requests the facility Director to provide notice to these individuals and to afford these individuals the opportunity to submit written material according to the process below:

NOTE: There is no opportunity for a personal appearance. In the event that the practitioner cannot be notified, or decides not to provide a statement, such inability or refusal shall be documented by the facility Director and submitted to the Director, Office of Medical-Legal Affairs, prior to review by the panel.

(4) Upon notification by Regional Counsel that a medical malpractice payment has been made, the Director, Office of Medical-Legal Affairs, appoints professional reviewers. Reviewers may be VA employees or procured by contract, but may not be employees of the facility for which payment was made.

NOTE: See Appendix E for Sample Panel Exclusion Memorandum.

(a) The panel must consist of, at a minimum, three off-station reviewers who are health care professionals, including at least one reviewer who is a member of the profession or occupation of the practitioner(s) represented in the case and/or claim under review. Reviewers meet as a panel.

(b) Panelists are designated as primary reviewers of the cases and/or claims of those practitioners of the same profession or occupation. The primary reviewer undertakes an examination of the documents provided and may make a determination as to whether consultation with a specialist is appropriate. Consultation may be requested and occur at any time during the review process, including during the deliberation of a case and/or claim by the full panel. All panel members must review all cases and/or claims for which they are required to make the determination described in subparagraph 5b(4)(c); however, the primary reviewer is the one who presents the case and/or claim to the panel during the deliberations process.

(c) The reviewers designated by the Office of Medical-Legal Affairs must conduct an assessment to determine which practitioners were involved in, or responsible for, the care of the patient related to the episode of care for which payment was made. For each of the episodes of care, and for each of the involved practitioners, the review panel must:

(1) Determine whether there was substandard care, professional incompetence or professional misconduct.

(2) Address each of the episodes of care for which payment was made, and specifically state for each of the involved practitioners whether there was substandard care, professional incompetence or professional misconduct.

(d) In the event that the professional review indicates that additional or other practitioners were involved in the episode of care, the review must cease, and the Director, Medical-Legal Affairs, must request that the facility Director provide such practitioners with written notice (See App. D).

(e) The review panel, at its discretion, may request the opinion of any consultant to assist in its deliberation.

(f) The conclusions of the review body must, at a minimum, be based on review of documents pertinent to the case and/or claim and, to the extent practicable, shall include information collected directly from the individual(s) for whom benefit payment was made (see subpar. 5b(3)). The panel, at its discretion, may request additional information from the practitioner.

(5) The Director, Office of Medical-Legal Affairs must provide a report to the facility Director documenting the conclusion(s) that the panel reached regarding substandard care, professional incompetence, or professional misconduct and the rationale for those conclusion(s). Any concerns or questions about the review process must be raised with the Chief Patient Care Services Officer, or designee, who will forward such concerns or questions to the Director, Office of Medical-Legal Affairs. The Director, Office of Medical-Legal Affairs must address the questions or concerns, and provide a response to the Chief Patient Care Services Officer, or designee. **NOTE:** *The panel's conclusions regarding substandard care, professional incompetence, or professional misconduct will not be reviewed.*

c. **Reporting Malpractice Payments**

(1) Payment will be considered to have been made for the benefit of a physician, dentist or other licensed health care practitioner when the Director, Office of Medical-Legal Affairs, notifies the Director of the facility that the conclusion (of at least a majority) of the review panel is that payment was related to substandard care, professional incompetence or professional misconduct on the part of the physician, dentist or other licensed health care practitioner. In any case where professional incompetence or professional misconduct is involved, coordination with other relevant processes should occur (e.g., Professional Standards Board, Disciplinary Appeals Board, or administrative investigations). Any coordination is not intended to delay processes outlined in this Handbook. A copy of the notification must be provided by the Director of the facility and to the individual(s) identified (see App. F for Sample Report of Panel Conclusions).

(2) Malpractice payments made as the result of a settlement, or judgment, of a claim of medical malpractice and subsequent to the formal review process outlined above is to be reported to the NPDB and SLB(s) in all state(s) where practitioners hold licenses, as well as in the state where a reportable episode of care occurred.

(3) The facility Director, or, in accordance with the requirements of subparagraph 5c(7), the Chief Patient Care Services Officer, must file a report with the NPDB, on behalf of the VA medical facility, or on behalf of any remote clinics operated by VA, regarding any medical malpractice payment that the review procedures established was related to substandard care, professional incompetence, or professional misconduct on the part of a physician, dentist, or other licensed health care professional.

(4) A copy of the NPDB report will also be filed with the Director, Office of Medical-Legal Affairs.

(5) If it is determined that a practitioner, past or present, claims and/or claimed a license that was not held, but would be reportable under provisions of this policy if a license was held, the practitioner must be reported to NPDB. **NOTE:** *In these cases, Item 22.a. of the Medical*

Malpractice Payment Report form on the NPDB website (www.npdb-hipdb.com) would be completed by inserting the words "No License," and attaching a statement signed by the facility's authorized representative explaining why the report is being filed without a license number.

(6) Facility Directors are responsible for filing the report within 30 days of receipt of notice from the Director, Office of Medical-Legal Affairs, of the determination by the review panel that a report(s) is to be made due to a finding of substandard care, professional incompetence, or professional misconduct on the part of the practitioner. Reports not made within this period are subject to reporting by the Chief Patient Care Services Officer. The Chief Patient Care Services Officer must contact the Veterans Integrated Service Network (VISN) Director prior to filing the report.

(7) Any corrections, revisions, additions, or voiding of previously submitted reports are to be submitted to NPDB, SLB(s), and any VA offices which received copies of the initial report. Canceled or voided reports will be removed from the practitioner's credentialing and privileging file and filed elsewhere with voided reports.

NOTE: *The facility Director is responsible for advising previous recipients of this information that the report to NPDB has been voided.*

(8) Payments made for claims of malpractice in which the review panel determines that the standard of care was met and there was no professional incompetence or professional misconduct, or which the panel determines are due solely to circumstances beyond the control of the practitioner (including, but not limited to, power failure, accidents unrelated to patient care, drugs mislabeled by the supplier, equipment malfunction, etc.) are not to be reported.

(9) Claims that are closed without payment, and compensation payments due to an award under the provisions of 38 U.S.C. 1151 are not reportable and are not to be referred to review panels.

d. **Forms.** Reports to the NPDB are to be submitted electronically using software provided by the NPDB, or on the appropriate form(s) supplied by the NPDB. These include:

(1) **Medical Malpractice Payment Report.** For submission of an initial report; correction, revision, addition or voiding of a previously submitted report per instructions on the NPDB website at www.npdb-hipdb.com.

(2) **Additional Information.** To complete information regarding any medical malpractice payment report for which the initial reporting form does not allow adequate space to provide all relevant information per instructions on the NPDB website at www.npdb-hipdb.com.

6. ADVERSE ACTIONS

a. Parameters for Reporting Adverse Actions

(1) After consideration of a professional review, the facility Director's determination that, a period longer than 30 days adversely affects (by reducing, restricting, suspending, revoking, or failing to renew) the clinical privileges of a physician or dentist relating to possible incompetence or improper professional conduct.

(2) The acceptance of the surrender of clinical privileges, or any restriction of such privileges, by a physician or dentist while such physician or dentist is under investigation by the health care entity for possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding, whether or not the individual remains in VA service. At the time a physician or dentist surrenders, or voluntarily accepts restriction of clinical privileges, resigns, or retires from the medical position in VA while under suspicion of possible professional incompetence or improper professional conduct, the physician must be formally notified that reporting to the NPDB is required. The physician must be offered due process (as outlined in VHA Handbook 1100.19, Credentialing and Privileging, regarding reduction and revocation of privileges). Individuals who choose not to avail themselves of the due process procedures waive their right to due process and must be reported.

(3) It is intended that the report be filed within 15 days of the date the action is made final by signature of the VA medical center Director.

b. **Provisions for Reporting Adverse Actions**

(1) Actions related to professional competence or conduct that adversely affect clinical privileges of a physician or dentist for a period longer than 30 days must be reported to the NPDB and a copy of this report must be sent to the SLB in the state in which the facility is located and the SLB in all states where the practitioner holds licenses. This report is called an "Adverse Action Report" by the NPDB. For purposes of this Handbook, adverse action is defined as reduction, suspension, or revocation of privileges for a period exceeding 30 days.

(a) Prior to reporting to any SLB or NPDB, appropriate internal VA medical center due process procedures, pursuant to the provisions of VHA Credentialing and Privileging policy regarding reduction and revocation of privileges, must be completed.

(b) Action taken to restore clinical privileges of physicians or dentists previously reported as restricted is to be reported in the same manner as the original report with copies to all recipients of the original report.

(c) Any corrections, revisions, additions, or voiding of previously submitted reports are to be submitted to the NPDB and SLB(s) in the same manner as the original report with copies to all recipients of the initial report. *NOTE: Actions to restore privileges previously reduced, suspended or revoked are not considered a void. Voided reports must be removed from the practitioner's credentialing and privileging file and filed elsewhere with voided reports. The facility Director is responsible for advising previous recipients of this information that the report to the NPDB has been voided.*

(2) Summary suspension of clinical privileges pending review by the executive committee of the medical staff or other review panel is not reportable. Final action by signature of the

Director following the review that adversely affects privileges for a period longer than 30 days is reportable.

(3) The acceptance of the surrender of clinical privileges, including the surrender of clinical privileges inherent in resignation or retirement, or any restriction of clinical privileges by a physician or dentist either while under investigation by the facility for possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding whether or not the individual remains in VA service, must be reported to the NPDB, and a copy of this report must be sent to the SLB in the state in which the facility is located and to the SLB in all states where the practitioner holds licenses.

(4) Independent contractors acting on behalf of VA are subject to the NPDB reporting provisions of this policy. In the following circumstances, VA must provide the contractor with notice that a report of a clinical privileges action is being filed with the NPDB with a copy to the SLB in the state(s) in which the contractor is licensed and in which the facility is located:

(a) Where VA terminates a contract for possible incompetence or improper professional conduct, thereby automatically revoking the contractor's clinical privileges, or

(b) Where the contractor terminates the contract, thereby surrendering clinical privileges, either while under investigation relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding.

c. **Responsibility For Reporting Adverse Actions**

(1) The Director of the VA medical facility will file an adverse action report, on behalf of the VA medical facility and on behalf of any satellite clinics operated by them, within 15 days of the date the action is made final by signature of the facility Director, with:

(a) NPDB,

(b) The SLB in the state in which the facility is located (copy), and

(c) The SLBs in all states in which the practitioner is licensed (copy).

(2) Prior to approving the report, the facility Director may notify the practitioner to be reported and provide an opportunity for discussion with appropriate facility officials, including the Director, before the report is submitted. Review of content prior to submission would reduce later misunderstanding. The NPDB will send a copy of the computerized report to the facility and the practitioner with a limited comment period in which to make any changes in the facts of the report.

d. **Forms**. Reports to the NPDB must be submitted electronically using software provided by NPDB or on the appropriate form(s) provided by the NPDB. These include:

(1) Adverse Action Report. For submission of initial report, correction, revision, addition, or voiding of a previously submitted report per instructions on the NPDB website at www.npdb-hipdb.com.

(2) Additional Information. For completing information regarding any adverse action report for which the initial format does not allow adequate space to provide all relevant information per instructions on the NPDB website at www.npdb-hipdb.com.

7. POST-NPDB REPORTING – THE HHS DISPUTE PROCESS

Following the reporting by the facility to the NPDB, the NPDB must send a copy of the computerized report to the facility and to the practitioner (*the Notification of a Report in the Data Bank(s)*) with a limited comment period.

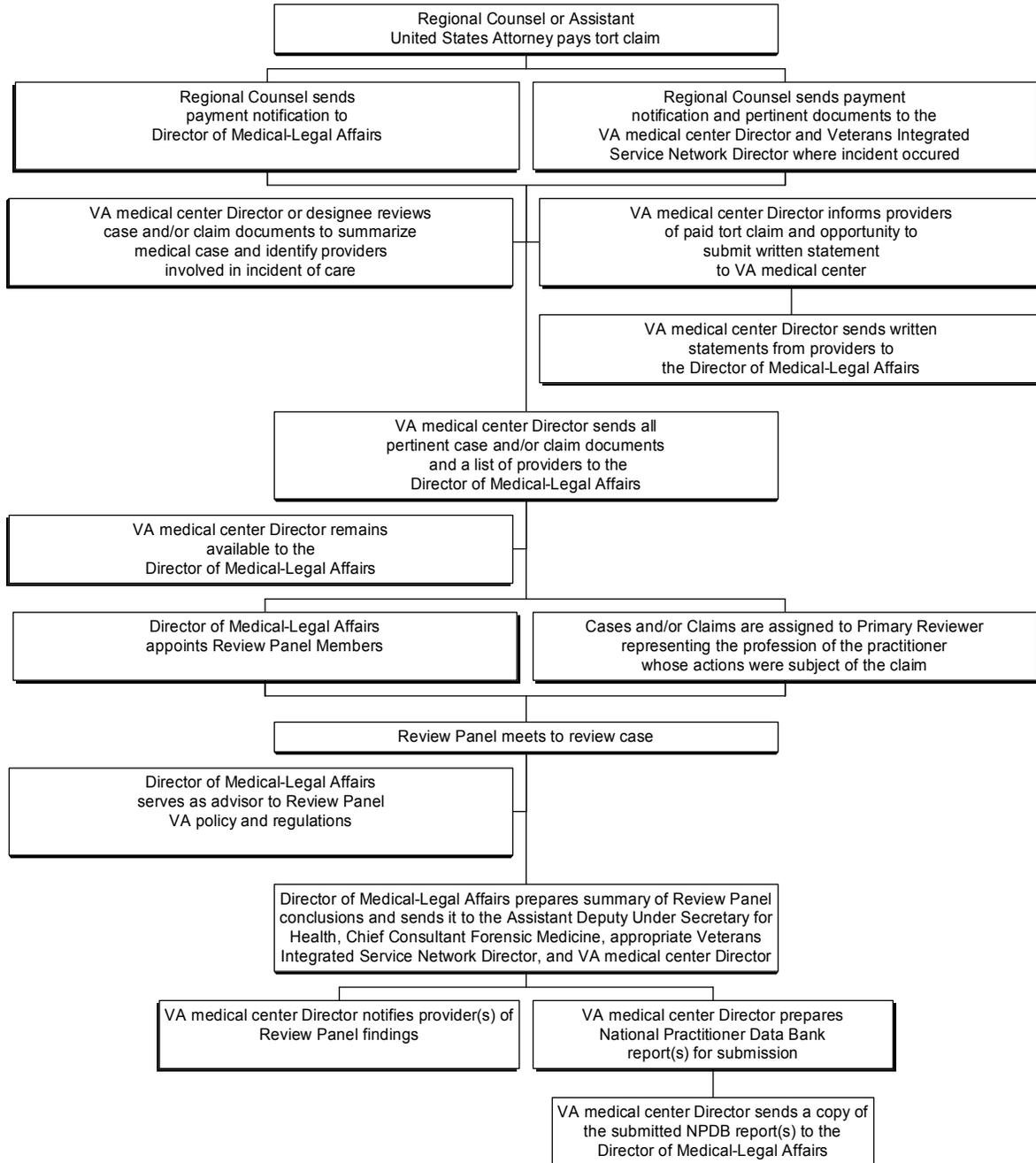
a. The practitioner can not submit changes to the report. If the practitioner believes the report contains factual inaccuracies, the practitioner must contact the reporting facility to request that it file a correction to the report in accordance with the NPDB's requirements. If the reporting facility declines to change the report, the provider may add a statement, initiate a dispute of the report in accordance with and through the NPDB dispute process, or both. HHS does have a dispute process for reports made to the NPDB. **NOTE:** *This process is external to VA and is initiated by the practitioner.*

b. Practitioners who wish to add a statement to or dispute the factual accuracy of a report should follow the instructions provided by the NPDB on *the Notification of a Report in the Data Bank(s)*. The NPDB dispute process is not an avenue to protest a payment or to appeal the underlying reasons for reporting. Practitioners who wish to dispute the factual accuracy of the report or that the report was not submitted in accordance with NPDB reporting requirements may do so. Information on this process can be obtained from HHS through the NPDB.

8. REFERENCES

- a. Public Law (Pub. L.) 99-660 and its revisions (Pub. L. 100-177).
- b. Title 45 CFR Part 60.
- c. Title 38 CFR Part 46.
- d. Title 38 U.S.C. 7401 and 7405.
- e. MOU between Department of Health and Human Services and Department of Veterans Affairs, effective October 1, 1990.
- f. VA Handbook 5005
- g. VA Handbook 5021, Part VI
- h. Privacy Act System of Records Notice, 77VA10Q, Health Care Provider Credentialing and Privileging Records - VA
- i. National Practitioner Data Bank Guidebook.

Veterans Health Administration Paid Tort Claim Review Process



SAMPLE FACILITY NOTIFICATION LETTER

Date:

From: Director, Medical-Legal Affairs (11ML)

Subj: Settlement of Malpractice Claim

To: «Title» (00)
«Facility»

1. A payment has been made on a claim against the United States (U.S.) arising from medical care provided at your facility in the case of :

VETERAN: _____«LastName», «FirstName»_____
SOCIAL SECURITY NUMBER _____ - ____ - _____

2. The Office of Medical-Legal Affairs will coordinate the panel review in support of the National Practitioner Data Bank (NPDB) reporting program.

a. The first step in preparation for the review is to inform each of the practitioners involved in the episode of care for which payment was made, and invite them to provide input for consideration of the panel. This will be the providers' only opportunity to submit their statements. Enclosed is a sample memo which may be used to inform the practitioner. It is suggested that this memo originate from either the Director or the Risk Manager to the practitioner in question. Within 10 days of receipt of this memo, forward to this office a list of pertinent providers involved in the allegation and their status at the time. If a resident is involved, provide the name of the resident's attending physician.

b. After receipt of input from involved practitioners (or their documented non-response), case materials for the review should be forwarded to the Office of the Director, Medical-Legal Affairs, within 14 calendar days of receipt of this memo. In addition to the practitioner's input, the materials should include:

- (1) The TCIS form pertinent to the case
- (2) VA Form SF-95
- (3) The pertinent sections of the medical record of the veteran patient that was for the practitioner(s) review to include:
 - (a) Physician's and nurse's progress sheets,
 - (b) Discharge summary,

(c) Laboratory and radiological reports, and, when applicable,

(d) VA Form 10-10M,

(e) Typed operative and autopsy reports, as well as anesthetic records and recordings of CT scans and sonograms.

***NOTE:** Records must be in chronological order and bound in folder stating the patient's name and social security number. Copies of medical records not in folders and bound only by rubber bands are not acceptable.*

3. Reports of Administrative Boards of Investigation, if any, where patient abuse when suspected, or of other reportable risk events. These documents are not protected by the confidentiality requirements of 38 U. S. C. Section 5705, Confidentiality of Quality Assurance Records.

4. If you have any questions about this procedure, do not hesitate to contact ____ (Insert Contact's Name) ____ at ____ (Insert Contact's Telephone Number) _____. Send the completed package to: Director, Medical-Legal Affairs (11ML), ____ (Insert Street Address) ____, ____ (Insert City) ____, ____ (Insert State) ____, ____ (Insert Zip Code) _____.

SAMPLE PROCEDURE FOR FACILITY REVIEW OF PAID TORT CLAIMS

1. The Medical Center Director, upon notification by the Regional Counsel that a tort claim has been finalized with a payment, assigns the case to a designee for processing. The designee is usually the risk or quality manager, or an individual knowledgeable in the tort claim process.
2. The designee provides a written description of the episode of care that resulted in the claim for which payment was made.
 - a. To the extent determinable, this description needs to include the name(s) and profession(s) of all practitioners involved in the episode of care.
 - b. All licensed providers of care related to the episode of care for which payment was made are to be identified, specifically to include:
 - (1) Head Nurse, staff nurses.
 - (2) Allied health professionals.
 - (3) Technicians.
 - (4) Medical students.
 - c. If a resident or fellow is named, this will be noted and the appropriate supervising physician should also be listed.
 - d. The identification of providers should also note those who were notified not only previously of the filing of the claim, but also the payment of the claim.
 - e. That a provider is deceased, since deceased providers are not reported.
3. The designee must extract and copy pertinent sections of the medical record to include:
 - a. Physician's and nurse's progress sheets,
 - b. Discharge summary,
 - c. Laboratory and radiologic reports, and when applicable,
 - d. Department of Veterans Affairs (VA) Form 10-10M,
 - e. Typed operative and autopsy reports,
 - f. Anesthetic records,

g. Pertinent radiologic films, and recordings of Computerized Tomography (CT) scans and sonograms,

h. Reports of Administrative Boards of Investigation where patient abuse is suspected, or of other reportable risk events. *NOTE: These documents are not protected by the confidentiality requirements of Title 38 United States Code (U. S. C.) Section 5705, Confidentiality of Quality Assurance Records.*

4. This material must be submitted to the Director, Medical-Legal Affairs, by overnight Federal Express within 30 working days of the facility's notification of the paid tort claim.

5. Identified providers involved in the management of care pertinent to the paid tort claim will be notified by certified mail, return receipt requested, by the facility director or a designee, and will be invited to submit written material for the panel's consideration. Attending physicians need to be informed that they may be reported to the National Practitioner Data Bank (NPDB) in their supervisory status if the act or omission was the responsibility of a practitioner in training. Material should be submitted by the practitioner to medical center Director, or designee, within 30 calendar days of receipt of notice, following which copies are submitted to the Office of the Director, Medical-Legal Affairs, by the facility director.

6. The Director's designee must be available, by telephone, to the Office of the Director, Medical-Legal Affairs, for assistance in clarification of illegible Xeroxed copies of pages or for any other questions that may arise during the panel's review.

7. Regional Counsels must send to the medical center Director and the Office of the Director, Medical-Legal Affairs, a copy of the initial letter of notification to the facility Director regarding the payment in settlement of a tort claim.

8. At the beginning of each month the Information Resources Management (IRM) liaison for General Counsel will send a Tort Claim Information System (TCIS) printout of all paid tort claims for the previous month to the Office of the Director, Medical-Legal Affairs.

9. The Office of the Director, Medical-Legal Affairs, must check TCIS printout against NPDB log and call each facility that has not yet notified the Office of the Director, Medical-Legal Affairs.

10. Upon receipt of the material from the facility director's designee, the Office of the Director, Medical-Legal Affairs must assign a minimum of three providers to be panelists. All panels must include a member of the same profession of the individual whose practice during an episode of care is being reviewed. Other types of professionals will be appointed as necessary. When the review of the episode of care requires knowledge of a specific surgical technique, or of a medical judgment requiring a specific cognizant function, the panel may request a consultation from an appropriate specialist.

11. Each panelist is assigned cases and is responsible for reviewing all of the material pertinent to each case. The panelist is to prepare a summary of the case and present it at the panel meeting for a discussion. The panel identifies the practitioner(s) responsible for the act(s) or omission(s)

for which payment was made, and decides, by majority vote, if this constituted substandard care, professional incompetence, or professional misconduct, and, in the case of residents, if care was considered to be gross negligence, or willful professional misconduct.

12. The non-voting Director, Medical-Legal Affairs, or designee, must participate in person with the panel to familiarize the panel and provide direction, as appropriate. The Director, Medical-Legal Affairs, ensures focus on identifying practitioners and determining if their care was substandard, the result of professional incompetence, or professional misconduct. In the case of residents, a determination must be made whether their care is a result of gross negligence or willful professional misconduct.

13. The Director, Medical-Legal Affairs, must prepare the panel's notification to the VA facility Director of its conclusions, have the notification signed by all participating panelists, and send it to the facility Director. After submitting the required report(s) to the NPDB, the VA facility Director must forward a copy of the report(s) to the Office of the Director, Medical-Legal Affairs.

SAMPLE PRACTITIONER NOTICE LETTER

Date:**From:** Medical Center Director (00)**Subj:** National Practitioner Data Bank Review Panel**To:**

1. You have been identified as a participant in the care provided to ___(Name of Veteran)___ with ___(Insert Social Security Number)___ for which a payment has been made in a tort claim. You were ___(Insert position, e.g. attending physician)___ during this episode of care ___(Insert dates)___ . This letter is to serve as notice that in accordance with Title 38 Code of Federal Regulations 46, you may be reported to the National Practitioner Data Bank (NPDB).
2. Reporting to the NPDB is based on the finding of a review panel that there was substandard care, professional incompetence, or professional misconduct during an episode of care. Attending staff are responsible for actions of interns and residents assigned under their supervision. When licensed residents in training are identified as providers of substandard care, professional incompetence, or professional misconduct, the attending physician may be reported in the supervisory capacity, without mention of the licensed trainee except where the trainee(s) ' care is described as gross negligence or willful professional misconduct. In this case, the resident is to be reported without mention of the attending.
3. Prior to convening the review panel, you have the opportunity to submit information to be considered by the panel. This information, if you choose to submit, must be in the form of written material. This information must be submitted to ___(Insert to Whom)___ within (Number of Days)___ days of receipt of this memo so that there is sufficient time to be received by VHA's Office of Medical-Legal Affairs, as specified in VHA Handbook 1100.17.
4. In gathering your information, you have the opportunity to review the veteran's medical record at the medical center, as well as the Tort Claim Information System form that identified you as participating in the episode of care and Standard Form (SF)-95, that instituted the tort claim. This is your only opportunity to provide information to the review panel. There will be no other opportunity to submit information either prior to or subsequent to the convening of the review panel.
5. If the review panel determines that the standard of care was met and there was no professional incompetence or misconduct, or that payment was based solely on circumstances beyond the control of the practitioners involved in the episode of care, you will not be reported.
6. If the review panel determines that your name should be reported to the NPDB, you will be afforded the opportunity to review and discuss the proposed report prior to filing with the National Practitioner Data Bank and any other appropriate individuals as designated by the

facility Director. This discussion can only encompass issues surrounding the accuracy of the report and is not to be considered as an appeal of the merits of the determination of the report.

7. Please contact ____ (Insert name of appropriate individual) ____ at ____ (Insert telephone number) ____ at the time you receive this memorandum so you will be afforded the fully allowable time for your review and preparation. Arrangements will be made at that time to answer any questions you may have and for you to review medical records and documentation as listed in paragraph 4.

(Signature of the Medical Center Director)
Name
Medical Center Director

SAMPLE PANEL EXCLUSION LETTER

Date:

From:

Subj: PANELIST'S GUIDELINES

To: Director, Medical-Legal Affairs (11ML)

CASE IDENTIFIER: _____ «LastName», «FirstName» _____
SOCIAL SECURITY NUMBER _____ - _____ - _____

1. I have reviewed the following restrictions for prospective Veterans Health Administration (VHA) National Practitioner Data Bank panelists. I have circled those that apply and hereby exclude myself from participating in panel review of the above referenced case.

- a. I am a family member of the claimant or the veteran patient for whom the tort claim is filed.
- b. I participated in the treatment of care of the veteran patient.
- c. I am related to the provider(s) being reviewed.
- d. I have a social relationship (or other type of relationship) with provider being reviewed.

2. None of the preceding apply to me, and I am able to serve on the panel.

(Signature)

(Date)

SAMPLE REPORT OF REVIEW PANEL

Date:

From: Director, Medical-Legal Affairs (11ML)

Subj: Conclusions of Review Panel

To: «Title» (00)
«Facility»

CASE IDENTIFIER: _____«LastName», «FirstName»_____
SOCIAL SECURITY NUMBER _____ - ____ - _____

1. A three-member panel convened on (date) to review the tort claim of the above referenced veteran. The conclusions require reporting of the following provider(s) to the National Practitioner Data Bank (NPDB):

NAME OF PROVIDER(S): _____

2. The act or omission for which payment was made according to the Regional Counsel:

3. Rationale for Panel conclusions:

4. Based on a review of the medical record as well as any additional information submitted by involved practitioners, the Panel determined that ___(the event)___ represented substandard care. The Panel concluded that this patient received substandard care and identified the attending physician, ___(Name of Provider)___, as the responsible practitioner.

5. Note that prior to filing a report with the NPDB the named practitioner(s) is to be afforded the opportunity to review the proposed report with the Director and any other appropriate individual as designated by the Director as required by VHA Handbook 1100.17, paragraph 6e. Note that this meeting and/or discussion is merely to review the proposed report to the NPDB. It is not intended that it be an opportunity to challenge the conclusions of the peer panel. **NOTE:** *The NPDB must send a copy of the submitted report to the practitioner with a limited comment period in which to make changes or append comments.*

6. After submitting the required report(s) to the NPDB, forward a copy of the report(s) to this office. If you have any questions, do not hesitate to call me at 716-862-8519.

(Signature of Head of Review Panel)

cc: Chief Network Officer (10N)
VISN Officer (10N#)