

National Practitioner Data Bank

2004 Annual Report



U.S. Department of Health and Human Services
Health Resources and Services Administration
Bureau of Health Professions
Practitioner Data Banks Branch

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2004 ANNUAL REPORT

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A Snapshot of the NPDB for 2004

The National Practitioner Data Bank (NPDB) receives reports of malpractice payments and adverse actions concerning health care practitioners. In 2004, the majority of reports for the NPDB were medical malpractice payments for physicians, dentists, and other licensed practitioners. Most reports for adverse actions were for State licensure actions. Adverse actions include: licensure actions, clinical privileges actions affecting a practitioner's privileges for more than 30 days, Medicare/Medicaid Exclusion actions, professional society membership disciplinary actions, actions taken by the DEA concerning authorization to prescribe controlled substances, and revisions to such actions. All of these must be reported to the NPDB if they are taken against physicians and dentists. Since 1997, the NPDB has also received reports of Medicare/Medicaid Exclusions taken against all types of health care practitioners.

Almost 9 out of 10 reports (85.2 percent) are original, initial reports submitted by reporters. Correction reports, which have been changed by entities to correct errors in previous reports, account for 11.1 percent of reports. Revision to Actions, which are reports concerning additional actions taken in relation to initially reported actions, account for 3.7 percent of reports. Revision to Actions may concern "non-adverse actions" such as reinstatements and reversals of previous actions.

Health care entities and agencies authorized by law can "query" to obtain copies of reports on specific practitioners. Queries increased after a small decrease last year. About 14.0 percent of queries in 2004 showed the practitioner had a reported medical malpractice payment or adverse action.

These facts and others are explained in the following snapshot of the NPDB for 2004. This snapshot gives the most important details about the contents of the NPDB, which has maintained records of State licensure, clinical privileges, professional society membership, Medical/Malpractice Exclusions, and Drug Enforcement Agency (DEA) actions taken against health care practitioners and malpractice payments made for their benefit since September 1, 1990. The NPDB at the end of 2004 contained reports on 364,296 adverse actions and malpractice payments involving 215,350 individual practitioners. Below in more detail are further significant facts about the NPDB in 2004 and cumulatively.

Most 2004 reports were Medical Malpractice Payment Reports, the majority of them for physicians: During 2004, 70.0 percent of all new reports received concerned malpractice payments; cumulatively, they comprised 73.6 percent of all reports. During 2004, physicians were responsible for 81.4 percent of Medical Malpractice Payment Reports, dentists 10.2 percent, and all other health care practitioners 8.5 percent. These figures are similar to percentages from previous years.

Medical Malpractice Reports decreased in 2004: The 17,696 Medical Malpractice Payment Reports received during 2004 are 6.8 percent less than the number of Malpractice Payment Reports received by the NPDB during 2003. This decrease comes after an increase of

0.2 percent in 2003. Medical malpractice payments represent 73.6 percent of all reports received cumulatively and 70.0 percent (17,696 of 25,275) of all reports received by the NPDB during 2004.

Adverse Action Reports¹, most for State licensure actions, increased in 2004: The 7,579 Adverse Action Reports (State licensure, clinical privileges, professional society membership, exclusions, and DEA actions) received during 2004 are 2.6 percent more than the number of Adverse Action Reports received by the NPDB during 2003. This increase comes after a decrease of 5.6 percent in 2003. The number of State Licensure Action Reports received increased 1.3 percent from 2003 to 2004. During 2004, State Licensure Action Reports comprised 53.3 percent of all Adverse Action Reports and Clinical Privileges Action Reports comprised 14.5 percent. Adverse actions represent 26.4 percent of all reports received cumulatively and 30.0 percent (7,579 of 25,275) of all reports received by the NPDB during 2004.

Entity requests for information from the NPDB (“queries”) grew 7 percent in 2004, and total cumulative queries were over 35 million: Over its existence the NPDB has responded to 35,458,411 inquiries ("queries") from authorized organizations such as hospitals and managed care organizations (HMOs, PPOs, etc.); State licensing boards; professional societies; and individual practitioners (who obtain a copy of their own records). From 2003 to 2004 entity query volume increased 7.3 percent, from 3,214,081 queries in 2003 to 3,448,514 queries in 2004. This increase followed a 1.2 decrease in queries from 2002 to 2003.

Most queries were voluntary and not required by law, and over half of voluntary queries came from Managed Care Organizations (MCOs): Hospitals are required by law to query. All other queries are voluntary. During 2004, 65.6 percent of queries were submitted by voluntary queriers; cumulatively well over half (60.2 percent) of the queries were voluntary. Of the voluntary queriers, MCOs were the most active, making 48.7 percent of all queries during 2004. Although they represented only 11.0 percent of all entities that had ever queried the NPDB, they had made 46.0 percent of all queries cumulatively. Over the NPDB’s existence the increase in voluntary queries has been much larger than the increase in mandatory hospital queries.

¹ “Adverse Action Reports” is a generic term for all licensure action, clinical privileges action, exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations (45 CFR Part 50) as well as reports for non-adverse “Revisions” (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

In 2004 about one out of seven queries showed the practitioner had a reported medical malpractice payment or adverse action: When a query is submitted concerning a practitioner who has one or more reports, a “match” is made, and the querier is sent copies of the reports. During 2004, 14.0 percent of all entity queries resulted in a match (484,040 matches). Cumulatively, the match rate is 11.5 percent (4,079,295 matches). No match on a query means a practitioner has no reports in the NPDB. Since the NPDB has been collecting reports since 1990, a non-match response indicating that a practitioner has no reported payments or actions is valuable to queriers as evidence the practitioner has had no medical malpractice payments or adverse actions for over 14 years.

Physicians, most of whom only have one report, were predominant in the NPDB: Of the 215,350 practitioners reported to the NPDB, 69.7 percent were physicians (including M.D.s and D.O.s residents and interns), 13.5 percent were dentists, 8.5 percent were nurses and nursing-related practitioners, and 2.8 percent were chiropractors. About two-thirds of physicians with reports (67.1 percent) had only one report in the NPDB, 85.7 percent had 2 or fewer reports, 97.3 percent had 5 or fewer, and 99.6 percent had 10 or fewer. Few physicians had both Medical Malpractice Payment Reports and Adverse Action Reports (not including Exclusion Reports). Only 5.7 percent had at least one report of both types.

Physicians had more reports per practitioner than any other practitioner group: Physicians had the highest average number (1.82) of reports per reported physician, and dentists, the second largest group of practitioners reported, had an average of 1.64 reports per reported dentist. Podiatrists and podiatric-related practitioners, who had 1.69 reports per reported practitioner, also had a high average of reports per practitioner as well as 6,717 total reports. Comparison between physicians and dentists and other types of practitioners, however, would be misleading since reporting of State licensure, clinical privileges, and professional society membership actions is required only for physicians and dentists.

Physicians had more than three-quarters of the malpractice payments in the NPDB: Physicians had 78.6 percent of the Malpractice Payment Reports cumulatively in the NPDB (267,948 reports), and they had 81.4 percent of payment reports in 2004 (14,396 reports). Physician Malpractice Payment Reports decreased by 5.8 percent from 2003 to 2004. This decrease followed a year of no increase or decrease in the number of payments for physicians in 2003 or compared to 2002. Dentists had 13.3 percent of Malpractice Payment Reports cumulatively in the NPDB (35,514 reports), and they had 10.2 percent of payment reports in 2004 (1,803 reports). Other practitioners had 8.1 percent of payment reports cumulatively (21,787 reports) and 8.5 percent of payment reports for 2004 (1,497 reports). Payments for dentists decreased by almost 20 percent in 2004.

Average medical malpractice payment amounts for physicians in 2004 were higher than in previous years: The median and mean medical malpractice payment amounts for physicians in 2004 were \$170,000 and \$298,460, respectively. Cumulatively since 1990 for physicians the median amount was \$100,000 (\$124,278 adjusting for inflation to standardize

payments made in prior years to 2004 dollars) and the mean amount was \$225,361 (approximately \$260,746 adjusting for inflation).²

Obstetrics-related medical malpractice payments for physicians continued to be higher than others, while miscellaneous payments were lower: During 2004, as in previous years, obstetrics-related cases, generating 8.1 percent of all 2004 physician Malpractice Payment Reports, had the highest median payment amounts (\$300,000). This median payment was \$10,000 more than in 2003. Equipment and product related incidents (0.4 percent of all reports) had the lowest median payments during 2004 (\$47,500).

Mean delay between an incident and its physician malpractice payment increased by a week: For 2004 physician medical malpractice payments, the mean delay between an incident that led to a payment and the payment itself was 4.61 years. This signifies an increase of 7 days from 2003. The 2004 mean physician payment delay varied markedly between the States, as in previous years, and ranged from 2.81 years in South Dakota to 6.69 years in Rhode Island.

Over half of the hospitals registered with the NPDB had not reported a clinical privileges action: Of those hospitals currently in “active” registered status with the NPDB, 52.7 percent of the hospitals had never submitted a Clinical Privileges Action Report. This percentage has steadily decreased over the years. Additionally, over the history of the NPDB, there were nearly four times more State Licensure Action Reports than Clinical Privileges Action Reports. Clinical privilege reporting seemed to be concentrated in a few facilities even in States with comparatively high overall hospital clinical privileging reporting levels. The Health Resources and Services Administration (HRSA) continues its efforts to examine the low level of clinical privilege reporting.

Most reports were not disputed by practitioners: A practitioner about whom a report has been filed may dispute either the accuracy of the report or the fact that the report should have been filed. At the end of 2004, 3.9 percent (2,048) of all State Licensure Action Reports, 13.8 percent (1,854) of all Clinical Privileges Action Reports, and 3.4 percent (9,191) of all Malpractice Payment Reports in the NPDB were in dispute.

Few practitioners requested Secretarial Reviews, most of which were for adverse actions: If the disagreement (dispute) is not resolved between the practitioner and the reporter, the practitioner may ultimately request a review of the report by the Secretary of Health and Human Services. Only a few practitioners who disputed reports also requested Secretarial Review; there were 64 requests out of 13,420 disputed reports for Secretarial Review during 2004. Adverse actions comprised 78.1 percent of all 2004 requests for Secretarial Review and 63.55 percent of all requests cumulatively for Secretarial Review. This was in sharp contrast to

²Generally for malpractice payment data the median is a better indicator of the “average” or typical payment than is the mean since the mean is skewed by a few very large payments. Inflation adjustment is based on the seasonally adjusted CPI-U U.S. City Average, All Items, as published by the U.S. Department of Labor, Bureau of Labor Statistics.

the 30.0 percent of all reports represented by adverse actions in 2004 and the 26.4 percent of all Adverse Action Reports cumulatively.

Most Secretarial Review requests resulted in the report staying in the NPDB: Cumulatively, 16.8 percent, or 285 out of 1,698 cumulative requests for Secretarial Review, had resulted in positive outcomes for practitioners (which included the request being closed by an intervening action such as submission of a corrected report by the reporting entity, the Secretary changing the report, and the Secretary voiding the report). If the Secretary believes that a report should be corrected the reporting entity is asked to submit a correction. The Secretary changes reports only if the reporting entity fails to do so. Of the 64 requests for Secretarial Review received in 2004, 35 cases were resolved this year. Of these resolved requests, 13 were closed by intervening action (such as submission of a corrected report by the reporting entity). None were voided and none were closed because the practitioner did not pursue review. The rest were unchanged and maintained as submitted.

The NPDB's Policies, Operations, and Improvements

The NPDB Program: Protecting the Public

The National Practitioner Data Bank (NPDB) has an important mission established by law – protecting the public by restricting the ability of unethical or incompetent practitioners to move from State to State without disclosure or discovery of previously damaging or incompetent performance. The following explains how this mission is accomplished and the rules and regulations under which the NPDB operates.

The NPDB and its mission were established by a law that also encourages the use of peer review: The National Practitioner Data Bank (NPDB) was established to implement the *Health Care Quality Improvement Act of 1986, Title IV of P.L. 99-660*, as amended (the *HCQIA*). Enacted November 14, 1986, the Act authorized the Secretary of Health and Human Services to establish a national data bank, the NPDB.

The *HCQIA* also includes provisions encouraging the use of peer review. Peer review bodies and their members are granted immunity from private damages if their review actions are conducted in good faith and in accordance with established standards. However, entities found not to be in compliance with certain NPDB reporting requirements may lose immunity for three years.

A division of the Federal government administers the NPDB and a contractor operates it, with input from an outside committee: During 2004 the Practitioner Data Banks Branch (PDBB) of the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr), Office of Workforce Evaluation and Quality Assurance (OWEQA) was responsible for administering and managing the NPDB program. The PDBB was formerly the Division of Practitioner Data Banks. The NPDB itself is operated by a contractor, SRA International, Inc. (SRA), which began doing so in June 1995.³ SRA created the Integrated Querying and Reporting Service (IQRS), an Internet reporting and querying system for the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB)⁴.

³SRA replaced Unisys Corporation, which had operated the NPDB from its opening on September 1, 1990.

⁴The Healthcare Integrity and Protection Data Bank (HIPDB) is a flagging system run by the Federal government to flag or identify health care practitioners, providers, and suppliers involved in acts of health care fraud and abuse. The HIPDB includes information on final adverse actions taken against health care practitioners, providers, or suppliers. Information is restricted to Federal and State government agencies and health plans. The NPDB and HIPDB are both operated under the direction of the PDBB, and entities report to and query both data banks through the same Web site at www.npdb-hipdb.com.

An Executive Committee provides health care expertise for SRA on operations matters. The committee includes approximately 30 representatives from various health professions, national health organizations, State professional licensing bodies, malpractice insurers, and the public. It usually meets two times a year with both SRA and PDBB personnel.

The NPDB receives information about five different types of actions taken against practitioners: The NPDB is a central repository of information about: (1) malpractice payments made for the benefit of physicians, dentists, and other health care practitioners; (2) licensure actions taken by State medical boards and State boards of dentistry against physicians and dentists; (3) professional review actions primarily taken against physicians and dentists by hospitals and other health care entities, including health maintenance organizations, group practices, and professional societies; (4) actions taken by the Drug Enforcement Administration (DEA), and (5) Medicare/Medicaid Exclusions.⁵ Information is collected from private and government entities, including the Armed Forces, located in the 50 States and all other areas under U.S. jurisdiction.⁶

The NPDB's information is accessible to certain health care entities and licensing boards for specific reasons: NPDB information is made available upon request to registered entities eligible to query (State licensing boards, professional societies, and other health care entities that conduct peer review, including HMOs, PPOs, group practices, etc.) or required to query (hospitals). These entities query about practitioners who currently have or are requesting licensure, clinical privileges, affiliation, or professional society membership.

The NPDB's information alerts health care organizations receiving it that they may want to look closer at a practitioner's record: The NPDB's information alerts querying entities of possible problems in a practitioner's past so they may further review a practitioner's background as needed. The NPDB augments and verifies, not replaces, other sources of information. It is a flagging system only, not a system designed to collect and disclose full records of reported incidents or actions. It also is important to note the NPDB does not have information on adverse actions taken or malpractice payments made before September 1, 1990, the date it opened. As reports accumulate over time, the NPDB's information becomes more extensive, and therefore more valuable.

NPDB information helps health care organizations make good licensing and credentialing decisions: Although the *HCQIA* does not allow release of practitioner-specific NPDB information to the public, the public does benefit from it. Licensing authorities and peer reviewers get information needed to identify possibly incompetent or unprofessional physicians,

⁵Hospitals and other health care entities also may voluntarily report professional review (clinical privileges) actions taken against licensed health care practitioners other than physicians and dentists.

⁶In 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, Guam, and the Northern Mariana Islands.

dentists, and other health care practitioners. They can use this information to make better licensing and credentialing decisions that protect the public.

The NPDB research program and public use file helps improve health care through analysis of data: In addition, to help the public better understand medical malpractice and disciplinary issues, the NPDB responds to individual requests for statistical information, conducts research, publishes articles, and presents educational programs. A Public Use File containing selected information from each NPDB report also is available.⁷ This file can be used to analyze statistical information. For example, researchers could use the file to compare malpractice payments made for the benefit of physicians to those made for physician assistants in terms of numbers and dollar amounts of payments, and types of incidents leading to payments. Similarly, health care entities could use the file to identify problem areas in the delivery of services so they could target quality improvement actions toward them.

The NPDB receives required reports on “adverse” actions: Adverse Action Reports⁸ must be submitted to the NPDB in several circumstances.

- When a State medical board or State board of dentistry takes certain licensure disciplinary actions, such as revocation, suspension, voluntary surrender while under investigation, or restriction of a license, for reasons related to a practitioner's professional competence or conduct, a report must be sent to the NPDB. Revisions to previously reported actions also must be reported.
- When a hospital, HMO, or other health care entity takes certain professional review actions that adversely affect for more than 30 days the clinical privileges of a physician or dentist, or when a physician or dentist voluntarily surrenders or restricts his or her clinical privileges while being investigated for possible professional incompetence or improper professional conduct or in return for an entity not conducting an investigation or reportable professional review action. Revisions to previously reported actions also must be reported. Clinical privileges actions also may be reported for health care practitioners other than physicians and dentists, but it is not required; revisions to these actions must be reported.
- When a professional society takes a professional review action based on reasons related to professional competence or professional conduct that adversely affects a physician's or a dentist's membership, that action must be reported. Revisions to previously reported

⁷Information identifying individual practitioners, patients, or reporting entities other than State licensing boards is not released to the public in either the Public Use File or in statistical reports. The Public Use File may be obtained from the NPDB Web site at www.npdb-hipdb.com. A detailed listing of the numbers and values for each variable is also available at www.npdb-hipdb.com.

⁸ “Adverse Action Reports” is a generic term for all licensure action, clinical privileges action, Exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse “Revisions” (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

actions also must be reported. Such actions also may be reported for health care practitioners other than physicians or dentists.

- When the DEA revokes or receives voluntary surrenders by practitioners of DEA registration “numbers,” which is reported under the Memorandum of Understanding (MOU) between the U.S. Department of Health and Human Services and the DEA.
- When HHS excludes a practitioner from Medicare or Medicaid reimbursement. The Exclusion Action is also published in the Federal Register and posted on the Internet. Placing the information in the NPDB makes it conveniently available to queriers, who do not have to search the Federal Register or the Internet to find out if a practitioner has been excluded from participation in these programs.

The NPDB receives required reports on malpractice payments: Medical Malpractice Payment Reports must be submitted to the NPDB when an entity (but not a practitioner out of his or her personal funds⁹) makes a payment for the benefit of a physician, dentist, or other health care practitioner in settlement of, or in satisfaction in whole or in part of, a claim or judgment against that practitioner.

Certain health care entities can request information from the NPDB: Hospitals, certain health care entities, State licensure boards, and professional societies may request information from (“query”) the NPDB. Hospitals are required to routinely query the NPDB. A hospital also may query at any time during professional review activity. Malpractice insurers cannot query the NPDB.¹⁰ In all cases, an entity may query only on practitioners who are applicants, current licensees, staff members, or professional society members.

A hospital *must* query the NPDB:

- When a physician, dentist, or other health care practitioner applies for medical staff appointments (courtesy or otherwise) or for clinical privileges at the hospital; and
- Every 2 years (biennially) on all physicians, dentists, and other health care practitioners who are on its medical staff (courtesy or otherwise) or who hold clinical privileges at the hospital.

Other eligible entities *may* request information from the NPDB:

⁹Self-insured practitioners originally reported their malpractice payments. However, on August 27, 1993, the U.S. Court of Appeals for the D.C. Circuit reversed the December 12, 1991, Federal District Court ruling in *American Dental Association, et al., v. Donna E. Shalala*, No. 92-5038, and held that self-insured individuals were not “entities” under the *HCQIA* and did not have to report payments made from personal funds. All such reports have been removed from the NPDB.

¹⁰Self-insured health care entities may query for peer review but not for “insurance” purposes.

- Boards of medical or dental examiners or other State licensing boards may query at any time.
- Other health care entities, including professional societies, may query when entering an employment or affiliation relationship with a practitioner or in conjunction with professional review activities.

The NPDB also may be queried in two other circumstances:

- Physicians, dentists, or other health care practitioners may "self-query" the NPDB about themselves at any time. Practitioners may not query to obtain records of other practitioners.
- A plaintiff or an attorney for a plaintiff in a malpractice action against a hospital may query and receive information from 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 to the NPDB on the practitioner. If the attorney or plaintiff specifically demonstrated the hospital failed to query as required, the attorney or plaintiff will be provided with information the hospital would have received had it queried.

Fees for requests for information (queries) are used to operate the NPDB, which is self-supporting: As mandated by law, user fees, not taxpayer funds, are used to operate the NPDB. The NPDB fee structure is designed to ensure the NPDB is self-supporting. All queriers must pay a fee for each practitioner about whom information is requested. July 1, 2003, the query fee was reduced to \$4.25 from \$5.00. Self-queries, which are more expensive to process because they require some manual intervention, cost a total of \$16 for both the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB). Self-queries must be submitted to both data banks to ensure that queriers receive complete information on all NPDB-HIPDB reports. All query fees must be paid by credit card at the time of query submission or through prior arrangement using automatic electronic funds transfer (EFT).

NPDB information about practitioners is confidential and available to users for only specific reasons: Under the terms of the *HCQIA*, NPDB information that permits identification of particular practitioners or entities is confidential. The HHS has designated the NPDB as a confidential "System of Records" under the Privacy Act of 1974. Authorized queriers who receive NPDB information must use it solely for the purposes for which it was provided. Any person violating the confidentiality of NPDB information is subject to a civil money penalty of up to \$11,000 for each violation.

Criminal penalties punish those who disclose or report information under false pretenses: The *HCQIA* does not allow the NPDB to disclose information on specific practitioners to medical malpractice insurers or the public. Federal statutes provide criminal and civil penalties, including fines and imprisonment, for individuals who knowingly and willfully query the NPDB under false pretenses or who fraudulently gain access to NPDB information.

There are similar criminal penalties for individuals who knowingly and willfully report to the NPDB under false pretenses.

Practitioners receive copies of reports and may add personal statements to their reports: Reports to the NPDB are entered exactly as received from reporters. To ensure accuracy, each practitioner reported to the NPDB is notified a report has been made and is provided a copy of it. Since March 1994, the NPDB has allowed practitioners to submit a statement expressing their views of the circumstances surrounding any report concerning them. The practitioner's statement is disclosed along with the report.

Practitioners may dispute or ask for Secretarial Review of their reports: If a practitioner decides to dispute the report's accuracy in addition to or instead of filing a statement, the practitioner is requested to notify the NPDB that the report is being disputed. The report in question is then noted as under dispute when released in response to queries. The practitioner also must attempt to work with the reporting entity to reach agreement on correction or avoidance of a disputed report. If a practitioner's concerns are not resolved by the reporting entity, the practitioner may ask the Secretary of Health and Human Services to review the disputed information. The Secretary then makes the final determination whether a report should remain unchanged, be modified, or be voided and removed from the NPDB.

Federal agencies and health care entities participate in the NPDB program under Memoranda of Understanding (MOUs): Section 432(b) of the Act prescribes that the Secretary shall seek to establish an MOU with the Secretary of Defense and with the Secretary of Veterans Affairs to apply provisions of the Act to hospitals, other facilities, and health care providers under their jurisdictions. Section 432(c) prescribes that the Secretary also shall seek to enter into an MOU with the Administrator of the U.S. Department of Justice, Drug Enforcement Administration (DEA) concerning the reporting of information on physicians and other practitioners whose registration to dispense controlled substances has been suspended or revoked under Section 304 of the Controlled Substances Act.

The Secretary signed an MOU with the U.S. Department of Defense (DOD) September 21, 1987, with the DEA on November 4, 1988 (revised on June 19, 2003), and with the U.S. Department of Veterans Affairs (VA) November 19, 1990. In addition, MOUs with the U.S. Department of Transportation, U.S. Coast Guard and with the U.S. Department of Justice, Bureau of Prisons were signed June 6, 1994 and August 21, 1994, respectively. Policies under which the Public Health Service participates in the NPDB were implemented November 9, 1989 and October 15, 1990.

Medicare/Medicaid Exclusions have been reported under an agreement since 1997: Under an agreement between HRSA, the Center for Medicaid and Medicare Services (CMS), and the Office of Inspector General (OIG), Medicaid and Medicare Exclusions were placed in the NPDB in March 1997 and have been updated periodically. Reinstatement reports were added in October 1997. The initial reports included all Exclusions in effect as of the March 1997 submission date to the NPDB regardless of when the penalty was imposed.

The NPDB: Proven Successful in Influencing Licensing and Privileging of Health Care Practitioners

The National Practitioner Data Bank (NPDB) in 2003 received a high grade from both users who obtain information from (queriers) and users who submit information to (reporters) the NPDB in a recent customer satisfaction survey. The 2003 American Customer Satisfaction Index (ACSI) scores for the NPDB are 78 for queriers and 76 for reporters, on a 0-100 scale. The scores for both NPDB queriers and reporters are considerably higher than the current Federal Government-wide ACSI 2003 score of 71. The survey, the ACSI, is a uniform, cross-industry quarterly index of private and public sector customer satisfaction. It was adopted as the “gold standard” measure for Federal government agencies in 1999, and it is internationally accepted and used in more than 20 countries.

The NPDB score ranks among the highest Federal agency scores, except for those agencies involved in providing direct payments of benefits. Federal agencies the NPDB scored higher than include the U.S. General Services Administration’s Federal Supply Service with a score of 77; the U.S. Department of Labor, Bureau of Labor Statistics with a score of 74; and the U.S. Department of State’s Web site with a score of 72.

The NPDB’s score is also higher than most private sector scores. The private sector average was 74.4. The average for the hospital industry was 76.

An ACSI survey was also taken in 2002 for the Healthcare Integrity and Protection Data Bank (HIPDB), which helps prevent health care fraud and abuse by collecting and disclosing certain adverse actions, such as losses of licenses and health care related criminal convictions and civil judgments, involving health care practitioners, providers, and suppliers.

The NPDB score for queriers is comparable to the HIPDB queriers' 2002 score of 76, and the NPDB score for reporters is significantly higher than the HIPDB reporters' score of 68 for 2002.

The ACSI scores for queriers and reporters are derived from customer responses to three questions dealing with overall satisfaction with the NPDB, each of which is given a score:

- How satisfied are you with the programs and services provided by NPDB? (a score of 82 for querying; a score of 80 for reporting);
- To what extent have the programs and services provided by the NPDB met your expectations? (a score of 78 for querying; a score of 76 for reporting);

- How well do you think NPDB compares with an ideal system for querying (or reporting)? (a score of 73 for querying; a score of 72 for reporting).

Many surveyed quierers found the NPDB convenient to use (a score of 88) with a staff that helpfully answered their questions (a score of 84). Customers rated the NPDB's EFT/Credit card payment method an 88, the timeliness of query responses an 89, and query information meeting their needs an 86. Several of those surveyed would also recommend the NPDB for querying, giving this activity a score of 79.

Many surveyed reporters found reporting to the NPDB to be easy (a score of 80) with a staff that helpfully answered their questions (81). Customers rated the ease of using the IQRS system an 82; the ease of obtaining required information an 80; and the amount of information needed a 77.

The NPDB is working on several improvements that address some of the survey's results, some of which showed a need for clearer guidance about reporting and querying. The PDBB is working on revising the NPDB Guidebook and preparing more informational materials to make regulations clearer to NPDB users. The NPDB is also considering a Proactive Disclosure Service (PDS), a service where quierers would be notified of new reports naming any of their registered practitioners as subjects when reports are received by the data banks.

For more information on the NPDB-HIPDB, visit www.npdb-hipdb.com. For more information on the ACSI, visit www.customerservice.gov. The Web site's Federal agency ACSI scores for 2003 do not include the NPDB because its survey was completed after the deadline for inclusion. As a result, the NPDB will be included in the 2004 ACSI scores, although the survey was taken in 2003.

The NPDB Improves Its Operations and Policies in 2004

In 2004 the Practitioner Data Banks Branch (PDBB), the government organization which administers the National Practitioner Data Bank (NPDB), was recognized with the Health Resources and Services Administration Administrator's Group Performance Award for Outstanding Achievement. The PDBB staff received the award at the HRSA Awards Ceremony in December 2004.

The PDBB was formerly known as the Division of Practitioner Data Banks (DPDB). As part of the Bureau of Health Professions (BHP) reorganization, the DPDB was renamed and made a part of the Office of Workforce Evaluation and Quality Assurance (OWEQA). The reorganization did not affect PDBB's responsibility to administer the data banks.

The NPDB also experienced an increase in NPDB query volume, which may be a result of long term care facilities required querying. Long term care facilities, which are subject to new JCAHO guidelines, were notified during the year of their obligation to query and report to the data banks.

The following improvements were made to the NPDB system and Web site in 2004:

- Improvements suggested by Integrated Querying and Reporting Service (IQRS) users through the IQRS User Review Panel (URP) were implemented, including the ability to retrieve historical summaries of their queries and reports, limited to 1-year increments within 4 years from the search date. Users are able to search historical organization queries or reports by a specific organization name within a specified date range.
- Shortening and making more concise query response documents, a URP suggestion, was also implemented. Query responses are now 1-page, re-organized and consolidated, reducing paperwork and providing match/no match information as the first item in the response.
- The NPDB self-query for practitioners was reduced from \$10.00 to \$8.00, effective July 1, 2004.
- A new section on the IQRS User Account Information screen, entitled *Query Response Preference*, was developed. It allows users to specify how they wish to receive multi-name query responses, including bundling them to make it easier to view and print the results of large multi-name queries.
- The IQRS offered enhanced subject database import functionality, which allows entities to add a large number of subjects into their IQRS subject database, in fixed-width or XML file format. Some of the enhancements include: providing users with detailed information on what occurs during an import of information into the entity's IQRS subject database, allowing users to cancel the import after it is initiated, displaying a high-level summary of the subject database imports

performed within the last 30 days, giving users the ability to update and delete subject data imported into the subject database, permitting users to import organization subjects, and introducing a new Subject ID# field for the entity's personal use.

- The IQRS was enhanced to allow users to resolve potential duplicate subjects in their subject database. When the IQRS detects a potential duplicate subject, a warning alerts the user. New database sorting and subject deletion functions have also been added.
- The Medical Malpractice Payment Report (MMPR) Form was revised, increasing the specificity of the information the report provides to queriers.
- The IQRS migrated to a new credit card billing interface, Pay.gov, a Government-wide transaction portal sponsored by U.S. Department of the Treasury, Financial Management Service (FMS).
- The NPDB now accepts American Express in addition to Master Card, Visa, and Discover.
- Security enhancements were made to protect the integrity of Data Bank information, including allowing only the Customer Service Center to reset IQRS account passwords.
- The “What’s New” information page was regularly updated to keep users informed and various new publications, such as NPDB-HIPDB Newsletters, were added when they were published.
- The user interface continued to be improved. The Web site was updated to make it easier for customers to find information, which was provided using straightforward terminology.
- The IQRS quality of service was enhanced through a software architecture upgrade.

Beyond operations improvements, the NPDB had several successful policy-related accomplishments in 2004. For example, the NPDB took major efforts to ensure compliance with reporting requirements. The NPDB staff also attended and presented at several credentialing and health care organization meetings, and developed publications publicizing the data bank's mission, requirements, and achievements.

- Proactive Disclosure Service (PDS) – The NPDB-HIPDB is considering a service where queriers would be notified of new reports naming any of their registered practitioners as subjects when reports are received by the data banks. Credentialing organizations such as NCQA, URAC, and JCAHO were consulted about implementing the PDS and they gave positive feedback about the service. In follow-up meetings in several major cities in the United States, attendees have indicated a positive interest in the proposed PDS program. Possible design and pricing options of this service are being considered, but no decision has been made as to whether such a system will be implemented.
- Secretarial Review – The PDBB Secretarial Review team created a letter explaining to practitioners “what to submit” and “what not to submit” in support of requests for dispute

resolution of NPDB reports. This letter is included with notifications that the NPDB has received a practitioner's request for Secretarial Review. The letter is meant to help practitioners send only materials that are relevant to their case and which can be considered by Dispute Resolution Managers.

- Health Plan Letter – The NPDB sent a letter to health plans advising them about their responsibilities regarding reporting and querying the Data Banks. The NPDB received a good response to this letter and provided advice to health plans that needed more information.
- Brochures – The brochure, “NPDB: A Success Story” brochure, was updated for a reprint of 5,000 copies. The brochure includes updated reporting and querying statistics and information, and it will be distributed by the NPDB to entities at conferences and on the NPDB-HIPDB Web site. Another brochure, “The Practitioner’s Guide to the Data Banks: A Road Map for Physicians, Dentists, and Other Health Care Practitioners,” was published in early 2004 and distributed to State boards and practitioners. The brochure explains how practitioners can self-query the NPDB-HIPDB, correct errors in NPDB-HIPDB reports, and dispute reports.
- Articles – Several articles explaining the NPDB and HIPDB were published in health care organization newsletters and magazines. They include: two articles for the NAMSS newsletter “Synergy” discussing NPDB and HIPDB rules for reporting and querying; two articles about reporting and statistics for speech-language pathologists and audiologists in the newsletter for the National Council of State Boards of Examiners for Speech-Language Pathology and Audiology; an article, “Data Banks: A Resource in Improving Quality of Care,” published in “Healthplan” magazine, which is published by the AAHP-HIAA; and an article titled, “What Hospitals and Medical Staff Should Know about Reporting to the NPDB: A Health Lawyer’s Primer,” for the American Health Lawyers Association Peer Review/Hospital Credentialing Practice Group newsletter.
- Hospitals – Hospitals listed in the “American Hospital Association Guidebook” continued to be checked for registration in the NPDB. Unregistered hospitals were contacted and made aware of their requirements to query and report to the data banks. As a result, hospitals in several States registered with the data banks or provided their Data Bank Identification Number (DBID) to the PDBB, demonstrating that they were registered under another name.
- Outreach – NPDB staff presented at or exhibited materials at the conferences of several organizations, as well as discussed NPDB issues with representatives of several organizations. This included a presentation on the Data Banks at the *European Union Health Care Professionals Crossing Borders Conference* in Amsterdam. Twenty-eight countries were represented at the December meeting, which had the aim of seeking practical ways of exchanging information on health care professionals among member states in the light of quality control of health care. Other groups NPDB staff presented to included the U.S. Air Force, National Council of State Boards of Nursing (NCSBN), National Credentialing Forum (NCF), American Association of Nurse Attorneys, America’s Health Insurance Plans (AHIP), California Association of Medical Staff Services (CAMSS), Michigan Association of Medical Staff

Services (MI AMSS), National Association of Medical Staff Services, National Committee for Quality Assurance (NCQA), Joint Commission for Accreditation of Healthcare Organizations (JCAHO), Florida Department of Public Health, American Accreditation HealthCare Commission (URAC), American Osteopathic Association – Health Care Facility Accreditation Program (HFAP), Centers for Medicare and Medicaid Services (CMS), and Federation of State Medical Boards (FSMB). These contacts greatly promoted the NPDB’s missions and helped increase compliance with reporting and querying requirements.

- Agency for Healthcare Research and Quality (AHRQ) – On November 8 and 9, 2004, PDBB staff, along with staff from the Agency for Healthcare Research and Quality, facilitated a working meeting entitled “*Quality and Patient Safety in Managed Care Organizations: Whose Responsibility Is It, Anyway?*” The meeting was convened in response to a recommendation by an HHS OIG report that HRSA and AHRQ jointly convene a conference to discuss MCO quality improvement issues. The 15 participants, representing a broad group of health care organizations, met to develop a consensus on MCOs’ responsibility for health care quality and patient safety. It was also charged with developing real-world recommendations that could be implemented within 4 years to improve health care quality for MCOs and the health care system as a whole. A report to the OIG and the public is being developed, reflecting the thinking and goals of the participants.
- Malpractice Payment Reporting – A comparison was made of NPDB report information to 2001 and 2002 data from National Association Insurance Commissioners (NAIC). NAIC data provides information for total amount paid and the total number of payments made for medical malpractice by insurance companies. As a result of the comparison, letters were sent to specific insurance companies asking for information on their reporting and the NPDB received additional Medical Malpractice Payment Reports.
- Compliance – *The Health Care Fraud Report*, *Health Law Reporter*, and *Medical Malpractice Newsletters* were reviewed to find any and all situations that involved actions that should be reported to the NPDB and HIPDB. Actions not reported were investigated by PDBB staff for compliance to NPDB reporting requirements.
- State Boards – NPDB staff called State dental and medical boards to confirm that the boards were continuing to report to the data banks. Those State boards that were late or found not to be in compliance with *HCQIA* regulations were sent letters notifying them of their reporting obligations and consequences for not reporting.
- Sanctions – The HHS Office of Inspector General (OIG) reached a monetary settlement in the amount of \$10,000 with a hospital that was accused of violating the NPDB’s confidentiality provisions. The OIG accused the hospital of improperly querying twice on a physician on which it was not entitled to query and disclosing confidential NPDB information about this physician to a formal employee. The OIG also alleged that the hospital violated the NPDB regulations when it failed to update the original Adverse Action Report (AAR) it had submitted to the NPDB regarding this physician.

- Reporting Multiple Actions – NPDB staff sent a letter to State boards explaining the proper way to submit reports from one Board order that have multiple action and/or basis for action codes. Boards must submit one report for each Board order, using up to five adverse action codes and up to five bases for action codes. They should include a Description of Act(s) or Omission(s) or Other Reasons for Action to explain the circumstances.

The following are research activities and achievements that the NPDB accomplished in 2004. They include activities directed at enhancing the accuracy of data in the NPDB.

- Duplicate Reports – NPDB staff worked on identifying and cleaning up reports for medical malpractice payments, clinical privileges actions, and exclusion or debarment actions that appeared to be duplicates, i.e. reports submitted by the same entity, for the same practitioner, for the same adverse action date. Reports or samples of reports from SRA were critically analyzed to identify which duplicate reports should be corrected, revised, deleted, or maintained in the Data Banks as Initial Reports.
- Report Clean-Up – NPDB staff re-coded Basis for Action and Adverse Action write-ins designated as “Other” in the narratives of reports submitted to the NPDB. NPDB staff also worked on cleaning up reports in which the States submitting the reports were different from any of the States listed as States for the practitioner’s licensure.

Types of Reports: Medical Malpractice Payments

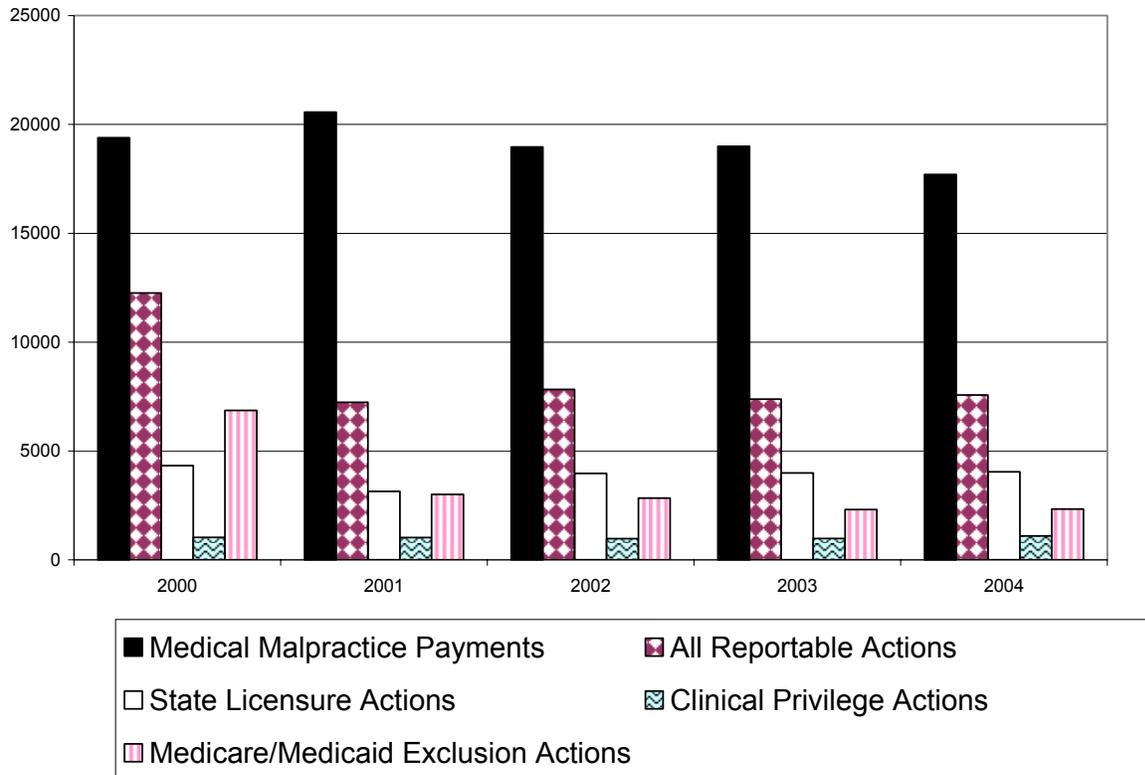
Malpractice Payment Reports Continue to Remain the Majority in the NPDB

Each year, Medical Malpractice Payment Reports represent the greatest proportion of reports contained in the NPDB, as shown in Figure 1. Although only physicians and dentists must be reported to the NPDB if an adverse action (except for Exclusions, which are reported for all health care practitioners) is taken against them, all licensed health care practitioners must be reported to the NPDB if a malpractice payment is made for their benefit.¹¹ The following narratives give details about the nature of these reports, including their number, their distribution among dentists, physicians and other practitioners, and variations in payment amounts and delays. For more information on malpractice reporting, see Tables 1 through 3 in the statistical section of this Annual Report.

Seven out of ten reports were malpractice payments: Cumulative data show that at the end of 2004, 73.6 percent of all the NPDB's reports concerned malpractice payments. During 2004, the NPDB received 17,696 such reports (70.0 percent of all reports received). Cumulatively, physicians were responsible for 210,647 malpractice payment reports (78.6 percent), dentists were responsible for 35,514 reports (13.3 percent), and all other types of practitioners were responsible for 21,787 reports (8.1 percent).

¹¹Allopathic physicians; allopathic interns and residents; osteopathic physicians; and osteopathic physician interns and residents are all considered physicians for statistical purposes. Dentists and dentist residents are considered dentists for statistical purposes. For statistical purposes, the "other" category includes all remaining practitioner types which may be or have been reported to the NPDB: pharmacists; pharmacists (nuclear); pharmacy assistants; registered (professional) nurses; nurse anesthetists; nurse midwives; nurse practitioners; advanced practice nurses; clinical nurse specialists; licensed practical or vocational nurses; nurses aides; home health aides (homemakers); psychiatric technicians; dieticians; nutritionists; EMT, basic; EMT, cardiac/critical care; EMT, intermediate; EMT, paramedic; social workers; podiatrists; psychologists; clinical psychologists; school psychologists; psychological assistants, associates or examiners; audiologists; art/recreation therapists; massage therapists; occupational therapists; occupational therapy assistants; physical therapists; physical therapy assistants; rehabilitation therapists; speech/language pathologists; medical technologists; nuclear medicine technologists; cytotechnologists; radiation therapy technologists; radiologic technologists; acupuncturists; athletic trainers; chiropractors; dental assistants; dental hygienists; denturists; homeopaths; medical assistants; mental health counselors; midwives, lay (non-nurse); naturopaths; ocularists; opticians; optometrists; orthotics/prosthetics fitters; physician assistants; physician assistants, osteopathic; perfusionists; podiatric assistants; professional counselors; professional counselors (alcohol); professional counselors (family/marriage); professional counselors (substance abuse); respiratory therapists; respiratory therapy technicians; and any other type of health care practitioner which is licensed in one or more States.

Figure 1: Number and Type of Reports Received by the NPDB (2000-2004)



Medical Malpractice Payment Reports, including those for physicians, decreased in number in 2004: The number of malpractice payments reported in 2004 (17,696) decreased by 6.8 percent from the number reported during 2003 (18,996). The 2004 total represents a 13.9 decrease from 2001. In 2004 physician malpractice payments decreased by 5.8 percent from 2003 to 2004. Dentist malpractice payments decreased by 19.7 percent and “other practitioners” malpractice payments increased by 1.7 percent.

Malpractice Payments: Physicians

Physicians have about four-fifths of the Medical Malpractice Payment Reports in the NPDB. They make up the majority of practitioners reported to the NPDB and that are queried on the most by entities. The following describes the information the NPDB contains on them. For more information about this reporting, see Tables 3 through 5 in the statistical section of this Annual Report.

Physicians were responsible for 8 out of 10 Malpractice Payment Reports:

Cumulatively, physicians were responsible for 210,647 (78.6 percent) of the NPDB's Malpractice Payment Reports. The number of physician malpractice payments reported decreased by 5.8 percent from 2003 to 2004. During 2004, physicians were responsible for 14,396 Malpractice Payment Reports (81.4 percent of all Malpractice Payment Reports received during the year).

Behavioral health related equipment or product related, and miscellaneous incidents for physicians had both few reports and low payments: During 2004, incidents relating to miscellaneous and equipment or product related incidents had the lowest median payments (\$70,000 and \$47,500, respectively). Equipment or product related incidents had the lowest mean payments (\$120,126) with behavioral health related incidents having the next lowest mean payment (\$177,244). There were only 207 miscellaneous reports, 62 equipment and product related reports, and 43 behavioral health related reports. Together they represented only 1.7 percent of all physician malpractice payments in 2004.

Obstetrics related incidents had the biggest mean payments and equipment or product related incidents had the largest median payments. Diagnosis related payments were the most reported for physicians in 2004: As in previous years, physicians' obstetrics-related cases (1,361 reports, 9.5 percent of all 2004 physician Malpractice Payment Reports) in 2004 had the highest mean payments (\$503,564) and the highest median payments (\$300,000) this year. In 2004, diagnosis related payments for physicians totaling 4,799 (33.3 percent of all physician 2004 payments) were the most frequently reported.

Obstetrics related incidents took the longest to resolve for physicians and equipment or product related cases settled the most quickly for physicians: The 1,361 obstetrics related physician payments in 2004 (9.5 percent of 2004 payments) had the longest mean delay between incident and payment (6.01 years) and the longest median delay (5.01 years). The shortest mean delay for 2004 physician malpractice payments was for equipment or product related cases (3.45 years). There were 62 such cases for physicians, representing 0.4 percent of all 2004 physician malpractice payments. The shortest median delay for 2004 physician payments was also for equipment or product related incidents (3.19 years).

The cumulative median and mean malpractice payment delays for physicians were 4.03 years and 4.76 years, respectively: Cumulatively, the mean payment delay for all

payments for physicians was 4.76 years and the median was 4.03 years. For 2004, the mean payment delay for all payments for physicians was 4.61 years and the median is 4.10 years.

Malpractice Payments: Nurses and Physician Assistants

Although physicians and dentists have the most Medical Malpractice Payment Reports in the NPDB, there are also many of these reports for nurses and physician assistants. There has been particular interest in both of these professions' reports, as shown in requests for information made to the PDBB, and the following describes the information the NPDB contains on them. The NPDB classifies registered nurses into five licensure categories: Nurse Anesthetist, Nurse Midwife, Nurse Practitioner, Clinical Nurse Specialist/Advanced Practice Nurse, and non-specialized Registered Nurse not otherwise classified, referred to in the tables as Registered Nurse¹². For more information about this reporting, see Tables 6 through 9 in the statistical section of this Annual Report.

Only about 1 out of 100 Malpractice Payment Reports were for nurses, most for other-classified RNs: All types of Registered Nurses have been responsible for 3,139 malpractice payments (1.2 percent of all payments) over the history of the NPDB. Non-specialized Registered Nurses were responsible for 62.7 percent of the payments made for nurses. Nurse Anesthetists were responsible for 20.7 percent of nurse payments. Nurse Midwives were responsible for 9.2 percent, Nurse Practitioners were responsible for 7.3 percent, and Advanced Nurse Practitioners were responsible for 0.2 percent of all nurse payments.

Reasons for nurse Malpractice Payment Reports varied depending on type of nurse: Monitoring, treatment, and medication problems were responsible for the majority of payments for non-specialized nurses, but obstetrics and surgery-related problems were also responsible for significant numbers of payments for these nurses. As would be expected, anesthesia-related problems were responsible for 83.4 percent of the 1,035 payments for Nurse Anesthetists. Similarly, obstetrics-related problems were responsible for 79.7 percent of the 459 Nurse Midwife payments. Diagnosis-related problems were responsible for 44.8 percent of the 368 payments for Nurse Practitioners. Treatment-related problems were responsible for another 23.9 percent of payments for these nurses. Of the eight reports for Clinical Nurse Specialists/Advanced Nurse Practitioners, five were for treatment-related problems, one was for an anesthesia-related problem, one was for a medication-related problem, and one was for a surgery-related problem.

Median nurse payment amounts were smaller than physicians', but mean nurse payment amounts were larger: The median and mean payment for all types of nurses in 2004 was \$100,000 and \$302,738 respectively. The median nurse payment was \$70,000 less than the median physician payment (\$170,000) but the mean nurse payment was \$4,278 larger than the

¹²The category of Advanced Practice Nurse was added in March 2001, but no reports for these practitioners were received until 2002. There were only eight reports for these practitioners, which does not impact the numbers of nurse payments as a whole significantly. The category was replaced with Clinical Nurse Specialists on September 9, 2002.

mean physician payment in 2004 (\$298,460). Similarly, the inflation-adjusted cumulative median nurse payment of \$101,392 was \$22,886 less than the \$124,278 inflation-adjusted cumulative median payment for physicians. The inflation-adjusted cumulative mean nurse payment of \$316,949 was \$56,203 larger than the inflation-adjusted cumulative mean physician payment of \$260,746. The mean payment amount for nurses was likely larger because there were relatively fewer nurse payments, which means one significantly large payment can impact the mean more than if there were more nurse payments. The median payment amount was more representative of typical payments.

There was a wide variation in States' nurse Malpractice Payment Reports compared to physicians' reports: Vermont had only 6 nurse Malpractice Payment Reports in the NPDB while New Jersey had the most (615). The ratio of nurse payment reports to physician payment reports (using adjusted figures¹³) for Vermont (with only 6 nurse payments) was one of the lowest in the nation at 0.01, but 8 States had only one nurse payment report for 100 or more physician payment reports. In contrast, the ratio for Alabama, which was the highest in the Nation, was 9 nurse payment reports for every 100 physician payment reports. Four other States also had ratios of 7 nurse payment reports for every 100 physician payment reports. There may be several explanations for differences in the ratio of payment reports for nurses and physicians, including possible differences in the ratio of nurses to physicians in practice in the State.

Physician Assistants had less than one percent of all Medical Malpractice Payment Reports, most of them for diagnosis-related problems: Physician Assistants have been responsible for only 912 malpractice payments since the opening of the NPDB (0.34 percent of all payments). Both cumulatively and during 2004, diagnosis-related problems were involved in about half of all Physician Assistant malpractice payments (55.8 percent cumulatively and 46.7 percent in 2004). Treatment-related payments were the second largest category both cumulatively and in 2004 (24.7 percent and 29.6 percent, respectively).

Payments in the diagnosis-related category for Physician Assistants were larger than treatment-related payments: Payments in the diagnosis category had a median payment amount of \$100,000 in 2004 and a cumulative inflation-adjusted median payment amount of \$103,215, while treatment-related payments had a median payment of \$67,500 for 2004 and a cumulative inflation-adjusted median payment of about \$35,052.

¹³ The "adjusted" number of reports accounts for those reports concerning payments made by State malpractice funds. These adjusted reports accounted for only 1.6 percent of nurse payment reports.

States Vary in Malpractice Payment Amounts and Times from Incident to Payments

States vary widely in the number of Medical Malpractice Reports for their practitioners, their mean and median medical malpractice amounts, and their “payment delay,” which is how long it takes to receive a malpractice payment after an incident occurs. The following narrative examines these differences in detail. For more information on malpractice reporting among the States, see Tables 10 through 13 in the statistical section of this Annual Report.

“Adjusted” numbers of Medical Malpractice Payment Reports helped to give a more realistic picture of States payment reports: To make the statistics more informative and realistic, this narrative relies on an “adjusted” number of Malpractice Payment Reports, which excludes reports for malpractice payments made by State malpractice funds. Nine States¹⁴ have or had such funds, and most, but not all, fund payments pertaining to practitioners practicing in these States.

Usually when payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner’s primary malpractice carrier. These funds sometimes make payments for practitioners reported to the NPDB as working in other States. Payments by the funds are excluded from the “adjusted” counts so malpractice incidents are not counted twice.

Although the “adjusted” number is the best available indicator of the number of distinct malpractice incidents which result in payments, it is an imperfect measure. Some State funds are also the primary insurer and only payer for some claims. Since these primary payments cannot be readily identified, they are excluded from the “adjusted” scores even though they are the only report in the NPDB for the incident. The “adjusted” counts also do not take into account insurers of last resort which, in most cases, provide primary coverage but which, in other cases, provide secondary coverage for payments over primary policy limits and report these over-limit payments.¹⁵

The ratio of physician payment reports to dental payment reports varied widely among the States: Nationally, using the adjustment described above, there was about one Medical Malpractice Payment Report for dentists for every six payments reports for physicians. In California, Utah, Washington, and Wisconsin, however, there was about one dentist payment report for about every three physician payment reports. In Mississippi, Montana, North

¹⁴Florida, Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina, and Wisconsin.

¹⁵Kansas is an example of a State in which the fund is the primary carrier in some cases; the Kansas fund is the primary carrier for payments for practitioners at the University of Kansas Medical Center. New York is an example of a State with an insurer of last resort which sometimes provides over-limits coverage but usually is a practitioner's primary insurer.

Carolina, and West Virginia there was less than 1 dental payment report for every 10 physician payment reports.

State reporting numbers can be affected by many settlements for a practitioner and delinquent reports: The number of reports in any given year in a State may be impacted by unusual circumstances, such as the settlement of a large number of claims against a single practitioner. For example, the high ratio of dental payment reports to physician payment reports in Utah was largely the result of a very large number of payment reports for one dentist during 1994. State report counts may also be substantially impacted by other reporting artifacts, such as a reporter submitting a substantial number of delinquent reports at the same time. Indiana reporting, for example, was impacted by the NPDB's receipt of delinquent reports during 1996 and 1997.

States' malpractice statutes affected medical malpractice payment reporting numbers: The number of payment reports in any given State was affected by the specific provisions of the malpractice statutes in each State. Statutory provisions may make it relatively easier or more difficult for plaintiffs to sue for malpractice and obtain a payment. For example, there are differences from State to State in the statute of limitations provisions governing when plaintiffs may sue. There also are differences in the burden of proof. Some States also limit payments for non-economic damages (e.g., pain and suffering). Caps on recovery of non-economic damages or other limitations on recoveries may reduce the number of claims filed by reducing the total potential recovery and the financial incentive for plaintiffs and their attorneys to file suit, particularly for children or retirees who are unlikely to lose earned income because of malpractice incidents. Plaintiffs with meritorious but complex cases may find it difficult to obtain representation because of legal limitations on attorney contingency fees. Sometimes changes in malpractice statutes may be responsible for changes in the number of payment reports within a State observed from year to year. Changes in State statutes, however, are unlikely to explain differences in reporting trends observed for physicians and dentists within the same State. For example, the number of physician payment reports in Georgia increased from 2000 to 2004 while the number of dentist payment reports decreased over the same period.

Median payment amounts for physician Medical Malpractice Payment Reports varied by thousands of dollars among the States: The cumulative, inflation-adjusted median physician malpractice payment for the NPDB was \$124,278 and the 2004 median payment was \$170,000. Illinois had the highest 2004 median payment of \$375,000. The lowest 2004 median was found in Utah at \$50,000. Next lowest, Alaska and California had a median payment of \$75,000, and Michigan, \$90,000.¹⁶ These numbers were not adjusted for the impact of State

¹⁶The California median payment for physicians is artificially impacted by a State law which requires reporting to the State only malpractice settlements of \$30,000 or more and all arbitration awards or court judgments in any amount. If a practitioner has three settlements in excess of \$30,000 in a ten-year period beginning on January 1, 2003, the fact that these settlements exist will be made public. During 2004, 120 (9.7 percent) of California physician's 1,243 malpractice payments were for \$29,999. Payments for \$29,999 are extremely rare in other States. Another 48 California payments were for exactly \$30,000, which is immediately below the actual reporting threshold, which required reporting of malpractice payments over \$30,000. When these categories are combined, fully 13.6 percent of California physician malpractice payments are within \$2.00 of the State reporting threshold. In addition to reporting of settlements of more than \$30,000, California law requires reporting of malpractice arbitration awards, judgments and settlements-after-judgment regardless of payment amount.

malpractice funds, which have the effect of lowering the observed mean and median payment. Because mean payments can be substantially impacted by a single large payment or a few such payments, a State's median payment is normally a better indicator of typical malpractice payment amounts.¹⁷

Mean “payment delays” for physician Medical Malpractice Payment Reports lower in 2004 than average “delays” over time: “Payment delay” is how long it takes to receive a malpractice payment after an incident occurs. For all physician Malpractice Payment Reports in the NPDB, the mean delay between incident and payment was 4.76 years. For 2004 payments, the mean delay was 4.61 years. Thus during 2004, payments were made on average about two months quicker than the average for all payments in the NPDB. The average physician payment came about seven days later than in 2003, which is a reversal of the previous trend toward quicker resolution of malpractice cases.

States varied widely in their “payment delays”: On average, during 2004 payments were made most quickly in South Dakota (a mean payment delay of 2.81 years) and California (3.26 years). Payments were slowest in Rhode Island (6.69 years).

¹⁷Half the payments are larger and half the payments are smaller than the median payments. For example, consider the following eleven malpractice payments, \$11,000; \$12,000; \$13,000; \$14,000; \$15,000; \$16,000; \$17,000; \$18,000; \$19,000; \$20,000 and \$1,000,000, the median payment is \$16,000. The mean of these payments (the total divided by the number of payments) is \$105,000. Clearly the median is a better representation of the typical or “average” payment for this data than is the mean.

Three Issues – Corporate Shield, Federal Entity Policies, and Physician Residents – Affect Malpractice Payment Reporting

Three aspects of malpractice payment reporting may be of particular interest to reporters, queriers, practitioners, and policy makers. First, the “corporate shield” issue reflects possible under-reporting of malpractice payments. The second issue involves differences in reporting requirements for Federal agencies based on memoranda of understanding. The third issue, reporting physicians in residency programs, concerns the appropriateness of reporting malpractice payments made for the benefit of physicians in training who are supposed to be acting only under the direction and supervision of attending physicians.

“Corporate Shield” may mask the extent of substandard care and diminish NPDB’s usefulness as a flagging system: Malpractice payment reporting may be affected by use of the “corporate shield.” Attorneys have worked out arrangements in which the name of a health care organization (e.g., a hospital or group practice) is substituted for the name of the practitioner, who would otherwise be reported to the NPDB. This is most common when the health care organization is responsible for the malpractice coverage of the practitioner. Under current NPDB regulations, if a practitioner is named in the claim but not in the settlement, no report about the practitioner is filed with the NPDB unless the practitioner is excluded from the settlement as a condition of the settlement.

As required by the Health Care Quality Improvement Act, Federal agencies have negotiated policies with HHS for malpractice payment reporting to the NPDB: Under the provisions of the Federal Tort Claims Act, the government, not individual practitioners, is sued when malpractice is alleged concerning a Federal practitioner. The U.S. Department of Defense’s (DOD) policy requires malpractice payments to be reported to the NPDB only if the practitioner was responsible for an act or omission that was the cause (or a major contributing cause) of the harm that gave rise to the payment. Also, it is reported only if at least one of the following circumstances exists about the act or omission: (1) The Surgeon General of the affected military department (Air Force, Army, or Navy) determines that the practitioner deviated from the standard of care; (2) The payment was the result of a judicial determination of negligence and the Surgeon General finds that the court’s determination was clearly based on the act or omission; and (3) The payment was the result of an administrative or litigation settlement and the Surgeon General finds that based on the case’s record as whole, the purpose of the NPDB requires that a report be made. The U.S. Department of Veterans Affairs (VA) uses a similar process when deciding whether to report malpractice payments.

In 2003 and 2004 the NPDB Executive Committee examined the issue of required reporting of residents’ malpractice payments: The *HCQIA* makes no exceptions for malpractice payments made for the benefit of residents. Payments for residents must be reported to the NPDB. A committee of the Executive Committee examined the issues surrounding the reporting of residents to the NPDB. They considered both residents with primary responsibility

(practicing independently) and residents with ancillary responsibility (training in a residency program under supervision). The issue of reporting residents has also been discussed in articles in the *Bulletin of the American College of Surgeons*.¹⁸ A common misperception is that since residents act under the direction of supervising attending physicians, as long as they are acting within the bounds of their residency program, residents by definition are not responsible for the care provided. Therefore, it is incorrectly believed that regardless of whether or not they are named in a claim for which a malpractice payment is ultimately made, they should not be reported to the NPDB. However the *HCQIA* requires reporting of all licensed practitioners for whom a payment is made, regardless of residency status.

Physician interns and residents had 1,803 Medical Malpractice Payment Reports in the NPDB: At the end of 2004 a total of 1,669 physicians had Malpractice Payment Reports listing them as allopathic or osteopathic interns or residents at the time of the incident which led to the payment. Of these 1,669 physicians, 1,451 were allopathic residents and 218 were osteopathic residents. The NPDB contained a total of 1,803 interns or resident-related Malpractice Payment Reports for these practitioners (1,565 for allopathic interns or residents and 238 for osteopathic interns or residents). These payments constituted only 0.9 percent of all physician Malpractice Payment Reports cumulatively.

Most allopathic physician interns and residents had only one Medical Malpractice Payment Report: A total of 1,385 of the reported allopathic interns and residents had only 1 Malpractice Payment Report as an intern or resident; 61 had 2 such reports; 3 had 3 reports; 1 had 4 reports; and one had 45 Malpractice Payment Reports for incidents while an intern or resident.

Most osteopathic physician interns and residents had only one Medical Malpractice Payment Report: A total of 200 of the reported osteopathic interns and residents had only 1 Malpractice Payment Report as an intern or resident; 17 had 2 such reports; and 1 had 4 reports.

¹⁸Fischer, J.E. and Oshel, R.E. The National Practitioner Data Bank: What You Need to Know. *Bulletin of the American College of Surgeons*. June 1998, 83:2; 24-26. Fischer, J.E. The NPDB and Surgical Residents. *Bulletin of the American College of Surgeons*. April 1996. 81:4; 22-25. Ebert, P.A. As I See It. *Bulletin of the American College of Surgeons*. July 1996. 81:7; 4-5. See also reply by Chen, V. and Oshel, R. Letters, *Bulletin of the American College of Surgeons*, January 1997. 82:1; 67-68.

Types of Reports: Adverse Actions

NPDB Receives Many Reports on Adverse Actions

Beyond Medical Malpractice Payment reports, which make up more than 70 percent of NPDB reports, the NPDB also receives many reports on “adverse actions,”¹⁹ which must be reported to the NPDB if they are taken against physicians and dentists. Reporting of Medicare/Medicaid Exclusions taken against health care practitioners, which are considered to be adverse actions, began in 1997. Reporting of all other types of adverse actions began in 1990 when the NPDB opened. The following gives significant details about these types of reports. For more information, see Tables 1, 2 and Table 14 in the statistical section of this Annual Report.

Adverse Action Reports,²⁰ almost one-third of all reports, increased slightly in 2004: Adverse actions represented 30.0 percent of all reports received during 2004 and, cumulatively, 26.4 percent of all NPDB reports. The number of Adverse Action Reports received increased by 190 to a total of 7,579 (a 2.6 percent increase) from 2003 to 2004. There was an increase of 4,726 reports from 1999 to 2000, which resulted from many more Exclusion Reports being submitted in 2000 than usual because the HIPDB fully opened that year.

State Licensure Action Reports, most of them for physicians, decreased in 2004: During 2004, State licensure actions made up 53.3 percent of all adverse actions and 16.0 percent of all NPDB reports (including malpractice payments and Medicare/Medicaid Exclusions). They continued to represent the majority of adverse actions (cumulatively 54.3 percent of all adverse actions). State Licensure Action Reports increased by 1.3 percent from 2003 to 2004. Those for physicians increased by 0.3 percent in 2004. State Licensure Action Reports for dentists increased by 6.3 percent. State Licensure Action Reports for physicians constituted 83.0 percent of all State Licensure Action Reports in 2004.

¹⁹ “Adverse Action Reports” is a generic term for all licensure action, clinical privileges action, Exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse “Revisions” (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

²⁰ Some Adverse Action Reports are non-adverse “Revisions.” Of the 52,295 reported licensure actions in the NPDB, 5,819 reports or 11.1 percent were for licenses reinstated or restored. Of the 13,473 reported clinical privileges actions, 1,054 reports or 7.8 percent concerned reductions, reinstatements, or reversals of previous actions. Of the 524 reported professional society membership actions, 27 reports or 5.2 percent were reinstatements or reversals of previous actions. None of the 416 reported DEA Reports were considered non-adverse. Of the 29,640 Exclusion Reports, 3,774 or 12.7 percent are reinstatements.

Clinical Privileges Action Reports, making up only about four percent of all 2004 NPDB reports, increased slightly: There were 988 Clinical Privileges Action Reports in 2003 and 1,098 in 2004, an increase of 11.1 percent. Physician Clinical Privileges Action Reports increased by 3.6 percent.

Less than one percent of NPDB reports were for professional society membership actions and DEA actions: Professional society membership actions (only 49 reported) made up 0.6 percent of all adverse actions during 2004. Fifty-nine DEA reports were received during 2004, 0.8 percent of all adverse actions during 2004. The number of reported professional society and DEA actions has remained almost negligible throughout the NPDB's history. Cumulatively, DEA reports and professional society action reports together represented only 0.9 percent of all Adverse Action Reports.

Physicians were responsible for most 2004 State licensure, clinical privileges, and professional society membership actions but less than 1 of 10 Medicare/Medicaid Exclusion actions: During 2004, physicians were responsible for 83.0 percent of State licensure actions, 87.1 percent of clinical privileges actions, and 85.7 percent of professional society membership actions. In contrast, physicians were responsible for only 7.6 percent of all Exclusion actions, but were responsible for 67.6 percent of the Exclusion actions reported for physicians and dentists.

Physicians were responsible for almost all physician and dentist Clinical Privileges Action Reports: In 2004 physicians, representing slightly over four-fifths of the nation's total physician-dentist workforce, were responsible for 83.0 percent of State Licensure Action Reports for this workforce. They were also responsible for 91.3 percent of all Clinical Privileges Action Reports for physicians and dentists. This result is expected, however, since dentists frequently do not hold clinical privileges at a health care entity and thus could not be reported for a clinical privileges action.

Dentists had a much smaller percentage of reports than physicians: Dentists, who comprise approximately 18.5 percent of the nation's total physician-dentist workforce, were responsible for 17.0 percent of physician and dentist State licensure actions, 8.7 percent of clinical privileges actions, 12.5 percent of professional society membership actions, 13.0 percent of DEA actions, and 32.4 percent of Exclusion actions for physicians and dentists in 2004. Thus, dentists had a greater number of Exclusions than might be expected, but were relatively under-represented for other types of adverse actions.

Reporting of Medicare/Medicaid Exclusion Reports increased slightly from 2003: There were 2,312 Exclusion Reports in 2003 and 2,333 in 2004, an increase of 0.9 percent. Physician Exclusion Reports decreased by 21.0 percent and Exclusion Reports for non-physicians/non-dentists increased by 3.3 percent to a total of 2,071. Exclusion Reports represented 9.2 percent of all 2004 reports and 8.1 percent of all NPDB reports cumulatively. The large increase in the number of Exclusion Reports for 2000 shown in Table 2 reflected reports for non-health care practitioners and nurse practitioners being submitted to the NPDB for

2000 and previous years. Exclusion Reports for non-health care practitioners are being removed from the NPDB.

Reports for “other practitioners” in 2004 were mostly for Medicare/Medicaid Exclusions: “Other practitioners” had 2,071 Exclusion Reports in 2004, which made up most (57.1 percent) of their reports in 2004. “Other Practitioners” also had 1,497 Medical Malpractice Payment Reports, 51 Clinical Privileges Action Reports, 5 DEA Action Reports, and 1 Professional Society Membership Action Report. “Other practitioners” accounted for about 9 out of 10 Exclusion Reports (88.8 percent of 2,333 reports) added to the NPDB during 2004. Entities are not required to report clinical privileges actions and professional membership actions on “other practitioners” to the NPDB. Exclusion actions for “other practitioners” are reported to the NPDB.

Cumulatively, almost half of “other practitioners” reports were for Medicare/Medicaid Exclusions: “Other practitioners” had 20,961 Exclusion Reports in the NPDB, which was 48.5 percent of all their reports and 97.7 percent of all their Adverse Action Reports (they had only 4 Professional Membership Action Reports total). Cumulatively, “other practitioners” accounted for almost three-quarters of Exclusion Reports (70.7 percent of 29,640 reports) in the NPDB. “Other practitioners” are required to be reported for Medicare/Medicaid Exclusions to the NPDB.

Under-reporting May Affect Numbers of Adverse Action Reports; States Vary in Reporting Activity

Two issues can affect the interpretation of the reporting of adverse actions – the under-reporting of clinical privileges actions and the reporting of adverse State licensure actions taken by Boards against their physician or dentists licensees who are actually practicing in another State. Both of them have an impact on how the information on Adverse Action Reports²¹ should be viewed. The following narrative explores these issues in depth. For more in-depth data on these issues, see Tables 15 through 18 in the statistical companion to the Annual Report.

Efforts to increase clinical privileges reporting and research into the issue of clinical privileges reporting are making a difference and are continuing: The NPDB has been conducting research on the reporting issue and working with relevant organizations to try to ensure that actions that should be reported actually are reported. However, even with some progress in these efforts, the number of clinical privileges actions reported remains low. For this reason, in 2003 PricewaterhouseCoopers was contracted by PDBB to develop and test a methodology for gaining access to needed records on clinical privileges actions to ensure compliance with NPDB reporting requirements. The project was designed to determine whether hospitals and managed care organizations will voluntarily participate in clinical privileges reporting compliance audits and to develop a methodology for such audits. Hospitals and Managed Care Organizations (MCOs) proved to be reluctant to participate in voluntary audits, although the methodology worked well in the few entities that agreed to participate in testing it.

Less than half of non-Federal hospitals with “active” NPDB registrations had reported an action to the NPDB: As of December 31, 2004, 52.7 percent of non-Federal hospitals registered with the NPDB and in “active”²² status had never reported a clinical privileges action to the NPDB. Percentages of “active” registered non-Federal hospitals that had never reported an action to the NPDB range from 26.7 percent in Rhode Island and New Hampshire to 77.6 percent in South Dakota. This percentage of non-reporters has steadily decreased over the years. Analysis in a previous year showed that clinical privileges reporting seems to be concentrated in a few facilities even in States which have comparatively high over-all clinical privileges reporting levels. This pattern may reflect a willingness (or unwillingness) to take reportable adverse clinical privileges actions more than it reflects a concentration of problem physicians in only a few hospitals.

²¹ “Adverse Action Reports” is a generic term for all licensure action, clinical privileges action, Exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse “Revisions” (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

²² “Active” registration excludes formerly registered hospitals which have closed, merged into other hospitals, etc.

States showed extreme variations in clinical privileges reporting and adverse State licensure action reporting: The ratio of adverse Clinical Privileges Action Reports (excluding reinstatements, etc.) to adverse State Licensure Action Reports (again excluding reinstatements, etc.) ranged from a low of one adverse Clinical Privileges Action Report for every 4.8 adverse State Licensure Action Reports in Alaska and Connecticut to a high of 1.55 adverse Clinical Privileges Action Reports in Nevada for every adverse State Licensure Action Report (i.e., more adverse Clinical Privilege Action Reports than adverse State Licensure Action Reports). While these ratios reflect variations in the reporting of both State licensure actions and clinical privileges actions, the extreme variation from State to State is instructive. It seems likely that the extent of the observed differences may at least in part reflect variations in willingness to take actions rather than a substantial difference in the conduct or competence of the physicians practicing in the various States.

Most State licensure actions for physicians and dentists were adverse (i.e., are not reinstatements, etc.): For physicians, 87.7 percent of all State licensure actions reported to the NPDB had been adverse in nature. For dentists, about 93.9 percent had been adverse. In Nevada and New York 99.4 percent of physician State licensure actions had been adverse. This contrasts with South Carolina, in which only 73.8 percent of the physician State licensure actions had been adverse.

One measure of how active States were in taking actions against dentists and physicians was their percentage of adverse State licensure actions for in-State practitioners: Physicians and dentists are often licensed in more than one State. If one State takes a licensure action, other States often take a parallel or reciprocal action because of the first State's action. Typically the practitioner is actively practicing in the first State which takes action (defined as an "in-State physician"); actions taken by the other States in which the practitioner is licensed prevent the practitioner from shifting his or her practice to the other States, but these actions do not reflect the extent of actions taken by the boards in relation to problems occurring in their States.

Overall, almost three-fourths of physicians' adverse State licensure actions were for in-State physicians: Nationally, 72.9 percent of State licensure actions were both adverse and concerned physicians who were actively practicing in the State whose Board took the licensure action ("in-State physicians"). There was a wide range of percentages, from a low of 43.8 percent of all adverse licensure actions for in-State physicians in Hawaii to a high of 90.2 percent in Oregon. Twelve States had more than 80 percent of their adverse State licensure actions concerning in-State physicians.

Almost all dentist State licensure actions were adverse and affect in-State dentists: Nationally, 93.0 percent of State licensure actions were both adverse and pertain to in-State dentists. Percentages ranged from a low of 71.4 percent in Vermont to a high of 100.0 percent in 6 States in which all dental State licensure actions were adverse and pertained to in-State dentists.

Multiple Reports

Physicians with Multiple Reports Also Tend to Have Other Types of Reports

Most reported physicians had only one report, usually a Medical Malpractice Report, but there were also some who had multiple reports of different types. Physicians with multiple reports of different types have certain characteristics that the following narrative explains in detail. For more information about these characteristics, see Tables 19 and 20 in the statistical companion to the Annual Report.

Over two-thirds of physicians had only one report, one in five had only two reports, and very few had more than five: At the end of 2004, a total of 215,350 individual practitioners had disclosable reports in the NPDB. Of these, 150,184 (69.7 percent) were physicians. As shown in Figure 2 on the next page, most physicians (67.1 percent) with reports in the NPDB had only one report, but the mean number of reports per physician was 1.82. Physicians with only two reports made up 18.6 percent of the total. About 97.3 percent had 5 or fewer reports and 99.6 percent of physicians with reports had 10 or fewer reports. Only 889 (0.4 percent of physicians with reports) had more than 10 reports.

Most physicians with reports had only Medical Malpractice Payment Reports: Of the 150,184 physicians with reports, 123,097 (82.0 percent) had only Malpractice Payment Reports; 8,965 (6.0 percent) had only State Licensure Action Reports; 2,702 (1.8 percent) had only Clinical Privileges Action Reports; and 1,413 (0.9 percent) had only Medicare/Medicaid Exclusion Reports.

About one in twenty had a Malpractice Payment Report and another type of report: Notably, only 7,585 (5.1 percent) had at least one Malpractice Payment Report and at least one State Licensure Action Report, and only 3,816 (2.5 percent) had at least one Malpractice Payment Report and at least one Clinical Privileges Action Report. Only 1,737 (1.2 percent) had Malpractice Payment, State Licensure Action, and Clinical Privileges Action Reports. Only 343 (0.2 percent) had at least one Medical Malpractice Payment, State Licensure Action, Clinical Privileges Action, and Exclusion Report at the end of 2004.

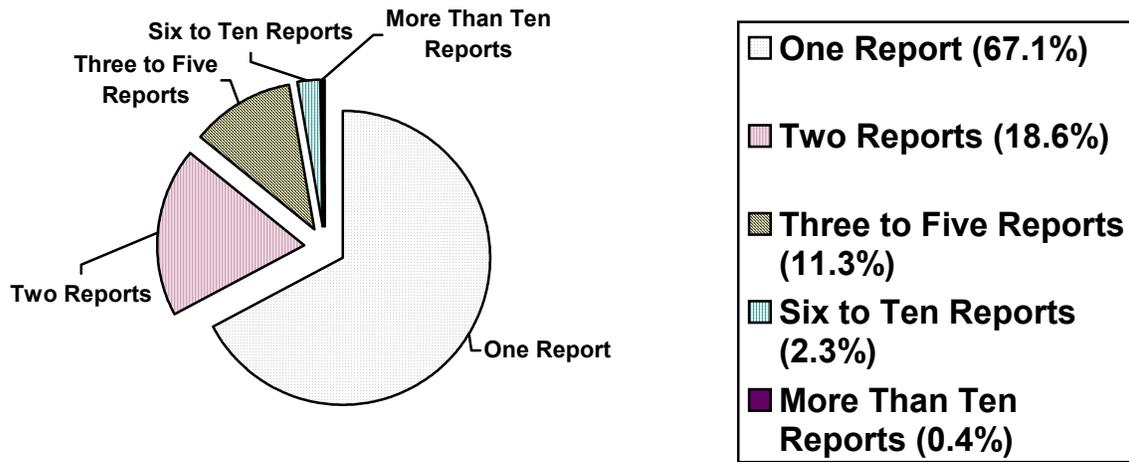
Physicians with high numbers of Malpractice Payment Reports tended to have at least some Adverse Action Reports²³ and Medicare/Medicaid Exclusion Reports, and vice versa: Although 95.5 percent of the 90,086 physicians with only one Malpractice Payment Report in the NPDB had no Adverse Action Reports, only 67.5 percent of the 434 physicians with 10 or more Malpractice Payment Reports had no Adverse Action Reports. Generally, the

²³ Adverse Action Reports discussed in this paragraph do not include Medicare/Medicaid Exclusion Reports.

data show that as a physician’s number of Malpractice Payment Reports increases, the likelihood that the physician has Adverse Action Reports²⁴ also increases.

Physicians with at least two Malpractice Payment Reports were responsible for the majority of Malpractice Payment Reports for physicians: Approximately 32.3 percent of the 132,990 physicians with Malpractice Payment Reports had 2 or more such reports. These 42,904 physicians had a total of 120,561 Malpractice Payment Reports. This was 57.2 percent of the 210,647 Malpractice Payment Reports in the NPDB for physicians.

Figure 2: Percentage of Physicians with Number of Reports in the NPDB (1990-2004)



A few physicians were responsible for a large proportion of malpractice payment dollars paid: The 1 percent of physicians with the largest total-payments in the NPDB were responsible for about 11.8 percent of all the money paid for physicians in malpractice judgments or settlements reported to the NPDB. The five percent of physicians with the largest total payments in the NPDB were responsible for just under a third of the total dollars paid for physicians. *Eleven percent of physicians with at least one malpractice payment were responsible for half of all malpractice dollars paid from September 1, 1990 through December 31, 2004.*

²⁴ “Adverse Action Reports” is a generic term for all licensure action, clinical privileges action, Exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse “Revisions” (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

Types of Practitioners Reported

Physicians, Dentists Are Reported Most Often to the NPDB

Physicians make up the majority of practitioners reported to the NPDB, having about seven out of three reports in the NPDB. The following describes the number of practitioners reported to the NPDB and the number of reports for each practitioner type. For more information about types of practitioners reported, see Table 21 in the statistical section of this Annual Report.

Physicians, most of whom only have one report, were predominant in the NPDB: Of the 215,350 practitioners reported to the NPDB, 69.7 percent were physicians (including M.D.s and D.O.s residents and interns), 13.5 percent were dentists, 8.5 percent were nurses and nursing-related practitioners, and 2.9 percent were chiropractors. About two-thirds of physicians with reports (67.1 percent) had only 1 report in the NPDB, 85.7 percent had 2 or fewer reports, 97.3 percent had 5 or fewer, and 99.6 percent had 10 or fewer. Few physicians had both Medical Malpractice Payment Reports and Adverse Action Reports. Only 5.1 percent had at least one report of both types.

Physicians had more reports per practitioner than any other practitioner group: Physicians had the highest average number (1.82) of reports per reported practitioner, and dentists, the second largest group of practitioners reported, had an average of 1.64 reports per reported dentist. Podiatrists and podiatric-related practitioners, who had 1.69 reports per reported practitioner, also had a high average of reports per practitioner as well as 6,717 reports. Comparison between physicians and dentists and other types of practitioners, however, would be misleading since reporting of State licensure, clinical privileges, and professional society membership actions is required only for physicians and dentists.

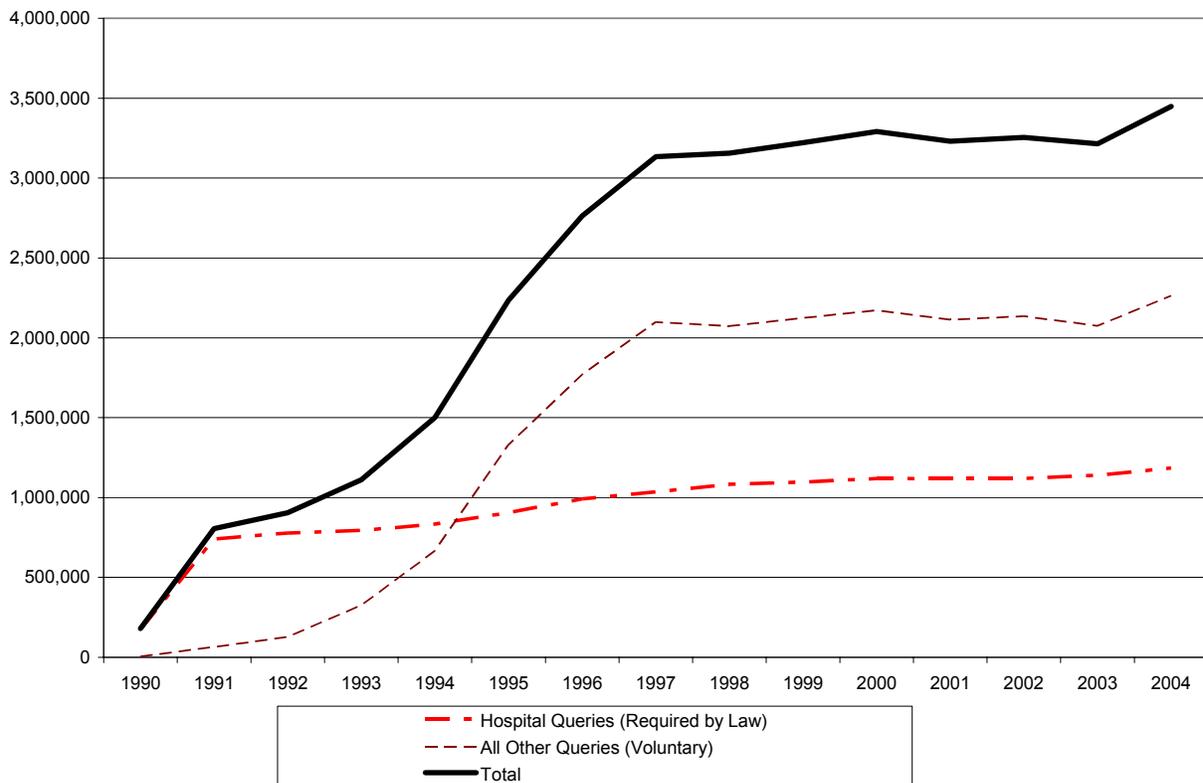
Querying

Querying Increased in 2004; Match Rate Increased

The NPDB experienced an increase (7.3 percent) in querying during 2004. The number of entity queries increased from 3,214,081 in 2003 to 3,448,514 in 2004. This was a reversal of a slight decrease in querying last year.

The 2004 count represents an average of 1 query every 10 seconds. It is 4 times as many queries as the 809,844 queries processed during the NPDB's first full year of operation, 1991. Over the 14 years the NPDB has been open, there have been cumulatively 35,458,411 entity queries. The following graph, Figure 3, gives more information about the types of queries to the NPDB. For additional information about querying, see Tables 22 through 25 in the statistical section of this Annual Report.

Figure 3: Queries by Querier Type (September 1, 1990 - December 31, 2004)



Entity queriers showed they valued information with a large number of queries over NPDB's existence: Over time NPDB information has become much more valuable to users. The number of voluntary queries (those not required by law) from entities grew from 65,269 in 1991 to 2,263,248 in 2004, an increase of over 3,368 percent. Voluntary queries represented 65.6 percent of all entity queries during 2004.

Hospitals, which are required to query the NPDB, also increased querying over time: The growth in required queries by hospitals has not been as large as that of voluntary queriers. Their queries increased by 60.1 percent from 740,262 in 1991 (the NPDB's first full year of operation), to 1,185,266 queries in 2004. Hospitals are required to query for all new applicants for privileges or staff appointment, existing applicants when changes in privileges occur, and once every 2 years concerning their privileged staff. They made most of the queries to the NPDB during its first few years of operation but now are responsible for only about one-third of all queries. Hospitals may voluntarily query for other peer review activities, but for analysis purposes it is assumed all hospital queries are required.

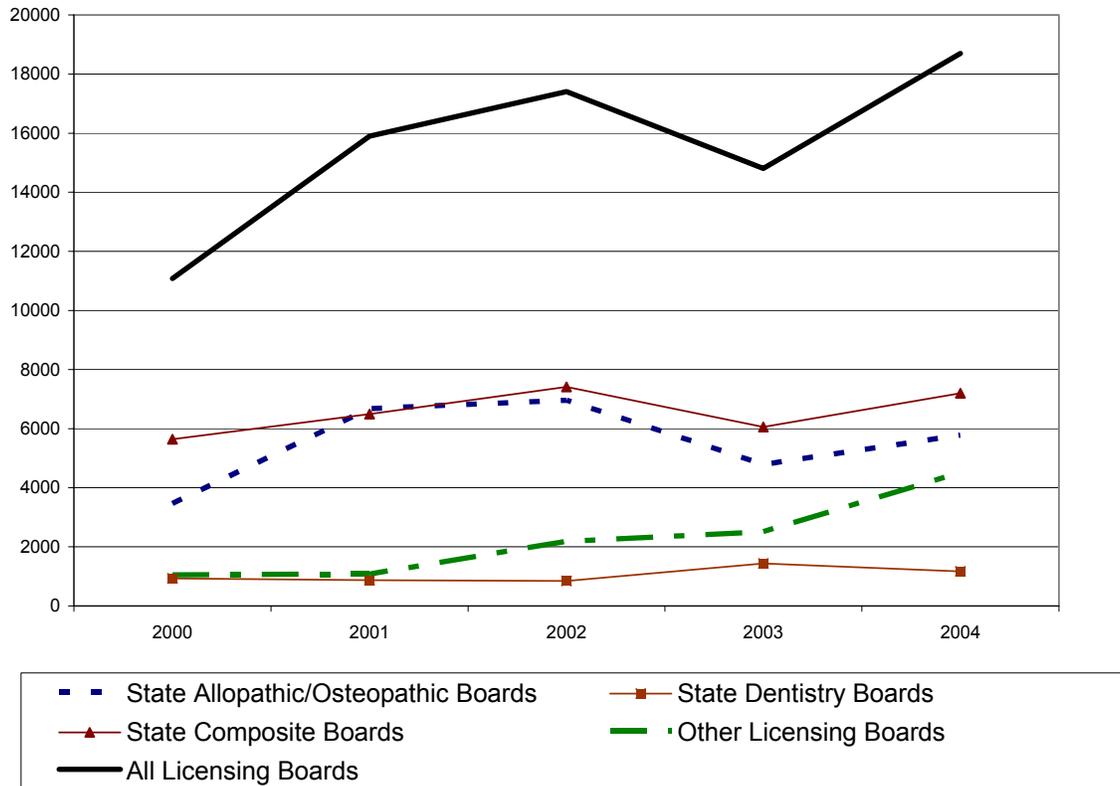
MCOs submitted almost half of all voluntary entity queries: Managed care organizations (MCOs) are the most active voluntary queriers. MCOs in this case are defined as including HMOs and PPOs. Although they represented 7.6 percent of all querying entities during 2004 and 11.0 percent of all entities that have ever queried the NPDB, they made 48.7 percent of all queries during 2004 and have been responsible for 46.0 percent of queries ever submitted to the NPDB.

State licensing boards made less than one percent of all queries: State licensing boards made 0.5 percent of queries during 2004 and 0.5 percent cumulatively, but queries by State boards increased by 26.1 percent in 2004. (The low volume of State board queries may be explained by the fact that entities are required to provide State boards copies of reports when they are sent to the NPDB so the boards do not need to query to obtain reports for in-State practitioners and by the fact that some boards require practitioners to submit self-query results with applications for licensure.) Figure 4 on the next page shows the number of State board queries by year and the increase in queries for 2004.

Other entities also requested information from the NPDB: Other health care entities made 16.2 percent of the queries in 2004 and 13.4 percent cumulatively. Examples of other health care entities include health maintenance organizations (HMOs), preferred provider organizations (PPOs), group practices, nursing homes, rehabilitation centers, hospices, renal dialysis centers, and free-standing ambulatory care and surgical service centers. Professional societies were responsible for 0.2 percent of queries during 2004 and 0.3 percent cumulatively.

Entities submitted most of their queries for physicians and dentists: Queriers request information on many types of practitioners, but mostly query on physicians and dentists. During a sample period from April through December 2004, allopathic physicians were by far the subject of most queries; 66.5 percent of queries submitted concerned allopathic physicians, interns and residents. The second largest category, dentists, accounted for 6.0 percent of all queries. Osteopathic physicians accounted for 4.0 percent, clinical social workers for 2.8 percent, psychologists for 2.6 percent, and optometrists accounted for 2.1 percent.

Figure 4: Number of State Licensing Board Queries by Year (2000-2004)



Query match rate continued to rise in 2004: When an entity submits a query on a practitioner, a match occurs when that individual is found to have a report in the NPDB. The 484,040 entity queries matched during 2004 represented a match rate of 14.0 percent. Although the match rate has steadily risen since the opening of the NPDB, we hypothesize that it will plateau once the NPDB has been in operation for the same length of time as the average practitioner practices, all other factors (such as malpractice payment rates for older and younger physicians) remaining constant.

A “no match” response is useful and valuable to queriers: About 86.0 percent of entity queries submitted in 2004 received a “no match” response from the NPDB, meaning that the practitioner in question does not have a report in the NPDB. This does not mean, however, that there was no value in receiving these responses. In a 1999 study of NPDB users by the Institute for Health Services Research and Policy Studies at Northwestern University and the Health Policy Center Survey Research Laboratory at the University of Illinois at Chicago, three-quarters of surveyed queriers rated NPDB information, including responses that there were no reports in the NPDB on a queried practitioner, a “six” or a “seven,” with seven representing “very useful” on a one to seven scale. A majority of surveyed queriers rated NPDB information influential in decision-making regarding practitioners (6 and 7 on a 7 point scale). At the end of 2004, a “no match” response to a query confirmed that a practitioner has had no reports in over

14 years. These responses will become even more valuable as the NPDB continues to receive reports.

Self-queries increased during 2004, but most do not show reports for practitioners:

In addition to entity queries, the NPDB also processes self-queries from practitioners seeking copies of their own records, which includes 47,948 self-query requests during 2004. The 2004 number of self-queries represented an increase of 13.6 percent from the number of self-queries processed during 2003 but represented a decrease of 8.8 percent from the record 52,603 self-queries processed during 1997. Of the self-query requests during 2004, 4,823 (10.1 percent) were matched with reports in the NPDB. Cumulatively, from the opening of the NPDB, 503,937 self-queries have been processed; 42,927 (8.5 percent) of these queries were matched with reports in the NPDB.

Physicians, dentists, counselors, and physician assistants submitted most of the NPDB self-queries: As shown in Table 25, many types of practitioners request information on themselves, but the majority of them are physicians. During a sample period of April through December 2004, allopathic physicians and allopathic physician interns/residents made the most self-queries (73.2 percent of all self-queries). Osteopathic physicians and osteopathic physicians/interns made the second largest number of self-queries (6.1 percent of all self-queries), dentists the third largest (5.5 percent), and clinical social workers and allopathic physician assistants the fourth largest (1.7 percent each). Some licensure boards, malpractice insurers, or health care service providers may request that practitioners submit self-query results with their applications for licensure, malpractice insurance, clinical privileges, panel participation, etc. The level of self-querying and types of self-queries may be influenced by these requests.

NPDB Reporters and Queriers

The NPDB receives information from and provides information to registered entities that certify that they meet the eligibility requirements of the *HCQIA*. The following gives some information about these entities. Some entities have (or had in the past) multiple registration numbers either simultaneously or sequentially, so the data may not necessarily reflect the actual number of individual entities which have reported to or queried the NPDB. For more information, see Table 26 in the statistical section of the Annual Report.

Almost half of registered entities that have reported or queried were Other Health Care Entities: A total of 15,428 registered entities had active²⁵ status as of December 31, 2004. At the end of 2004, Other Health Care Entities²⁶ held 6,962 active registrations (45.1 percent). Hospitals accounted for 6,471 (41.9 percent) of the NPDB's active registered entities and Managed Care Organizations accounted for 1,299 active registrations (8.4 percent). The 406 malpractice insurers with active registrations accounted for only 2.6 percent of all active registrations. Other categories accounted for even smaller percentages of the NPDB's active registrations at the end of 2004.

About 4 out of 10 registered entities active at any time over the NPDB's existence were Other Health Care Entities: A total of 19,709 registered entities were ever active over the NPDB's existence. Other Health Care Entities accounted for 8,466 (43.0 percent) of the entities which had ever registered with the NPDB and had queried or reported at least once. Hospitals accounted for 7,942 (40.3 percent) registrations at any time and MCOs accounted for 2,096 registrations (10.6 percent). The 787 malpractice insurers ever registered accounted for only 4.0 percent of all registrations. Other categories accounted for even smaller percentages of the NPDB's registrations throughout its existence.

²⁵ "Active" registration excludes formerly registered entities which have closed, merged into other entities, etc.

²⁶ Other Health Care Entities must provide health care services and follow a formal peer review process to further quality health care. The phrase "provides health care services" means the delivery of health care services through any of a broad array of coverage arrangements or other relationships with practitioners by either employing them directly, or through contractual or other arrangements. This definition specifically excludes indemnity insurers that have no contractual or other arrangement with physicians, dentists, or other health care practitioners. Examples of other health care entities may include nursing homes, rehabilitation centers, hospices, renal dialysis centers, and free-standing ambulatory care and surgical service centers.

Ensuring Accurate Reports: Secretarial Review

Through the dispute and Secretarial Review process, practitioners get a chance to challenge reports that they feel should be changed or should not be in the NPDB because they are either inaccurate or should not have been filed under applicable regulations. Only a small percentage of reports are disputed, though, and those that have gone through Secretarial Review usually have been upheld by the Secretary as being accurate and reportable. The following narrative explains the process of NPDB disputes and Secretarial Reviews. For more information about Secretarial Review data, see Tables 27 through 29 in the statistical section of the Annual Report.

Practitioners must use an established administrative process when disputing a report, including working through the reporting entity to change the report: When practitioners are notified of a report in the NPDB that they believe is inaccurate or should not have been filed, they may dispute the report and/or insert their own statement. Before requesting Secretarial Review, they must first contact the reporting entity to ask them to correct the matter. When the NPDB receives a dispute from a practitioner, notification of the dispute is sent to all queriers who received the report within the last 3 years and is included with the report when it is released to future queriers.

Queriers are informed about a report's status as "disputed": Practitioners who have disputed reports must attempt to negotiate with entities that filed the reports to revise or void the reports before requesting Secretarial Review. The fact that a report is disputed simply means that the practitioner disagrees with the accuracy of the report. When disputed reports are disclosed to queriers, they are notified that the practitioner disputes the accuracy of the report.

If the reporting entity does not change the disputed report to the practitioner's satisfaction, then the practitioner may ask the Secretary of HHS to review the disputed report: When asking for Secretarial Review, the practitioner must send documentation to the NPDB that briefly discusses the facts in dispute, documents the inaccuracy of the report, and proves that he or she tried to resolve the disagreement with the reporting entity.

Secretarial Reviews are limited to accuracy and appropriateness of reporting, not the underlying decision to make a malpractice payment or take an adverse action: Secretarial Review does not include a review of the merits of a medical malpractice claim or the basis for an adverse action. Reviews are limited to factual accuracy and whether the report was submitted in accordance with the NPDB reporting requirements. All other reasons (such as a claim that although a malpractice payment was made for the benefit of the named practitioner, the named practitioner did not really commit malpractice or that there were extenuating circumstances) are "outside the scope of review." Factual accuracy means that the report accurately described the practitioner and the payment or action and reasons for the payment or action as reflected in decision documents.

Reviewed reports can be determined to be accurate or inaccurate: If the Secretary concludes the information in the report is accurate, the Secretary sends an explanation of the decision to the practitioner. The practitioner may then submit a statement (limited to 2,000 characters) that is added to the report. If the practitioner had already submitted a statement, any new statement will replace the original statement. If a report is determined to be inaccurate, the Secretary will request that the reporting entity file a correction. If no correction is forthcoming the Secretary notes the correction in the report. The Secretary can only remove (“void”) a report from the NPDB if it was not legally required or permitted to be submitted.

Issues raised also can be determined to be “outside the scope of review”: The Secretary also may conclude that the issue in dispute is outside the scope of review, i.e., that the only issues raised concern whether a payment should have been made or an action should have been taken. The Secretary cannot substitute his or her judgment on the merits for that of the entity that made the payment or took the action. In such cases determined to be “outside the scope of review,” the Secretary directs the NPDB to add an entry to that effect to the report and to remove the dispute notation from the report. The practitioner may also submit a statement that is added to the report.

Reviews may be administratively dismissed or reconsidered: The Secretary may administratively dismiss requests for Secretarial Review if the practitioner does not provide required information or if the matter is resolved with the reporting entity to the satisfaction of the practitioner while the Secretarial Review is in progress. Practitioners may ask for a reconsideration of a Secretarial Review decision.

The majority of disputed reports were for medical malpractice payments: At the end of 2004, a total of 13,420 reports, or 3.7 percent of all reports, were disputed. This number was made up of 2,048 State Licensure Action reports, 1,854 Clinical Privileges Action Reports, 33 Professional Society Membership Reports, 16 DEA reports, 278 Exclusion actions, and 9,191 Malpractice Payment Reports. Exclusion Reports for actions taken prior to August 21, 1996²⁷ cannot be disputed with the NPDB.

Clinical Privileges Action Reports had the biggest percentage of reports that were disputed among the types of reports: Disputed reports constituted 3.9 percent of all State Licensure Action Reports, 13.8 percent of all Clinical Privileges Action Reports, 6.3 percent of Professional Society Membership Reports, 3.8 percent of DEA reports, and 3.4 percent of Malpractice Payment Reports.

Secretarial Reviews increased by one-fifth from 2003 to 2004: Requests for review by the Secretary increased by 20.8 percent from 2003 to 2004. A total of 64 requests for review by the Secretary were received during 2004 compared to 53 in 2003. Bearing in mind that requests

²⁷Exclusion actions taken before August 21, 1996 are included in the NPDB by a memorandum of agreement between HRSA, Centers for Medicare and Medicaid Services (formerly HCFA), and U.S. Department of Health and Human Services, Office of Inspector General. Exclusion actions taken on August 21, 1996 and later are reported to the HIPDB by law and are disputed under the normal process. HIPDB Secretarial Review decisions on these reports also apply to the NPDB.

for Secretarial Review during a given year cannot be tied directly to either reports or disputes received during the same year, we can still approximate the relationship between requests for Secretarial Review, disputes, and reports. During 2004, the number of new requests for Secretarial Review was 0.3 percent of the number of new Malpractice Payment Reports and Adverse Action Reports received by the NPDB.

Adverse Action Reports²⁸ were more likely to be appealed to the Secretary than were Malpractice Payment Reports: During 2004, 78.1 percent (50 requests) of all requests for Secretarial Review concerned adverse actions (i.e., State Licensure Action, Clinical Privileges Action, or Professional Society Membership Reports) even though only 30.0 percent of all 2004 reports fell in this category. While about three-fourths of all cumulative reports in the NPDB are for malpractice payments almost 8 out of 10 of 2004 reports in Secretarial Review are for Adverse Action Reports. During 2004 Clinical Privileges Action Reports represented 78.0 percent of all Adverse Action Reports involved in Secretarial Review.

Most resolved Secretarial Reviews in 2004 resulted in unchanged reports: At the end of 2004, 29 (45.3 percent) of the 64 requests for Secretarial Review received during the year remained unresolved. Of the 35 new 2004 cases which were resolved, none were voided. Reports were not changed (the Secretary maintained report as submitted or the Secretary decided the Secretarial Review request was outside the scope of review²⁹) in 22 cases (62.8 percent) of the 2004 cases that were resolved. For 13 cases the result was submission of a corrected report by the reporting entity, closing the case by “intervening action.” Generally the corrections were filed at the request of the Secretary.

About one in six of all Secretarial Reviews resulted in outcomes that were beneficial for the practitioners: By the end of 2004, 17.2 percent of all closed requests for Secretarial Review had resulted in outcomes that were beneficial to the practitioner (a void of a report, a change in the report, or a closure because of an intervening action, such as the entity changing the report to the practitioner's satisfaction.) At the end of 2004, 2.2 percent of all requests for Secretarial Review remained unresolved. Only 73 (11.9 percent) of the total of 614 Malpractice Payment Reports with completed Secretarial Reviews (the total number of requests minus the number of unresolved requests) have resulted in outcomes that were beneficial to the practitioner. In the case of reviews of clinical privileges actions, 123 (18.2 percent) of the 675 closed requests resulted in a positive outcome for the practitioner. For licensure actions, 81 (25.1

²⁸ “Adverse Action Reports” is a generic term for all licensure action, clinical privileges action, Exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse “Revisions” (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

²⁹ Out-of-scope determinations are made when the issues at dispute can not be reviewed because they do not challenge the information's accuracy or its requirement to be reported to the NPDB, e.g. the practitioner claims not to have committed malpractice. The Secretary can only determine whether a payment was made and if the report is otherwise accurate. If a payment was made, a report of the payment must remain in the NPDB. Whether or not the practitioner committed malpractice is not relevant to keeping the payment report in the NPDB.

percent) of the 323 closed requests resulted in a positive outcome, and for professional society membership actions, six closed requests (33.3 percent) resulted in a positive outcome.

NPDB: 2005 and the Future

The NPDB Continued Improving Its Operations in 2005

The NPDB made several improvements to its operations and future policy initiatives in 2005. It also continued updating and organizing its Web site, www.npdb-hipdb.com, to make it easier for customers to find information.

The following improvements were made to the NPDB-HIPDB system in 2005:

- IQRS data security was bolstered in April 2005. More stringent password security procedures, which established a new set of requirements for NPDB users, was implemented. These procedures enhance system security for information stored in the NPDB-HIPDB, as well as reduce the risk of unauthorized access user accounts. The improvements increase administration password restrictions, minimize the use of common or easily guessed passwords, and tighten password expiration rules.
- A new Extensible Markup Language (XML) reporting and querying interface became an option to NPDB users on January 31, 2005. The Querying and Reporting XML Service (QRXS) will improve the exchange of data between users and the NPDB by providing an industry-standard format for query and report data exchange. Initially, use of the QRXS was limited to submitting Adverse Action Reports (AARs). Querying and submission of Medical Malpractice Payment Reports were added in late 2005. QRXS is an electronic service similar to ITP for reporters who wish to interface their data processing system directly with the data banks to submit reports and receive responses. Entities can continue using the Integrated Querying and Reporting Service (IQRS) or the Interface Control Document (ICD) Transfer Program (ITP) for querying and reporting.
- As of April 2005 it is now easier for NPDB users to view new Data Bank Correspondence messages. The *Registration Confirmation* screen displays new Data Bank Correspondence messages on-screen immediately after the user logs in to the IQRS. Previously read Data Bank Correspondence messages remains available for 30 days on the *Data Bank Correspondence* screen for review. Additionally, Customer Service Center functions are extended, including user access to a view-only version of the IQRS.
- The NPDB upgraded the browser versions supported in the IQRS to include Internet Explorer versions 6.0, 6.0 SP1, and 6.0 SP2. In addition, supported Netscape versions were upgraded to include 7.02, 7.1, and 7.2

Some of the policy initiatives taking place in 2005 included:

- The NPDB published articles about NPDB policies and operations in health care publications, including an article about the NPDB-HIPDB reportability of psychologists for the National Register of Health Services Providers in Psychology Newsletter.
- NPDB staff made presentations at several meetings of health care organizations in 2005, including the New Jersey Association Medical Staff Services, NCQA Advanced Credentialing Workshop, and the Association of Dental Administrators.
- The NPDB is holding additional meetings with entities concerning the Proactive Disclosure Service (PDS), particularly looking at feedback from NPDB customers about the cost for the PDS.
- The NPDB had its first Policy Forum at SRA in Fairfax, Virginia. The first group of participants in the forum were medical malpractice payment reporters. The development of this Policy Forum is in response to demand from customers as expressed in conferences NPDB staff have attended, speeches that were given by PDBB staff, PDS focus groups and questions received at the IQRS Users Review Panel.
- Continual reporting enforcement efforts, including comparing the data bank registrations of hospitals with the American Hospital Association (AHA) Guide, are ongoing to ensure all hospitals are properly querying and reporting to the data banks.

Conclusion: NPDB Continues to Grow, Become More Useful

The total number of reports in the NPDB now exceeds 364,000 and the cumulative number of queries is more than 35 million. Although Medical Malpractice Payment Reports still represent the majority of reports in the NPDB, an increasing number of Adverse Action Reports (e.g., Medicare/Medicaid Exclusion, State Licensure Action, Clinical Privileges Action, Professional Society Membership, and Federal Licensure and DEA reports) have been entered into the NPDB. Several compliance projects are studying ways to make sure that the NPDB is receiving all the reports it should be, data improvement efforts are ensuring the accuracy of NPDB reports, and projects to market the benefits of the NPDB to reporters and queriers are being implemented.

As NPDB information accumulates, the NPDB's value as a source of aggregate information and its public use data for research increases, and its usefulness as an information clearinghouse for eligible queriers about specific practitioners grows. Over time, the data generated will provide useful information on trends in malpractice payments, adverse actions, and professional disciplinary behavior. Most importantly, however, the NPDB will continue to benefit the public by serving as an information clearinghouse that facilitates comprehensive peer review, and thereby, improves U.S. health care quality.

The "Third Generation" contract for the data banks continues to update and improve the Integrated Querying and Reporting Service (IQRS). System improvements – such as giving users the ability to retrieve historical summaries of their queries and reports – continue to be made to better serve the NPDB's customers. The continuing work to educate users about the NPDB and improve the data and reporting compliance ensures the NPDB will remain a prime source of medical malpractice and disciplinary information. This supports the legislative intent to protect the public by restricting the ability of incompetent or unprofessional practitioners to move from State to State without disclosure or discovery of their past history.

Glossary of Acronyms

AAR - Adverse Action Report

ACSI - American Consumer Satisfaction Index

AHA - American Hospital Association

AHIP - America's Health Insurance Plans

AHRQ - Agency for Healthcare Research and Quality

BHPr - Bureau of Health Professions

CAMSS - California Association Medical Staff Services

CMS - Centers for Medicare and Medicaid Services

DBID - Data Banks Identification Number

DEA - Drug Enforcement Administration

D.O. - Doctor of Osteopathy

DOD – U.S. Department of Defense

DPDB - Division of Practitioner Data Banks

EFT - Electronic Funds Transfer

FMS - Financial Management Service

FSMB - Federation of State Medical Boards

HCQIA - The Health Care Quality Improvement Act of 1986, as amended 42 USC, Sec. 11101, et. reg.

HFAP - Healthcare Facilities Accreditation Program

HHS – U.S. Department of Health and Human Services

HIPDB - Healthcare Integrity and Protection Data Bank

HMO - Health Maintenance Organization

HRSA - Health Resources and Services Administration

ICD - Interface Control Document

IQRS - Integrated Querying and Reporting Service

ITP - Interface Control Document (ICD) Transfer Program

JCAHO - Joint Commission on Accreditation of Healthcare Organizations

MCO - Managed Care Organization

M.D. - Doctor of Medicine (Allopathic Physician)

MMER - Medicare/Medicaid Exclusion Report

MMPR - Medical Malpractice Payment Report

MOU - Memorandum of Understanding

NAIC - National Association of Insurance Commissioners

NCF - National Credentialing Forum

NCQA - National Committee for Quality Assurance

NCSBN - National Council of State Boards of Nursing

NPDB - National Practitioner Data Bank

NPRM - Notification of Proposed Rule Making

OIG - Office of Inspector General

OWEQA - Office of Workforce Evaluation and Quality Assurance

PDBB - Practitioner Data Banks Branch

PDS - Proactive Disclosure Service

PPO - Preferred Provider Organization

QRXS - Querying and Reporting XML Service

RN - Registered Nurse

SRA - SRA International, Inc.

URAC - American Accreditation HealthCare Commission

URP - Users Review Panel

VA – U.S. Department of Veterans Affairs

XML - Extensible Markup Language

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Table 1: Number and Percent Distribution of Reports by Report Type, Last Five Years and Cumulative Through 2004
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

Report Type	2000		2001		2002		2003		2004		Cumulative through 2004	
	Number	Percent	Number	Percent								
Malpractice Payment Reports	19,389	61.3%	20,563	74.0%	18,967	70.8%	18,996	72.0%	17,696	70.0%	267,948	73.6%
Adverse Action Reports*	12,254	38.7%	7,231	26.0%	7,824	29.2%	7,389	28.0%	7,579	30.0%	96,348	26.4%
State Licensure	4,328	13.7%	3,151	11.3%	3,975	14.8%	3,989	15.1%	4,040	16.0%	52,295	14.4%
Clinical Privilege	1,041	3.3%	1,028	3.7%	971	3.6%	988	3.7%	1,098	4.3%	13,473	3.7%
Professional Society Membership	28	0.1%	33	0.1%	45	0.2%	46	0.2%	49	0.2%	524	0.1%
DEA	0	0.0%	9	0.0%	0	0.0%	54	0.2%	59	0.2%	416	0.1%
Medicare/Medicaid Exclusion**	6,857	21.7%	3,010	10.8%	2,833	10.6%	2,312	8.8%	2,333	9.2%	29,640	8.1%
All Reports	31,643	100.0%	27,794	100.0%	26,791	100.0%	26,385	100.0%	25,275	100.0%	364,296	100.0%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* "Adverse Action Reports" are defined in footnote 1 on page 6 of this report.

** The large increase in the number of Exclusion Reports for 2000 reflects reports for practitioners other than physicians and dentists submitted to the NPDB for 2000 and previous years with the initiation of reporting to the HIPDB.

Table 2: Number of Reports Received and Percent Change by Report Type, Last Five Years
National Practitioner Data Bank (January 1, 2000 - December 31, 2004)

Report Type	2000		2001		2002		2003		2004	
	Number	% Change 1999-2000	Number	% Change 2000-2001	Number	% Change 2001-2002	Number	% Change 2002-2003	Number	% Change 2003-2004
Malpractice Payment Reports	19,389	2.2%	20,563	6.1%	18,967	-7.8%	18,996	0.2%	17,696	-6.8%
Adverse Action Reports*	12,254	65.2%	7,231	-41.0%	7,824	8.2%	7,389	-5.6%	7,579	2.6%
State Licensure	4,328	7.4%	3,151	-27.2%	3,975	26.2%	3,989	0.4%	4,040	1.3%
Clinical Privilege	1,041	12.7%	1,028	-1.2%	971	-5.5%	988	1.8%	1,098	11.1%
Professional Society Membership	28	55.6%	33	17.9%	45	36.4%	46	2.2%	49	6.5%
DEA	0	-100.0%	9	...	0	...	54	...	59	9.3%
Medicare/Medicaid Exclusion**	6,857	187.5%	3,010	-56.1%	2,833	-5.9%	2,312	-18.4%	2,333	0.9%
All Reports	31,643	19.9%	27,794	-12.2%	26,791	-3.6%	26,385	-1.5%	25,275	-4.2%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

Percent changes that cannot be calculated because no reports were submitted for specified periods are indicated by "..."

* "Adverse Action Reports" are defined in footnote 1 on page 6 of this report.

** The large increase in the number of Exclusion Reports for 2000 reflects reports for practitioners other than physicians and dentists submitted to the NPDB for 2000 and previous years with the initiation of reporting to the HIPDB.

**Table 3: Number, Percent Distribution, and Percent Change of Medical Malpractice Payment Reports by Practitioner Type, Last Five Years and Cumulative Through 2004
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)**

Practitioner Type*	2000			2001			2002		
	Number	Percent	% Change 1999-2000	Number	Percent	% Change 2000-2001	Number	Percent	% Change 2001-2002
Physicians	15,553	80.2%	3.1%	16,648	81.0%	7.0%	15,276	80.5%	-8.2%
Dentists	2,351	12.1%	0.0%	2,315	11.3%	-1.5%	2,084	11.0%	-10.0%
Other Practitioners	1,485	7.7%	-3.8%	1,600	7.8%	7.7%	1,607	8.5%	0.4%
All Practitioners	19,389	100.0%	2.2%	20,563	100.0%	6.1%	18,967	100.0%	-7.8%

Practitioner Type*	2003			2004			Cumulative through 2004	
	Number	Percent	% Change 2002-2003	Number	Percent	% Change 2003-2004	Number	Percent
Physicians	15,280	80.4%	0.0%	14,396	81.4%	-5.8%	210,647	78.6%
Dentists	2,244	11.8%	7.7%	1,803	10.2%	-19.7%	35,514	13.3%
Other Practitioners	1,472	7.7%	-8.4%	1,497	8.5%	1.7%	21,787	8.1%
All Practitioners	18,996	100.0%	0.2%	17,696	100.0%	-6.8%	267,948	100.0%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents. The "Dentists" category includes dental residents. The "Other Practitioners" category includes other health care practitioners, non-health care professionals and non-specified professionals.

Table 4: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2004 and Cumulative Through 2004 - Physicians* National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

Malpractice Reason	2004 Only			Cumulative through 2004				
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Mean Payment	Median Payment	Actual Mean Payment	Inflation-Adjusted Median Payment
Anesthesia Related	397	\$419,592	\$225,000	6,607	\$265,378	\$100,000	\$308,555	\$114,893
Behavioral Health Related**	43	\$177,244	\$95,000	43	\$177,244	\$95,000	\$177,244	\$95,000
Diagnosis Related	4,799	\$305,973	\$200,000	71,861	\$247,855	\$135,000	\$285,741	\$158,097
Equipment or Product Related	62	\$120,126	\$47,500	782	\$81,103	\$20,000	\$94,422	\$24,874
IV or Blood Products Related	38	\$279,252	\$125,000	788	\$176,742	\$75,000	\$210,053	\$89,615
Medication Related	717	\$220,131	\$125,000	11,847	\$166,936	\$63,207	\$195,417	\$74,163
Monitoring Related	385	\$345,109	\$150,000	2,661	\$238,923	\$100,000	\$272,585	\$114,911
Obstetrics Related	1,366	\$503,564	\$300,000	18,119	\$386,405	\$200,000	\$449,068	\$241,736
Surgery Related	3,764	\$255,418	\$147,304	57,340	\$181,806	\$90,000	\$210,211	\$103,215
Treatment Related	2,618	\$251,811	\$142,647	37,358	\$195,182	\$90,000	\$226,039	\$103,215
Miscellaneous	207	\$177,809	\$70,000	3,094	\$107,500	\$25,000	\$126,976	\$32,015
All Reasons	14,396	\$298,460	\$170,000	210,500	\$225,361	\$100,000	\$260,746	\$124,278

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Cumulative totals exclude 120 Medical Malpractice Payment Reports that are missing data necessary to calculate payment or malpractice reason.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** The "Behavioral Health" category was added on January 31, 2004. Reports involving behavioral health issues filed before January 31, 2004 used other reporting categories. Cumulative data in this category includes only reports filed after January 31, 2004.

Table 5: Mean and Median Delay Between Incident and Payment by Malpractice Reason, 2004 and Cumulative Through 2004 - Physicians*
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

Malpractice Reason	2004 Only			Cumulative through 2004		
	Number of Payments	Mean Delay Between Incident and Payment (Years)	Median Delay Between Incident and Payment (Years)	Number of Payments	Mean Delay Between Incident and Payment (Years)	Median Delay Between Incident and Payment (Years)
Anesthesia Related	396	4.09	3.66	6,578	3.74	3.26
Behavioral Health Related**	43	4.09	3.47	43	4.09	3.47
Diagnosis Related	4,783	4.80	4.31	71,522	4.82	4.23
Equipment or Product Related	62	3.45	3.19	775	6.24	3.67
IV or Blood Products Related	37	4.78	4.01	784	5.40	4.23
Medication Related	714	4.09	3.71	11,751	5.17	3.76
Monitoring Related	384	4.16	3.84	2,650	4.94	4.07
Obstetrics Related	1,361	6.01	5.01	18,035	6.17	4.93
Surgery Related	3,756	4.18	3.80	57,119	4.26	3.72
Treatment Related	2,608	4.52	4.05	37,174	4.71	4.01
Miscellaneous	204	4.07	3.72	3,054	4.78	3.70
All Reasons	14,348	4.61	4.10	209,485	4.76	4.03

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Medical Malpractice Payment Reports which are missing data necessary to calculate payment delay or malpractice reason (48 reports for 2003 and 1,135 reports cumulatively) are excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** The "Behavioral Health" category was added on January 31, 2004. Reports involving behavioral health issues filed before January 31, 2004 used other reporting categories. Cumulative data in this category includes only reports filed after January 31, 2004.

**Table 6: Number of Medical Malpractice Payment Reports by Malpractice Reason - Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Practice Nurses/Clinical Nurse Specialists)
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)**

Malpractice Reason	RN (Professional) Nurse	Nurse Anesthetist	Nurse Midwife	Nurse Practitioner	Advanced Practice Nurse/ Clinical Nurse Specialist*	Total
Anesthesia Related	117	863	1	6	1	988
Behavioral Health Related**	2	1	0	0	0	3
Diagnosis Related	208	16	36	165	0	425
Equipment or Product Related	51	6	0	2	0	59
IV or Blood Products Related	156	14	0	2	0	172
Medication Related	511	24	3	49	1	588
Monitoring Related	619	12	11	15	0	657
Obstetrics Related	340	8	366	23	0	737
Surgery Related	325	57	9	7	1	399
Treatment Related	620	29	32	88	5	774
Miscellaneous	182	5	1	11	0	199
All Reasons	3,131	1,035	459	368	8	5,001

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Medical Malpractice Payment Reports which are missing data necessary to determine the malpractice reason (8 reports for RNs) are excluded.

* Reporting using the "Advanced Nurse Practitioner" category began on March 5, 2002. The "Advanced Nurse Practitioner" category was changed to "Clinical Nurse Specialist" on September 9, 2002. Prior to March 5, 2002, these nurses were included in the "RN (Professional Nurse)" category.

** The "Behavioral Health" category was added on January 31, 2004. Reports involving behavioral health issues filed before January 31, 2004 used other reporting categories. Cumulative data in this category includes only reports filed after January 31, 2004.

**Table 7: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2004 and Cumulative through 2004- Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Practice Nurses/Clinical Nurse Specialists)
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)**

Malpractice Reason	2004 Only			Cumulative through 2004				
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Mean Payment	Median Payment	Inflation-Adjusted	
							Mean Payment	Median Payment
Anesthesia Related	82	\$292,612	\$175,000	988	\$253,836	\$100,000	\$296,885	\$122,753
Behavioral Health Related**	3	\$17,035	\$25,000	3	\$17,035	\$25,000	\$17,035	\$25,000
Diagnosis Related	53	\$272,221	\$125,000	425	\$295,082	\$125,000	\$339,570	\$144,501
Equipment or Product Related	7	\$96,943	\$28,400	59	\$165,005	\$40,000	\$201,262	\$42,610
IV or Blood Products Related	11	\$690,970	\$100,000	172	\$225,424	\$75,000	\$262,276	\$78,230
Medication Related	45	\$426,206	\$110,000	588	\$253,052	\$60,854	\$289,103	\$67,733
Monitoring Related	62	\$173,087	\$62,500	657	\$301,607	\$90,000	\$347,372	\$104,489
Obstetrics Related	95	\$532,676	\$300,000	737	\$514,308	\$225,000	\$573,030	\$258,038
Surgery Related	37	\$109,054	\$75,000	399	\$150,918	\$50,000	\$174,518	\$53,202
Treatment Related	74	\$143,604	\$50,000	774	\$165,517	\$50,000	\$186,174	\$59,920
Miscellaneous	19	\$305,637	\$50,000	199	\$253,543	\$40,000	\$281,999	\$48,347
All Reasons	488	\$302,738	\$100,000	5,001	\$277,851	\$87,500	\$316,949	\$101,392

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Medical Malpractice Payment Reports which are missing data necessary to determine the malpractice reason (8 reports cumulatively) are excluded.

** The "Behavioral Health" category was added on January 31, 2004. Reports involving behavioral health issues filed before January 31, 2004 used other reporting categories. Cumulative data in this category includes only reports filed after January 31, 2004.

Table 8: Actual and Adjusted Medical Malpractice Payment Reports and Ratio of Adjusted Medical Malpractice Payment Reports by State - Physicians* and Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Practice Nurses/Clinical Nurse Specialists) National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

State	Number of Nurse Reports	Adjusted Number of Nurse Reports**	Adjusted Number of Physician Reports**	Ratio of Adjusted Physician Reports to Adjusted Nurse Reports	Ratio of Adjusted Nurse Reports to Adjusted Physician Reports
Alabama	76	76	861	11.33	0.09
Alaska	12	12	262	21.83	0.05
Arizona	79	79	3,295	41.71	0.02
Arkansas	39	39	1,002	25.69	0.04
California	202	202	21,798	107.91	0.01
Colorado	83	83	2,241	27.00	0.04
Connecticut	30	30	2,204	73.47	0.01
Delaware	9	9	526	58.44	0.02
District of Columbia	36	36	800	22.22	0.04
Florida**	397	397	14,692	37.01	0.03
Georgia	148	148	3,680	24.86	0.04
Hawaii	9	9	500	55.56	0.02
Idaho	32	32	434	13.56	0.07
Illinois	170	170	8,623	50.72	0.02
Indiana**	26	22	2,707	123.05	0.01
Iowa	27	27	1,664	61.63	0.02
Kansas**	87	64	1,560	24.38	0.04
Kentucky	60	60	2,292	38.20	0.03
Louisiana**	165	142	2,683	18.89	0.05
Maine	12	12	564	47.00	0.02
Maryland	88	88	3,425	38.92	0.03
Massachusetts	272	272	3,796	13.96	0.07
Michigan	113	113	10,946	96.87	0.01
Minnesota	36	36	1,588	44.11	0.02
Mississippi	55	55	1,607	29.22	0.03
Missouri	220	219	3,715	16.96	0.06
Montana	12	12	874	72.83	0.01
Nebraska**	40	38	820	21.58	0.05
Nevada	31	31	1,202	38.77	0.03
New Hampshire	37	37	773	20.89	0.05
New Jersey	615	615	8,366	13.60	0.07
New Mexico**	84	82	1,094	13.34	0.07
New York	282	282	27,020	95.82	0.01
North Carolina	90	90	3,189	35.43	0.03
North Dakota	7	7	351	50.14	0.02
Ohio	144	144	9,126	63.38	0.02
Oklahoma	70	70	1,528	21.83	0.05
Oregon	40	40	1,372	34.30	0.03
Pennsylvania**	163	140	12,534	89.53	0.01
Rhode Island	16	16	893	55.81	0.02
South Carolina**	32	30	1,336	44.53	0.02
South Dakota	15	15	335	22.33	0.04
Tennessee	123	123	2,503	20.35	0.05
Texas	430	430	14,811	34.44	0.03
Utah	23	23	1,463	63.61	0.02
Vermont	6	6	406	67.67	0.01
Virginia	86	86	2,972	34.56	0.03
Washington	78	78	3,387	43.42	0.02
West Virginia	42	42	2,012	47.90	0.02
Wisconsin**	39	37	1,406	38.00	0.03
Wyoming	9	9	369	41.00	0.02
All Jurisdictions***	5,009	4,927	199,845	40.56	0.02

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** Adjusted columns exclude reports from State patient compensation funds and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. Two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have or had these funds. Thus, the adjusted columns provide an approximate number of incidents resulting in payments rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the Annual Report narrative for additional details.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (10 reports for nurses and 2,220 reports for physicians); additional reports that lack information about the State are also included (2 reports for nurses and 20 reports for physicians).

**Table 9: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2004 and Cumulative Through 2004 - Physician Assistants
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)**

Malpractice Reason	2004 Only			Cumulative through 2004				
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Mean Payment	Median Payment	Inflation-Adjusted	
							Mean Payment	Median Payment
Anesthesia Related	0	--	--	6	\$112,148	\$50,000	\$117,420	\$51,608
Behavioral Health Related*	0	--	--	0	--	--	--	--
Diagnosis Related	63	\$206,860	\$100,000	509	\$187,508	\$95,000	\$203,539	\$103,215
Equipment or Product Related	1	\$27,500	\$27,500	1	\$27,500	\$27,500	\$27,500	\$27,500
IV or Blood Products Related	1	\$460,000	\$460,000	3	\$256,250	\$225,000	\$259,559	\$232,234
Medication Related	15	\$107,713	\$50,000	76	\$103,365	\$40,000	\$112,681	\$42,330
Monitoring Related	6	\$170,738	\$147,414	14	\$150,487	\$147,414	\$162,253	\$147,414
Obstetrics Related	1	\$250,000	\$250,000	5	\$258,000	\$125,000	\$284,919	\$131,747
Surgery Related	5	\$245,000	\$100,000	42	\$83,642	\$35,000	\$93,613	\$39,811
Treatment Related	40	\$152,845	\$67,500	225	\$99,781	\$31,000	\$109,776	\$35,052
Miscellaneous	3	\$219,187	\$145,000	31	\$127,773	\$50,000	\$134,862	\$57,048
All Reasons	135	\$180,787	\$100,000	912	\$151,412	\$70,972	\$164,680	\$78,230

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Behavioral Health" category was added on January 31, 2004. Reports involving behavioral health issues filed before January 31, 2004 used other reporting categories. Cumulative data in this category includes only reports filed after January 31, 2004.

Table 10: Actual and Adjusted Medical Malpractice Payment Reports and Ratio of Adjusted Medical Practitioner Reports by State, Physicians and Dentists, Cumulative Through 2004 National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

State	Physicians*		Dentists*		Ratio of Adjusted Physician Reports to Adjusted Dentist Reports	Ratio of Adjusted Dentist Reports to Adjusted Physician Reports
	Number of Reports	Adjusted Number of Reports**	Number of Reports	Adjusted Number of Reports**		
Alabama	870	861	170	170	5.06	0.20
Alaska	262	262	74	73	3.59	0.28
Arizona	3,314	3,295	522	522	6.31	0.16
Arkansas	1,010	1,002	145	145	6.91	0.14
California	21,828	21,798	7,244	7,244	3.01	0.33
Colorado	2,259	2,241	425	425	5.27	0.19
Connecticut	2,208	2,204	547	547	4.03	0.25
Delaware	539	526	59	59	8.92	0.11
District of Columbia	803	800	129	129	5.72	0.16
Florida**	14,761	14,692	1,763	1,763	8.33	0.12
Georgia	3,697	3,680	649	649	5.67	0.18
Hawaii	500	500	121	121	4.13	0.24
Idaho	436	434	65	65	6.68	0.15
Illinois	8,642	8,623	1,363	1,363	6.33	0.16
Indiana**	4,130	2,707	390	364	7.44	0.13
Iowa	1,667	1,664	201	201	8.28	0.12
Kansas**	2,344	1,560	239	237	6.58	0.15
Kentucky	2,312	2,292	349	349	6.57	0.15
Louisiana**	3,821	2,683	397	372	7.21	0.14
Maine	565	564	107	107	5.27	0.19
Maryland	3,434	3,425	799	799	4.29	0.23
Massachusetts	3,805	3,796	944	944	4.02	0.25
Michigan	10,956	10,946	1,548	1,548	7.07	0.14
Minnesota	1,600	1,588	309	309	5.14	0.19
Mississippi	1,613	1,607	141	140	11.48	0.09
Missouri	3,831	3,715	525	525	7.08	0.14
Montana	876	874	81	81	10.79	0.09
Nebraska**	992	820	134	134	6.12	0.16
Nevada	1,205	1,202	206	206	5.83	0.17
New Hampshire	774	773	158	158	4.89	0.20
New Jersey	8,447	8,366	1,214	1,214	6.89	0.15
New Mexico**	1,368	1,094	181	181	6.04	0.17
New York	27,050	27,020	4,260	4,260	6.34	0.16
North Carolina	3,222	3,189	279	279	11.43	0.09
North Dakota	355	351	35	35	10.03	0.10
Ohio	9,145	9,126	1,163	1,163	7.85	0.13
Oklahoma	1,548	1,528	358	358	4.27	0.23
Oregon	1,376	1,372	271	271	5.06	0.20
Pennsylvania**	18,278	12,534	2,262	2,262	5.54	0.18
Rhode Island	895	893	122	122	7.32	0.14
South Carolina**	1,689	1,336	149	144	9.28	0.11
South Dakota	337	335	59	59	5.68	0.18
Tennessee	2,516	2,503	323	323	7.75	0.13
Texas	14,848	14,811	1,996	1,996	7.42	0.13
Utah	1,465	1,463	484	484	3.02	0.33
Vermont	407	406	80	80	5.08	0.20
Virginia	2,984	2,972	504	504	5.90	0.17
Washington	3,396	3,387	1,175	1,175	2.88	0.35
West Virginia	2,015	2,012	162	162	12.42	0.08
Wisconsin**	1,642	1,406	477	477	2.95	0.34
Wyoming	370	369	38	38	9.71	0.10
All Jurisdictions***	210,647	199,845	35,514	35,454	5.64	0.18

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents. The "Dentists" category includes dental residents.

** Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with double asterisks have or had these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payments rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the Annual Report narrative for additional details.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (2,220 reports for physicians and 113 reports for dentists); an additional 25 reports (20 reports for physicians and 5 reports for dentists) that lack information about the State are also included in the total.

**Table 11: Number of Medical Malpractice Payment Reports by State, Last Five Years - Physicians*
National Practitioner Data Bank (January 1, 2000 - December 31, 2004)**

State	2000		2001		2002		2003		2004	
	Number of Reports	Adjusted Number of Reports**	Number of Reports	Adjusted Number of Reports**	Number of Reports	Adjusted Number of Reports**	Number of Reports	Adjusted Number of Reports**	Number of Reports	Adjusted Number of Reports**
Alabama	83	82	75	75	78	76	57	57	63	63
Alaska	17	17	20	20	20	20	19	19	17	17
Arizona	265	263	298	296	273	270	317	316	213	211
Arkansas	69	69	83	82	95	94	73	72	78	78
California	1,396	1,396	1,458	1,456	1,381	1,377	1,362	1,359	1,243	1,240
Colorado	144	143	136	134	180	180	178	176	151	151
Connecticut	167	167	172	170	178	178	226	226	168	168
Delaware	31	30	51	51	56	51	66	65	29	29
District of Columbia	62	62	76	76	60	58	46	46	47	47
Florida**	1,226	1,223	1,298	1,289	1,267	1,261	1,359	1,349	1,211	1,201
Georgia	275	274	272	272	282	281	329	327	336	333
Hawaii	40	40	41	41	35	35	49	49	36	36
Idaho	33	33	30	30	29	28	39	38	31	31
Illinois	590	589	528	527	491	489	503	501	477	473
Indiana**	286	168	323	217	156	155	434	191	236	137
Iowa	121	121	145	144	134	134	124	124	100	100
Kansas**	187	122	162	112	158	108	151	96	170	104
Kentucky	187	186	186	185	265	263	221	218	162	159
Louisiana**	294	188	305	208	320	200	294	187	279	194
Maine	65	65	39	39	37	37	39	38	37	37
Maryland	248	248	281	281	297	297	313	313	269	265
Massachusetts	324	323	340	338	228	228	258	256	268	267
Michigan	661	659	798	797	759	757	584	583	546	545
Minnesota	87	86	109	109	104	101	108	105	95	95
Mississippi	116	116	144	143	158	158	112	112	103	102
Missouri	201	197	296	286	259	257	230	221	274	261
Montana	67	67	69	69	64	64	62	62	40	40
Nebraska**	78	59	94	75	102	83	89	64	83	64
Nevada	116	116	90	89	122	122	112	112	103	102
New Hampshire	64	64	59	59	42	42	54	54	46	45
New Jersey	617	609	942	932	688	676	612	598	617	605
New Mexico**	108	89	110	89	69	69	76	74	82	82
New York	2,105	2,103	2,081	2,078	1,839	1,834	1,821	1,817	1,953	1,951
North Carolina	216	215	224	224	270	267	222	217	264	262
North Dakota	16	16	23	23	29	29	34	33	25	25
Ohio	846	846	674	674	535	532	589	586	486	485
Oklahoma	104	103	137	136	124	124	142	138	166	166
Oregon	81	81	87	87	111	110	129	128	112	111
Pennsylvania**	1,401	874	1,565	1,046	1,339	832	1,286	834	1,327	880
Rhode Island	67	67	59	59	55	55	75	74	44	44
South Carolina*	160	124	187	131	162	121	167	128	175	116
South Dakota	26	26	23	23	23	23	40	40	24	23
Tennessee	180	179	203	203	211	211	173	173	211	211
Texas	1,117	1,115	1,172	1,170	1,088	1,086	1,103	1,097	1,099	1,096
Utah	105	105	108	107	117	117	100	100	92	92
Vermont	23	23	24	24	19	19	27	26	21	21
Virginia	201	200	217	215	221	218	202	201	188	186
Washington	210	210	254	254	244	243	222	222	205	203
West Virginia	169	169	206	206	178	178	111	111	85	85
Wisconsin**	76	70	106	99	121	109	118	110	86	81
Wyoming	26	26	27	27	35	35	25	25	17	17
All Jurisdictions***	15,553	14,621	16,648	15,717	15,276	14,468	15,280	14,266	14,396	13,543

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** Adjusted columns exclude reports from state patient compensation and similar state funds which make payments in excess or amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with double asterisks have or had these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payments rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the Annual Report narrative for additional details.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (199 reports in 2000, 241 reports in 2001, 168 reports in 2002, 197 reports in 2003, and 206 reports in 2004); one additional report (in 2003) that lacks information about the State is also included in the total.

Table 12: Number of Medical Malpractice Payment Reports by State, Last Five Years - Dentists*
National Practitioner Data Bank (January 1, 2000 - December 31, 2004)

State	2000		2001		2002		2003		2004	
	Number of Reports	Adjusted Number of Reports**	Number of Reports	Adjusted Number of Reports**	Number of Reports	Adjusted Number of Reports**	Number of Reports	Adjusted Number of Reports**	Number of Reports	Adjusted Number of Reports**
Alabama	12	12	14	14	12	12	10	10	8	8
Alaska	7	7	7	7	2	2	8	8	6	6
Arizona	27	27	32	32	33	33	36	36	22	22
Arkansas	11	11	13	13	12	12	7	7	4	4
California	425	425	386	386	453	453	374	374	375	375
Colorado	21	21	24	24	24	24	28	28	20	20
Connecticut	36	36	20	20	21	21	42	42	44	44
Delaware	2	2	5	5	3	3	1	1	2	2
District of Columbia	8	8	8	8	4	4	7	7	4	4
Florida**	118	118	128	128	112	112	112	112	69	69
Georgia	93	93	34	34	57	57	37	37	23	23
Hawaii	15	15	7	7	3	3	6	6	7	7
Idaho	2	2	2	2	4	4	9	9	6	6
Illinois	68	68	78	78	84	84	48	48	47	47
Indiana**	12	11	15	15	14	14	14	14	18	18
Iowa	7	7	13	13	17	17	13	13	10	10
Kansas**	8	8	14	14	9	9	13	13	15	15
Kentucky	13	13	24	24	21	21	15	15	17	17
Louisiana**	21	18	24	19	18	17	30	25	27	23
Maine	8	8	5	5	7	7	7	7	7	7
Maryland	66	66	56	56	52	52	28	28	33	33
Massachusetts	92	92	42	42	59	59	54	54	44	44
Michigan	71	71	79	79	61	61	62	62	49	49
Minnesota	19	19	14	14	10	10	15	15	13	13
Mississippi	11	10	10	10	12	12	7	7	8	8
Missouri	23	23	30	30	21	21	12	12	15	15
Montana	3	3	4	4	7	7	2	2	3	3
Nebraska**	6	6	8	8	6	6	10	10	7	7
Nevada	8	8	17	17	26	26	16	16	52	52
New Hampshire	5	5	8	8	7	7	8	8	10	10
New Jersey	46	46	126	126	76	76	70	70	58	58
New Mexico**	13	13	19	19	16	16	12	12	9	9
New York	388	388	473	473	256	256	433	433	311	311
North Carolina	11	11	18	18	19	19	13	13	11	11
North Dakota	5	5	1	1	7	7	1	1	2	2
Ohio	85	85	53	53	56	56	51	51	39	39
Oklahoma	70	70	34	34	30	30	28	28	16	16
Oregon	44	44	25	25	14	14	14	14	15	15
Pennsylvania**	163	163	149	149	121	121	100	100	81	81
Rhode Island	7	7	8	8	4	4	4	4	5	5
South Carolina**	12	11	10	10	15	12	13	12	15	15
South Dakota	5	5	1	1	3	3	2	2	3	3
Tennessee	26	26	23	23	26	26	14	14	16	16
Texas	93	93	99	99	115	115	84	84	104	104
Utah	13	13	6	6	33	33	17	17	17	17
Vermont	7	7	4	4	8	8	6	6	2	2
Virginia	37	37	29	29	22	22	17	17	22	22
Washington	56	56	56	56	51	51	278	278	53	53
West Virginia	10	10	16	16	7	7	14	14	11	11
Wisconsin**	25	25	33	33	16	16	25	25	36	36
Wyoming	2	2	3	3	11	11	2	2	2	2
All Jurisdictions-***	2,351	2,345	2,315	2,310	2,084	2,080	2,244	2,238	1,803	1,799

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

*The "Dentists" category includes dental residents.

** Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have or had these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payments rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the Annual Report narrative for additional details.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (12 reports in 1999, 15 reports in 2000, 8 reports in 2001, 7 reports in 2002, and 15 reports in 2003).

Table 13: Mean and Median Medical Malpractice Payment and Mean and Median Delay Between Incident and Payment by State, 2004 and Cumulative Through 2004 - Physicians*
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

State	Payment Amounts						Delay Between Incident and Payment			
	2004 Only			Cumulative through 2004			2004 Only		Cumulative through 2004	
	Mean Payment	Median Payment	Rank of 2004 Median Payment***	Mean Payment	Median Payment	Rank of Cumulative Median Payment***	Mean Delay Between Incident and Payment (Years)	Median Delay Between Incident and Payment (Years)	Mean Delay Between Incident and Payment (Years)	Median Delay Between Incident and Payment (Years)
Alabama	\$346,279	\$250,000	3	\$351,656	\$150,000	6	4.19	3.94	4.29	3.97
Alaska	\$151,524	\$75,000	49	\$229,134	\$90,000	34	4.74	4.24	3.90	3.53
Arizona	\$324,558	\$200,000	15	\$235,949	\$110,000	22	4.19	3.86	3.86	3.37
Arkansas	\$295,465	\$150,000	29	\$197,143	\$100,000	23	3.69	3.38	3.50	3.13
California	\$185,746	\$75,000	49	\$136,328	\$50,000	50	3.26	2.79	3.33	2.78
Colorado	\$314,268	\$125,000	38	\$193,261	\$75,000	42	3.48	3.11	3.41	3.02
Connecticut	\$449,296	\$250,000	3	\$373,701	\$157,500	5	5.19	5.08	5.43	5.31
Delaware	\$430,490	\$180,000	19	\$265,517	\$116,875	19	4.18	4.24	4.49	4.13
District of Columbia	\$408,865	\$250,000	3	\$404,471	\$195,000	2	4.35	3.85	4.74	4.02
Florida**	\$241,204	\$162,500	26	\$232,210	\$150,000	6	3.98	3.79	3.98	3.47
Georgia	\$312,392	\$175,000	20	\$304,059	\$150,000	6	4.21	3.69	3.72	3.35
Hawaii	\$457,755	\$187,500	18	\$289,500	\$100,000	23	3.86	4.10	4.03	3.81
Idaho	\$332,220	\$175,000	20	\$220,913	\$70,000	49	4.44	4.36	3.59	3.21
Illinois	\$516,529	\$375,000	1	\$344,517	\$200,000	1	5.62	5.15	5.71	5.15
Indiana**	\$274,316	\$121,648	42	\$174,868	\$75,001	41	6.04	5.58	5.56	5.18
Iowa	\$481,776	\$125,000	38	\$197,805	\$77,500	40	3.90	3.58	3.31	3.12
Kansas**	\$175,247	\$171,875	24	\$162,463	\$113,555	21	3.74	3.57	3.98	3.32
Kentucky	\$219,604	\$117,500	43	\$185,777	\$75,000	42	4.15	3.91	4.09	3.45
Louisiana**	\$139,746	\$100,000	44	\$143,857	\$90,000	34	6.06	5.37	5.15	4.63
Maine	\$385,403	\$225,000	10	\$264,446	\$150,000	6	3.88	3.87	4.11	3.73
Maryland	\$349,697	\$228,000	9	\$264,225	\$149,995	13	4.25	3.99	4.60	4.18
Massachusetts	\$401,886	\$250,000	3	\$318,552	\$175,000	4	5.78	5.65	5.93	5.64
Michigan	\$137,484	\$90,000	48	\$106,613	\$75,000	42	4.10	3.79	4.33	3.62
Minnesota	\$305,483	\$125,000	38	\$206,392	\$79,280	39	3.37	3.36	3.22	2.84
Mississippi	\$323,567	\$150,000	29	\$217,219	\$100,000	23	5.03	4.37	4.19	3.59
Missouri	\$311,882	\$205,000	13	\$224,647	\$115,000	20	4.12	3.63	4.45	3.86
Montana	\$272,637	\$162,500	26	\$175,448	\$72,805	48	3.62	3.50	4.23	3.76
Nebraska**	\$206,885	\$175,000	20	\$143,110	\$92,500	33	4.14	3.98	3.98	3.54
Nevada	\$291,095	\$205,800	12	\$276,172	\$125,000	15	4.87	4.72	4.49	4.20
New Hampshire	\$317,647	\$237,475	8	\$260,397	\$150,000	6	3.80	3.45	4.73	4.13
New Jersey	\$368,672	\$225,000	10	\$274,525	\$150,000	6	5.95	5.21	6.09	5.12
New Mexico**	\$200,046	\$100,000	44	\$144,725	\$100,000	23	3.92	4.08	3.82	3.38
New York	\$404,762	\$250,000	3	\$287,009	\$150,000	6	5.01	5.24	6.78	5.90
North Carolina	\$366,447	\$150,000	29	\$268,499	\$120,000	18	4.19	3.72	3.82	3.45
North Dakota	\$416,080	\$125,000	38	\$196,114	\$85,000	37	3.66	3.22	3.41	3.21
Ohio	\$304,287	\$150,000	29	\$238,659	\$100,000	23	4.07	3.59	4.43	3.56
Oklahoma	\$235,197	\$150,000	29	\$254,524	\$90,000	34	4.15	4.02	3.90	3.37
Oregon	\$310,527	\$155,000	28	\$219,706	\$95,000	31	3.48	3.09	3.42	3.02
Pennsylvania**	\$337,579	\$300,000	2	\$238,715	\$185,000	3	5.58	4.95	5.92	5.45
Rhode Island	\$370,834	\$166,250	25	\$273,559	\$125,000	15	6.69	6.06	6.18	5.86
South Carolina**	\$239,055	\$100,000	44	\$195,944	\$100,000	23	4.73	4.26	4.58	4.13
South Dakota	\$223,723	\$136,875	36	\$212,155	\$75,000	42	2.81	2.18	3.47	3.03
Tennessee	\$244,408	\$127,500	37	\$222,964	\$95,000	31	3.79	3.43	3.74	3.24
Texas	\$237,989	\$150,000	29	\$195,525	\$100,000	23	3.44	3.19	3.81	3.40
Utah	\$154,452	\$50,000	51	\$157,391	\$50,000	50	4.10	3.70	3.60	3.32
Vermont	\$225,570	\$200,000	15	\$148,572	\$75,000	42	4.19	3.55	4.34	4.06
Virginia	\$283,567	\$200,000	15	\$213,953	\$125,000	15	3.93	3.27	3.82	3.26
Washington	\$288,207	\$175,000	20	\$216,879	\$82,500	38	3.90	3.52	4.27	3.66
West Virginia	\$255,506	\$150,000	29	\$218,560	\$98,750	30	5.02	3.99	5.32	4.14
Wisconsin**	\$365,662	\$202,500	14	\$328,922	\$140,000	14	4.75	4.32	4.80	4.21
Wyoming	\$225,865	\$100,000	44	\$171,837	\$75,000	42	3.63	3.25	3.22	3.01
All Jurisdictions***	\$298,460	\$170,000		\$225,334	\$100,000		4.61	4.10	4.76	4.03

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** These data are not adjusted for payments by State compensation funds and other similar funds. Mean and median payments for States with payments made by these funds understate the actual mean and median amounts received by claimants. Payments made by these funds may also affect mean and median delay times between incidents and payments. States with these funds are marked with an asterisk.

*** One denotes the largest median payment; 51 denotes the lowest median payment.

**** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (206 reports in 2004 and 2,212 reports cumulatively for payment amount and 2,186 reports cumulatively for delay between incident and payment); also included in the total are additional reports that lack information about the State (20 reports cumulatively for payment amount and 18 reports cumulatively for delay between incident and payment).

Table 14: Number, Percent Distribution, and Percent Change of Adverse Action and Medicare/Medicaid Exclusion Reports by Practitioner Type, Last Five Years and Cumulative Through 2004 National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

Report Type	2000			2001			2002			2003			2004			Cumulative through 2004	
	Number	Percent	% Change 1999-2000	Number	Percent	% Change 2000-2001	Number	Percent	% Change 2001-2002	Number	Percent	% Change 2002-2003	Number	Percent	% Change 2003-2004	Number	Percent
State Licensure Total	4,328	35.3%	7.4%	3,151	43.6%	-27.2%	3,975	50.8%	26.2%	3,989	54.0%	0.4%	4,040	53.3%	1.3%	52,295	54.3%
Physicians*	3,337	27.2%	6.1%	2,583	35.7%	-22.6%	3,324	42.5%	28.7%	3,343	45.2%	0.6%	3,353	44.2%	0.3%	42,205	43.8%
Dentists*	991	8.1%	16.0%	568	7.9%	-42.7%	651	8.3%	14.6%	646	8.7%	-0.8%	687	9.1%	6.3%	10,061	10.4%
Other Practitioners*	0	0.0%	0.0%	0	0.0%	...	0	0.0%	...	0	0.0%	...	0	0.0%	...	29	0.0%
Clinical Privilege Total	1,041	8.5%	12.7%	1,028	14.2%	-1.2%	971	12.4%	-5.5%	988	13.4%	1.8%	1,098	14.5%	11.1%	13,473	14.0%
Physicians*	960	7.8%	10.9%	955	13.2%	-0.5%	914	11.7%	-4.3%	923	12.5%	1.0%	956	12.6%	3.6%	12,695	13.2%
Dentists*	24	0.2%	20.0%	37	0.5%	54.2%	19	0.2%	-48.6%	20	0.3%	5.3%	91	1.2%	355.0%	323	0.3%
Other Practitioners*	57	0.5%	50.0%	36	0.5%	-36.8%	38	0.5%	5.6%	45	0.6%	18.4%	51	0.7%	13.3%	455	0.5%
Professional Society Membership Total	28	0.2%	55.6%	33	0.5%	17.9%	45	0.6%	36.4%	46	0.6%	2.2%	49	0.6%	6.5%	524	0.5%
Physicians*	26	0.2%	44.4%	23	0.3%	-11.5%	38	0.5%	65.2%	46	0.6%	21.1%	42	0.6%	-8.7%	473	0.5%
Dentists*	0	0.0%	...	9	0.1%	...	6	0.1%	...	0	0.0%	0.0%	6	0.1%	...	46	0.0%
Other Practitioners*	2	0.0%	...	1	0.0%	...	1	0.0%	...	0	0.0%	0.0%	1	0.0%	...	5	0.0%
DEA Total	0	0.0%	...	9	0.1%	...	0	0.0%	...	54	0.7%	...	59	0.8%	9.3%	416	0.4%
Physicians*	0	0.0%	...	9	0.1%	...	0	0.0%	...	46	0.6%	...	47	0.6%	2.2%	385	0.4%
Dentists*	0	0.0%	...	0	0.0%	...	0	0.0%	...	5	0.1%	...	7	0.1%	40.0%	22	0.0%
Other Practitioners*	0	0.0%	...	0	0.0%	...	0	0.0%	...	3	0.0%	...	5	0.1%	66.7%	9	0.0%
Medicare/Medicaid Exclusion Total**	6,857	56.0%	187.5%	3,010	41.6%	-56.1%	2,833	36.2%	-5.9%	2,312	31.3%	-18.4%	2,333	30.8%	0.9%	29,640	30.8%
Physicians*	1,825	14.9%	274.0%	598	8.3%	-67.2%	412	5.3%	-31.1%	224	3.0%	-45.6%	177	2.3%	-21.0%	6,544	6.8%
Dentists*	551	4.5%	222.2%	177	2.4%	-67.9%	130	1.7%	-26.6%	83	1.1%	-36.2%	85	1.1%	2.4%	2,135	2.2%
Other Practitioners*	4,481	36.6%	159.6%	2,235	30.9%	-50.1%	2,291	29.3%	2.5%	2,005	27.1%	-12.5%	2,071	27.3%	3.3%	20,961	21.8%
All Reports	12,254	100.0%	65.2%	7,231	100.0%	-41.0%	7,824	100.0%	8.2%	7,389	100.0%	-5.6%	7,579	100.0%	2.6%	96,348	100.0%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Percent changes that cannot be calculated because no reports were submitted during one of the specified years are indicated by "..."

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents. The "Dentists" category includes dentists and dental interns and residents. The "Other Practitioners" category includes other health care practitioners, non-health care professionals and non-specified professionals.

** Medicare/Medicaid Exclusions were first reported during 1997. Reports that year include exclusion actions taken in previous years if the practitioner had not been reinstated. Exclusion Reports for non-health care practitioners are being removed from the NPDB.

Table 15: Currently Active Registered Non-Federal Hospitals That Have Never Reported to the National Practitioner Data Bank by State*
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

State	Number of Hospitals with "Active" NPDB Registrations	Number of "Active" Hospitals that Have Never Reported	Percent of Hospitals that Have Never Reported
Alabama	128	82	64.1%
Alaska	18	10	55.6%
Arizona	87	39	44.8%
Arkansas	106	61	57.5%
California	472	186	39.4%
Colorado	78	44	56.4%
Connecticut	45	15	33.3%
Delaware	10	3	30.0%
District of Columbia	15	4	37.5%
Florida	249	129	51.8%
Georgia	197	89	45.2%
Hawaii	28	16	57.1%
Idaho	48	30	62.5%
Illinois	222	92	41.4%
Indiana	150	75	50.0%
Iowa	120	79	65.8%
Kansas	154	109	70.8%
Kentucky	126	74	58.7%
Louisiana	228	170	74.6%
Maine	42	19	45.2%
Maryland	71	31	43.7%
Massachusetts	111	55	49.5%
Michigan	176	71	40.3%
Minnesota	139	95	68.3%
Mississippi	111	72	64.9%
Missouri	144	73	50.7%
Montana	53	37	69.8%
Nebraska	97	66	68.0%
Nevada	46	28	60.9%
New Hampshire	30	8	26.7%
New Jersey	110	38	34.5%
New Mexico	49	26	53.1%
New York	266	91	34.2%
North Carolina	139	71	51.1%
North Dakota	50	36	72.0%
Ohio	221	97	43.9%
Oklahoma	155	105	67.7%
Oregon	68	26	38.2%
Pennsylvania	267	121	45.3%
Rhode Island	15	4	26.7%
South Carolina	78	39	50.0%
South Dakota	58	45	77.6%
Tennessee	156	92	59.0%
Texas	544	347	63.8%
Utah	49	20	40.8%
Vermont	17	7	41.2%
Virginia	115	49	42.6%
Washington	92	38	41.3%
West Virginia	67	32	47.8%
Wisconsin	143	87	60.8%
Wyoming	26	18	69.2%
All Jurisdictions**	6,229	3,280	52.7%

* "Currently active" registered hospitals are those listed by the NPDB as having active status registrations on December 31, 2004. Non-Federal hospitals are hospitals not owned and operated by the Federal government.

** The total includes hospitals in American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and U.S. Virgin Islands (43 hospitals with active registrations, 29 hospitals which have never reported).

Table 16: Clinical Privileges Reports and Ratio of Adverse Clinical Privileges Reports to Adverse In-State Licensure Reports by State - Physicians*
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

State	Number of Clinical Privileges Reports*	Number of Clinical Privileges Reports Adverse to the Practitioner**	Number of Licensure Reports Adverse to the Practitioner for In-State Physicians	Ratio of Clinical Privileges Reports Adverse to the Practitioner to In-State Licensure Reports Adverse to the Practitioner
Alabama	163	149	355	0.42
Alaska	24	21	99	0.21
Arizona	383	349	986	0.35
Arkansas	118	106	189	0.56
California	1,531	1,425	3,159	0.45
Colorado	224	215	910	0.24
Connecticut	85	82	384	0.21
Delaware	30	28	28	1.00
District of Columbia	45	41	41	0.83
Florida	650	595	1,437	0.41
Georgia	405	378	746	0.51
Hawaii	56	51	35	1.46
Idaho	58	49	74	0.66
Illinois	343	317	769	0.41
Indiana	276	253	179	1.41
Iowa	119	107	352	0.30
Kansas	198	187	179	1.04
Kentucky	163	154	546	0.28
Louisiana	175	158	416	0.38
Maine	55	52	146	0.36
Maryland	286	267	798	0.33
Massachusetts	473	421	634	0.66
Michigan	423	389	1,184	0.33
Minnesota	185	170	313	0.54
Mississippi	81	78	331	0.24
Missouri	221	206	522	0.39
Montana	55	49	98	0.50
Nebraska	117	108	73	1.48
Nevada	178	152	98	1.55
New Hampshire	66	61	111	0.55
New Jersey	384	350	913	0.38
New Mexico	71	66	80	0.83
New York	908	838	1,962	0.43
North Carolina	230	208	288	0.72
North Dakota	43	40	100	0.40
Ohio	561	522	1,722	0.30
Oklahoma	206	193	514	0.38
Oregon	153	143	472	0.30
Pennsylvania	472	438	608	0.72
Rhode Island	69	64	111	0.58
South Carolina	176	158	322	0.49
South Dakota	27	25	31	0.81
Tennessee	227	208	326	0.64
Texas	860	791	1,814	0.44
Utah	91	89	162	0.55
Vermont	40	33	88	0.38
Virginia	270	247	1,095	0.23
Washington	298	270	484	0.56
West Virginia	109	96	376	0.26
Wisconsin	214	192	248	0.77
Wyoming	25	24	48	0.50
All Jurisdictions***	12,695	11,679	26,967	0.43

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Clinical Privileges Reports were attributed to States based on the physician's reported work State. If work State was not included in a report, home State was used. Licensure Reports were considered to be for In-State physicians if the State of the board taking a reported action was the same as the State of the clinical privileges action as described above.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** "Clinical Privileges Reports" include truly adverse actions (e.g., revocations, probations, suspensions, reprimands, etc.) as well as reportable "adverse actions" which are not adverse to the practitioner (e.g., restorations and reinstatements). "Reports Adverse to the Practitioner" exclude restorations, reinstatements, etc.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (55 Clinical Privileges Reports; 48 adverse Clinical Privileges Reports, and 11 adverse Licensure Reports); additional reports that lack information about the State are also included in the total (20 Clinical Privileges Reports, 17 adverse Clinical Privileges Reports).

Table 17: Licensure Actions by State, Cumulative Through 2004 - Physicians*
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

State	Number of Licensure Reports	Number of Licensure Reports Adverse to Practitioner**	Percent of Licensure Actions Adverse to Practitioner	Number of Licensure Reports Adverse to the Practitioner for In-State Physicians***	Percent of Licensure Action Reports Adverse to the Practitioner for In-State Physicians
Alabama	569	479	84.2%	355	74.1%
Alaska	172	157	91.3%	99	63.1%
Arizona	1,301	1,144	87.9%	986	86.2%
Arkansas	253	225	88.9%	189	84.0%
California	4,909	4,217	85.9%	3,159	74.9%
Colorado	1,195	1,077	90.1%	910	84.5%
Connecticut	499	480	96.2%	384	80.0%
Delaware	58	49	84.5%	28	57.1%
District of Columbia	173	164	88.0%	41	60.6%
Florida	1,969	1,692	85.9%	1,437	84.9%
Georgia	1,045	954	91.3%	746	78.2%
Hawaii	87	80	92.0%	35	43.8%
Idaho	138	118	85.5%	74	62.7%
Illinois	1,223	959	78.4%	769	80.2%
Indiana	352	300	85.2%	179	59.7%
Iowa	690	614	89.0%	352	57.3%
Kansas	256	216	84.4%	179	82.9%
Kentucky	814	687	84.4%	546	79.5%
Louisiana	657	528	80.4%	416	78.8%
Maine	233	205	88.0%	146	71.2%
Maryland	1,116	1,008	90.3%	798	79.2%
Massachusetts	850	802	94.4%	634	79.1%
Michigan	1,807	1,575	87.2%	1,184	75.2%
Minnesota	542	441	81.4%	313	71.0%
Mississippi	471	423	89.8%	331	78.3%
Missouri	883	810	91.7%	522	64.4%
Montana	156	144	92.3%	98	68.1%
Nebraska	110	106	96.4%	73	68.9%
Nevada	154	153	99.4%	98	64.1%
New Hampshire	147	142	96.6%	111	78.2%
New Jersey	1,581	1,344	85.0%	913	67.9%
New Mexico	113	99	87.6%	80	80.8%
New York	3,878	3,856	99.4%	1,962	50.9%
North Carolina	530	429	80.9%	288	67.1%
North Dakota	230	170	73.9%	100	58.8%
Ohio	2,793	2,240	80.2%	1,722	76.9%
Oklahoma	698	605	86.7%	514	85.0%
Oregon	570	523	91.8%	472	90.2%
Pennsylvania	1,377	1,287	93.5%	608	47.2%
Rhode Island	162	152	93.8%	111	73.0%
South Carolina	531	392	73.8%	322	82.1%
South Dakota	58	55	94.8%	31	56.4%
Tennessee	502	427	85.1%	326	76.3%
Texas	2,349	2,053	87.4%	1,814	88.4%
Utah	264	214	81.1%	162	75.7%
Vermont	149	137	91.9%	88	64.2%
Virginia	1,718	1,514	88.1%	1,095	72.3%
Washington	769	637	82.8%	484	76.0%
West Virginia	619	497	80.3%	376	75.7%
Wisconsin	396	339	85.6%	248	73.2%
Wyoming	76	71	93.4%	48	67.6%
All Jurisdictions	42,205	37,003	87.7%	26,967	72.9%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Licensure Reports were attributed to States based on the State of the reporting licensing board.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** "Licensure Reports" include truly adverse actions (e.g., revocations, probations, suspensions, reprimands, etc.) as well as reportable "adverse actions" which are not adverse to the practitioner (e.g., restorations and reinstatements). Reports "Adverse to the Practitioner" exclude restorations, reinstatements, etc.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands (13 licensure actions, 13 adverse licensure actions, and 11 adverse licensure actions for in-State physicians). Licensure reports were considered to be for In-State physicians if the State of the board taking a reported action was the same as the reported work State of the physician. If work State was not included in a report, home State was used.

Table 18: Licensure Actions by State, Cumulative Through 2004 - Dentists*
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

State	Number of Licensure Actions*	Number of Licensure Actions Adverse to Practitioner**	Percent of Licensure Actions Adverse to the Practitioner	Number of Licensure Actions Adverse to the Practitioner for In-State Dentists***	Percent of Licensure Actions Adverse to the Practitioner for In-State Dentists
Alabama	123	122	99.2%	119	97.5%
Alaska	50	48	96.0%	45	93.8%
Arizona	752	750	99.7%	721	96.1%
Arkansas	42	37	88.1%	37	100.0%
California	476	469	98.5%	445	94.9%
Colorado	557	552	99.1%	510	92.4%
Connecticut	163	155	95.1%	144	92.9%
Delaware	2	2	100.0%	2	100.0%
District of Columbia	2	2	100.0%	2	100.0%
Florida	495	454	91.7%	435	95.8%
Georgia	185	185	100.0%	179	96.8%
Hawaii	7	7	100.0%	6	85.7%
Idaho	18	18	100.0%	17	94.4%
Illinois	502	360	71.7%	332	92.2%
Indiana	66	55	83.3%	47	85.5%
Iowa	196	185	94.4%	134	72.4%
Kansas	34	34	100.0%	32	94.1%
Kentucky	104	102	98.1%	98	96.1%
Louisiana	141	137	97.2%	133	97.1%
Maine	50	50	100.0%	45	90.0%
Maryland	270	218	80.7%	197	90.4%
Massachusetts	160	152	95.0%	138	90.8%
Michigan	541	475	87.8%	423	89.1%
Minnesota	198	155	78.3%	151	97.4%
Mississippi	58	57	98.3%	54	94.7%
Missouri	161	159	98.8%	139	87.4%
Montana	22	21	95.5%	18	85.7%
Nebraska	44	41	93.2%	33	80.5%
Nevada	43	40	93.0%	37	92.5%
New Hampshire	30	30	100.0%	28	93.3%
New Jersey	299	272	91.0%	259	95.2%
New Mexico	13	12	92.3%	11	91.7%
New York	555	552	99.5%	500	90.6%
North Carolina	305	298	97.7%	290	97.3%
North Dakota	2	2	100.0%	2	100.0%
Ohio	657	632	96.2%	619	97.9%
Oklahoma	104	103	99.0%	100	97.1%
Oregon	309	308	99.7%	287	93.2%
Pennsylvania	199	194	97.5%	146	75.3%
Rhode Island	15	15	100.0%	12	80.0%
South Carolina	103	98	95.1%	95	96.9%
South Dakota	3	3	100.0%	3	100.0%
Tennessee	180	162	90.0%	153	94.4%
Texas	428	424	99.1%	422	99.5%
Utah	96	76	79.2%	66	86.8%
Vermont	15	14	93.3%	10	71.4%
Virginia	777	733	94.3%	673	91.8%
Washington	302	287	95.0%	261	90.9%
West Virginia	20	19	95.0%	17	89.5%
Wisconsin	180	161	89.4%	148	91.9%
Wyoming	4	4	100.0%	4	100.0%
All Jurisdictions	10,061	9,444	93.9%	8,782	93.0%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Licensure Reports were attributed to States based on the State of the reporting licensing board.

*The "Dentists" category includes dental residents.

** "Licensure Reports" include truly adverse actions (e.g., revocations, probations, suspensions, reprimands, etc.) as well as reportable "adverse actions" which are not adverse to the practitioner (e.g., restorations and reinstatements). Reports "Adverse to the Practitioner" exclude restorations, reinstatements, etc.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (2 licensure actions, 2 adverse licensure actions, and 2 adverse licensure actions for in-State physicians). Licensure reports were considered to be for In-State physicians if the State of the board taking a reported action was the same as the reported work State of the physician. If work State was not included in a report, home State was used.

Table 19: Relationship Between Frequency of Medical Malpractice Payment Reports, Adverse Action Reports,* and Medicare/Medicaid Exclusion Reports -- Physicians
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)**

Number of Medical Malpractice Payment Reports	Number of Physicians with Specified Number of Malpractice Payment Reports	Number of Physicians with Specified Number of Medical Malpractice Payment Reports Also Having One or More Adverse Action Reports Other than Exclusions***		Number of Physicians with Specified Number of Medical Malpractice Payment Reports Also Having One or More Medicare/Medicaid Exclusion Reports	
		Number	Percent	Number	Percent
1	90,086	4,028	4.5%	677	0.8%
2	26,616	1,709	6.4%	286	1.1%
3	8,823	772	8.7%	143	1.6%
4	3,725	429	11.5%	60	1.6%
5	1,637	233	14.2%	40	2.4%
6	814	119	14.6%	29	3.6%
7	435	70	16.1%	16	3.7%
8	254	57	22.4%	12	4.7%
9	166	47	28.3%	4	2.4%
10 or More	434	141	32.5%	38	8.8%
Total	132,990	7,605	5.7%	1,305	1.0%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* "Adverse Action Reports" are as defined in footnote 1 on page 6 of this report, except that in this table Exclusion Reports are reported separately from other Adverse Action Reports.

** The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

*** For example, 90,086 physicians have one Medical Malpractice Payment Report in the NPDB; of these physicians, 4,028 have one or more adverse action reports (4.5%) and 86,058 (95.5%) have no Adverse Action Reports, not including Exclusion Reports. Similarly, of the 90,086 physicians with one Medical Malpractice Payment Report, 677 (0.8%) have one exclusion report and 89,409 (99.2%) have no Exclusion

Table 20: Relationship Between Frequency of Adverse Action Reports*, Medical Malpractice Payment Reports, and Medicare/Medicaid Exclusion Reports -- Physicians**

National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

Number of Adverse Action Reports for Each Physician	Number of Physicians with Specified Number of Adverse Action Reports (including Exclusions)*	Number of Physicians with Specified Number of Adverse Action Reports Having One or More Medical Malpractice Payment Reports***		Number of Physicians with Specified Number of Adverse Action Reports Having One or More Medicare/Medicaid Exclusion Reports	
		Number	Percent	Number	Percent
1	9,874	3,363	34.1%	1,009	10.2%
2	6,085	2,159	35.5%	1,550	25.5%
3	2,868	1,029	35.9%	910	31.7%
4	1,483	559	37.7%	581	39.2%
5	861	312	36.2%	351	40.8%
6	461	171	37.1%	215	46.6%
7	285	99	34.7%	139	48.8%
8	158	70	44.3%	76	48.1%
9	86	21	24.4%	53	61.6%
10 or More	175	71	40.6%	96	54.9%
Total	22,336	7,854	35.2%	4,980	22.3%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* "Adverse Action Reports" in this column are as defined in footnote 1 on page 6 of this report. This definition includes Medicare/Medicaid Exclusion Reports, which are also counted separately in the last column.

** The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

*** For example, 9,874 physicians have one Adverse Action Report in the NPDB; of these physicians, 3,363 have one or more Medical Malpractice Payment Reports (34.1%) and 6,511 (65.9%) have no Medical Malpractice Payment Reports. Similarly, of the 9,874 physicians with one Adverse Action Report, 1,009 (10.2%) have one Exclusion Report and 8,865 (89.8%) have no Exclusion Reports. Note that for the 1,009 physicians with one Adverse Action Report and one Exclusion Report, the Exclusion Report is their only Adverse Action Report.

Table 21: Practitioners with Reports
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

Practitioner Type	Number of Practitioners with Reports	Number of Reports*	Reports per Practitioner
Acupuncturists	89	92	1.03
Audiologists	31	33	1.06
Chiropractors	6,144	7,658	1.25
Counselors	561	638	1.14
Dental Assistants, Technicians, Hygienists	23	23	1.00
Dentists and Dental Residents	29,071	47,630	1.64
Denturists	10	10	1.00
Dieticians	7	7	1.00
Emergency Medical Practitioners	111	116	1.05
Homeopaths and Naturopaths	11	11	1.00
Medical Assistants	26	26	1.00
Nurses and Nursing-related Practitioners	18,388	19,529	1.06
Occupational Therapists and Related Practitioners	60	62	1.03
Optical-related Practitioners	589	715	1.21
Pharmacists and Pharmacy Assistants	2,334	2,687	1.15
Physical Therapists and Related Practitioners	788	828	1.05
Physician Assistants	1,025	1,153	1.12
Physicians (M.D., D.O. and Interns and Residents)	150,184	274,078	1.82
Podiatrists and Podiatric-related Practitioners	3,970	6,717	1.69
Prosthetists	5	5	1.00
Psychiatric Technicians and Aides	8	9	1.13
Psychology-related Practitioners	1,204	1,521	1.26
Respiratory Therapists and Related Practitioners	35	36	1.03
Social Workers	179	199	1.11
Speech and Language-related Practitioners	4	4	1.00
Technologists	157	161	1.03
Other Health Care Practitioners	3	3	1.00
Other Individuals	8	9	1.13
Unspecified or Unknown	325	336	1.03
All Types	215,350	364,296	1.69

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* "Number of Reports" include Medical Malpractice Payment Reports, Adverse State Licensure Action Reports, Clinical Privileges Reports, Professional Society Membership Reports, Drug Enforcement Administration Reports, and Medicare/Medicaid Exclusion Reports. Only physicians and dentists are reported for adverse licensure, clinical privilege, and professional society actions.

Table 22: Number, Percent, and Percent Change in Queries and Queries Matched, Last Five Years and Cumulative Through 2004
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

Query Type	2000	2001	2002	2003	2004	Cumulative
ENTITY QUERIES*						
Total Entity Queries	3,291,610	3,231,086	3,254,506	3,214,081	3,448,514	35,458,411
Queries Percent Increase/Decrease from Previous Year	4.3%	-1.8%	0.7%	-1.2%	7.3%	n/a
Matched Queries	416,559	428,440	439,793	440,830	484,040	4,079,295
Percent Matched	12.7%	13.3%	13.5%	13.7%	14.0%	11.5%
Matches Percent Increase/Decrease from Previous Year	11.4%	2.9%	2.6%	0.2%	9.8%	n/a
SELF-QUERIES						
Total Practitioner Self-Queries	33,248	36,608	37,804	42,214	47,948	503,937
Self-Queries Percent Increase/Decrease from Previous Year	-31.1%	10.1%	3.3%	11.7%	13.6%	n/a
Matched Self-Queries	2,743	3,293	3,763	4,174	4,823	42,927
Self-Queries Percent Matched	8.3%	9.0%	10.0%	9.9%	10.1%	8.5%
Matches Percent Increase/Decrease from Previous Year	-36.1%	20.1%	14.3%	10.9%	15.5%	n/a
TOTAL QUERIES (ENTITY AND SELF)	3,324,858	3,267,694	3,292,310	3,256,295	3,496,462	35,962,348
TOTAL MATCHED (ENTITY AND SELF)	419,302	431,733	443,556	445,004	488,863	4,122,222
TOTAL PERCENT MATCHED (ENTITY AND SELF)	12.6%	13.2%	13.5%	13.7%	14.0%	11.5%

* "Entity queries" include practitioner self-queries submitted electronically by entities for practitioners in 1999 and 2000.

Table 23: Queries by Type of Querying Entity, Last Five Years and Cumulative Through 2004
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

Entity Type*	2000			2001			2002		
	Number of Querying Entities	Number of Queries**	Percent of Queries	Number of Querying Entities	Number of Queries**	Percent of Queries	Number of Querying Entities	Number of Queries**	Percent of Queries
Required Queriers									
Hospitals	5,794	1,119,193	34.0%	5,776	1,117,589	34.6%	5,825	1,119,144	34.4%
Voluntary Queriers									
State Licensing Board	71	11,085	0.3%	73	15,897	0.5%	72	17,408	0.5%
Managed Care Organizations	1,189	1,695,936	51.5%	1,125	1,637,876	50.7%	1,038	1,628,569	50.0%
Professional Societies	78	9,240	0.3%	72	7,108	0.2%	71	6,724	0.2%
Other Health Care Entities	3,151	456,156	13.9%	3,419	452,616	14.0%	3,826	482,661	14.8%
Total Voluntary Queriers	4,489	2,172,417	66.0%	4,689	2,113,497	65.4%	5,007	2,135,362	65.6%
Total**	10,283	3,291,610	100.0%	10,465	3,231,086	100.0%	10,832	3,254,506	100.0%

Entity Type*	2003			2004			Cumulative through 2004		
	Number of Querying Entities	Number of Queries**	Percent of Queries	Number of Querying Entities	Number of Queries**	Percent of Queries	Number of Querying Entities	Number of Queries**	Percent of Queries
Required Queriers									
Hospitals	5,868	1,138,945	35.4%	5,943	1,185,266	34.4%	7,923	14,113,802	39.8%
Voluntary Queriers									
State Licensing Board	80	14,801	0.5%	85	18,669	0.5%	158	160,904	0.5%
Managed Care Organizations	968	1,549,495	48.2%	927	1,680,396	48.7%	2,053	16,317,228	46.0%
Professional Societies	69	8,152	0.3%	73	7,072	0.2%	209	97,557	0.3%
Other Health Care Entities	4,449	502,688	15.6%	5,245	557,111	16.2%	8,388	4,768,920	13.4%
Total Voluntary Queriers	5,566	2,075,136	64.6%	6,330	2,263,248	65.6%	10,808	21,344,609	60.2%
Total**	11,434	3,214,081	100.0%	12,273	3,448,514	100.0%	18,731	35,458,411	100.0%

* "Entity Type" is based on how an entity was registered on the last day of 2004 and may be different from previous years. Thus, the number of queriers for each entity type also may vary slightly from the number shown in annual reports for previous years.

** Queries listed in this table include all queries submitted by entities, including practitioner self-queries submitted electronically as a service to practitioners by entities in 1999 and

**Table 24: Number of Entity Queries and Matched Entity Queries by Practitioner/Subject Type
National Practitioner Data Bank, 2004**

Practitioner/Subject Type	Number of Entity Queries, 2004	Percent of Total Entity Queries	Number of Entity Queries Matched, 2004	Percent of Entity Queries Matched	Practitioner/Subject Type (continued)	Number of Entity Queries, 2004	Percent of Total Entity Queries	Number of Entity Queries Matched, 2004	Percent of Entity Queries Matched
Accountant (see Note 1)	15	0.0%	1	6.7%	Nurses Aide	373	0.0%	2	0.5%
Acupuncturist	3,264	0.1%	92	2.8%	Nutritionist	451	0.0%	2	0.4%
Adult Care Facility Administrator (see Note 1)	58	0.0%	8	13.8%	Occupational Therapy Assistant	154	0.0%	0	0.0%
Allopathic Physician Intern/Resident	12,575	0.4%	718	5.7%	Occupational Therapist	9,901	0.3%	8	0.1%
Allopathic Physician	2,280,831	66.1%	400,592	17.6%	Ocularist	49	0.0%	3	6.1%
Art/Recreation Therapist	97	0.0%	1	1.0%	Optician	445	0.0%	6	1.3%
Athletic Trainer (see Note 1)	211	0.0%	0	0.0%	Optometrist	70,933	2.1%	816	1.2%
Audiologists	5,009	0.1%	19	0.4%	Orthotics/Prosthetics Fitter	616	0.0%	1	0.2%
Bookkeepers (see Note 1)	2	0.0%	0	0.0%	Osteopathic Physician Intern/Resident	1,465	0.0%	76	5.2%
Business Manager (see Note 1)	3	0.0%	0	0.0%	Osteopathic Physician	136,810	4.0%	26,381	19.3%
Business Owner (see Note 1)	4	0.0%	0	0.0%	Other Health Care Practitioner, Not Classified (see Note 1)	12,153	0.4%	156	1.3%
Chiropractor	70,261	2.0%	4,218	6.0%	Other Non-Practitioner Occupation, Not Classified (see Note 1)	2,268	0.1%	66	2.9%
Clinical Nurse Specialist (see Note 2)	1,278	0.0%	8	0.6%	Perfusionist (see Note 1)	1,410	0.0%	4	0.3%
Corporate Officer (see Note 1)	6	0.0%	0	0.0%	Pharmacist	1,673	0.0%	22	1.3%
Cytotechnologist (see Note 1)	37	0.0%	0	0.0%	Pharmacist, Nuclear	24	0.0%	2	8.3%
Dental Assistant	1,797	0.1%	7	0.4%	Pharmacy Assistant	751	0.0%	13	1.7%
Dental Hygienist	651	0.0%	3	0.5%	Pharmacy Intern (see Note 2)	28	0.0%	1	3.6%
Dental Resident	264	0.0%	17	6.4%	Pharmacy Technician (see Note 2)	181	0.0%	16	8.8%
Dentist	206,694	6.0%	33,349	16.1%	Physician Assistant, Allopathic	59,945	1.7%	806	1.3%
Denturist	34	0.0%	2	5.9%	Physician Assistant, Osteopathic	2,460	0.1%	47	1.9%
Dietician	2,327	0.1%	1	0.0%	Physical Therapy Assistant	479	0.0%	0	0.0%
EMT, Basic	98	0.0%	2	2.0%	Physical Therapist	55,719	1.6%	363	0.7%
EMT, Cardiac/Critical Care	21	0.0%	0	0.0%	Podiatric Assistant	324	0.0%	22	6.8%
EMT, Intermediate	28	0.0%	1	3.6%	Podiatrist	62,094	1.8%	12,949	20.9%
EMT, Paramedic	418	0.0%	1	0.2%	Professional Counselor, Substance Abuse	862	0.0%	2	0.2%
Home Health Aide (Homemaker)	14	0.0%	3	21.4%	Professional Counselor, Alcohol	1,029	0.0%	1	0.1%
Homeopath	4	0.0%	1	25.0%	Professional Counselor, Family/Marriage (see Note 2)	7,736	0.2%	25	0.3%
Hospital Administrator (see Note 1)	2	0.0%	0	0.0%	Professional Counselor	37,198	1.1%	76	0.2%
Insurance Agent (see Note 1)	4	0.0%	0	0.0%	Psychiatric Technicians	272	0.0%	19	7.0%
Insurance Broker (see Note 1)	4	0.0%	0	0.0%	Psychological Assistant, Associate, Examiner (see Note 2)	309	0.0%	0	0.0%
Long Term Care Facility Administrator (see Note 1)	10	0.0%	0	0.0%	Psychologist	88,353	2.6%	645	0.7%
LPN or Vocational Nurse	4,005	0.1%	3	0.1%	Radiation Therapy Technologist	205	0.0%	2	1.0%
Marriage and Family Therapist (see Note 2)	11,742	0.3%	46	0.4%	Radiologic Technologists	784	0.0%	19	2.4%
Massage Therapist	3,017	0.1%	8	0.3%	Rehabilitation Therapist	699	0.0%	1	0.1%
Medical Assistant	1,217	0.0%	2	0.2%	Researcher, Clinical (see Note 1)	130	0.0%	1	0.8%
Medical Technologist	1,115	0.0%	14	1.3%	Respiratory Therapy Technician	66	0.0%	0	0.0%
Mental Health Counselor	17,862	0.5%	43	0.2%	Respiratory Therapist	367	0.0%	1	0.3%
Midwife, Lay (Non-Nurse)	257	0.0%	21	8.2%	RN (Professional) Nurses	58,763	1.7%	510	0.9%
Naturopath	640	0.0%	9	1.4%	Salesperson (see Note 1)	3	0.0%	1	33.3%
Nuclear Med. Technologist	88	0.0%	5	5.7%	School Psychologist (see Note 2)	114	0.0%	1	0.9%
Nurse Anesthetist	31,382	0.9%	936	3.0%	Social Worker, Clinical	97,369	2.8%	104	0.1%
Nurse Midwife	8,845	0.3%	427	4.8%	Speech/Language Pathologist	6,587	0.2%	6	0.1%
Nurse Practitioner	60,771	1.8%	306	0.5%	All Types	3,448,514	100.0%	484,040	14.0%

Note 1: Category first available for reporting and querying on November 22, 1999.
 Note 2: Category first available for reporting and querying on September 9, 2002.

Table 25: Self-Queries and Self-Queries Matched with Reports by Practitioner Type, Last Nine Months (National Practitioner Data Bank, April 1, 2004 - December 31, 2004)

Practitioner Type	Number of Self-Queries Processed Against NPDB Reports	Percent of Total Self-Queries	Number of Self-Queries that Matched At Least One NPDB Report	Percent of Self-Queries Matched with NPDB Reports
Accountant (see Note 1)	1	0.0%	0	0.0%
Acupuncturist	15	0.0%	0	0.0%
Adult Care Facility Administrator (see Note 1)	0	0.0%	0	0.0%
Allopathic Physician Intern/Resident	4,366	12.9%	22	0.5%
Allopathic Physician	20,476	60.3%	3,093	15.1%
Art/Recreation Therapist	1	0.0%	0	0.0%
Athletic Trainer (see Note 1)	2	0.0%	0	0.0%
Audiologists	5	0.0%	0	0.0%
Business Manager (see Note 1)	1	0.0%	1	100.0%
Business Owner (see Note 1)	1	0.0%	0	0.0%
Chiropractor	125	0.4%	11	8.8%
Clinical Nurse Specialist (see Note 2)	8	0.0%	0	0.0%
Corporate Officer (see Note 1)	1	0.0%	0	0.0%
Dental Assistant	2	0.0%	0	0.0%
Dental Hygienist	443	1.3%	0	0.0%
Dental Resident	56	0.2%	0	0.0%
Dentist	1,857	5.5%	226	12.2%
Dietician	8	0.0%	0	0.0%
EMT, Basic	261	0.8%	0	0.0%
EMT, Intermediate	5	0.0%	0	0.0%
EMT, Paramedic	40	0.1%	0	0.0%
Hospital Administrator (see Note 1)	2	0.0%	0	0.0%
Insurance Agent (see Note 1)	2	0.0%	0	0.0%
Insurance Broker (see Note 1)	1	0.0%	0	0.0%
Long Term Care Facility Administrator (see Note 1)	0	0.0%	0	0.0%
LPN or Vocational Nurse	21	0.1%	1	4.8%
Marriage and Family Therapist (see Note 2)	84	0.2%	1	1.2%
Massage Therapist	2	0.0%	0	0.0%
Medical Assistant	3	0.0%	0	0.0%
Medical Technologist	2	0.0%	0	0.0%
Mental Health Counselor	233	0.7%	1	0.4%
Midwife, Lay (Non-Nurse)	1	0.0%	0	0.0%
Naturopath	1	0.0%	0	0.0%
Nurse Anesthetist	146	0.4%	8	5.5%
Nurse Midwife	36	0.1%	2	5.6%
Nurse Practitioner	332	1.0%	1	0.3%
Nurses Aide	3	0.0%	1	33.3%
Occupational Therapist	14	0.0%	0	0.0%
Occupational Therapy Assistant	2	0.0%	0	0.0%
Optometrist	125	0.4%	5	4.0%
Orthotics/Prosthetics Fitter	2	0.0%	0	0.0%
Osteopathic Physician Intern/Resident	537	1.6%	3	0.6%
Osteopathic Physician	1537	4.5%	239	15.5%
Other Health Care Practitioner, Not Classified (see Note 1)	21	0.1%	0	0.0%
Other Non-Practitioner Occupation, Not Classified (see Note 1)	144	0.4%	0	0.0%
Perfusionist (see Note 1)	4	0.0%	0	0.0%
Pharmacist	40	0.1%	1	2.5%
Pharmacy Intern (see Note 2)	1	0.0%	0	0.0%
Pharmacy Technician (see Note 2)	2	0.0%	0	0.0%
Physician Assistant, Allopathic	567	1.7%	14	2.5%
Physician Assistant, Osteopathic	30	0.1%	0	0.0%
Physical Therapy Assistant	5	0.0%	0	0.0%
Physical Therapist	93	0.3%	2	2.2%
Podiatric Assistant	1	0.0%	1	100.0%
Podiatrist	176	0.5%	35	19.9%
Professional Counselor, Substance Abuse	468	1.4%	0	0.0%
Professional Counselor, Alcohol	42	0.1%	0	0.0%
Professional Counselor, Family/Marriage (see Note 2)	21	0.1%	0	0.0%
Professional Counselor	443	1.3%	0	0.0%
Psychiatric Technicians	6	0.0%	0	0.0%
Psychological Assistant, Associate, Examiner (see Note 2)	3	0.0%	0	0.0%
Psychologist	151	0.4%	1	0.7%
Radiologic Technologists	3	0.0%	0	0.0%
Rehabilitation Therapist	1	0.0%	0	0.0%
Researcher, Clinical (see Note 1)	3	0.0%	0	0.0%
Respiratory Therapy Technician	18	0.1%	0	0.0%
Respiratory Therapist	105	0.3%	0	0.0%
RN (Professional) Nurses	277	0.8%	3	1.1%
Salesperson (see Note 1)	3	0.0%	0	0.0%
School Psychologist (see Note 2)	1	0.0%	0	0.0%
Social Worker, Clinical	565	1.7%	2	0.4%
Speech/Language Pathologist	5	0.0%	0	0.0%
All Types	33,959	100.0%	3,674	10.8%

Note 1: Category first available for reporting and querying on November 22, 1999.
 Note 2: Category first available for reporting and querying on September 9, 2002.

**Table 26: Entities That Have Queried or Reported to the National Practitioner Data Bank
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)**

Entity Type	Active Status Registration on December 31, 2004	Active Registration Status At Any Time
Hospitals	6,471	7,942
State Licensing Boards	154	194
Managed Care Organizations	1,299	2,096
Professional Societies	136	224
Other Health Care Entities	6,962	8,466
Medical Malpractice Payers	406	787
Total	15,428	19,709

The counts shown in this table are based on entity registrations. A few entities have registered more than once. Thus, the entity counts shown in this table may be slightly exaggerated. Entities that report both clinical privileges actions and medical malpractice payments (e.g., hospitals and HMOs) are instructed to register as health care entities, not malpractice payers, and are not double counted if they registered only once.

**Table 27: Requests for Secretarial Review by Report Type, Last Five Years and Cumulative Through 2004
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)**

Category	2000			2001			2002		
	Number	Percent	% Change 1999-2000	Number	Percent	% Change 2000-2001	Number	Percent	% Change 2001-2002
Adverse Action Reports	74	58.3%	-5.4%	57	66.3%	-29.8%	84	70.6%	32.1%
State Licensure Actions	23	31.1%	-34.8%	17	29.8%	-35.3%	17	20.2%	0.0%
Clinical Privileges Actions	39	52.7%	-17.9%	30	52.6%	-30.0%	57	67.9%	47.4%
Professional Society Actions	2	2.7%	50.0%	1	1.8%	-100.0%	0	0.0%	...
Medicare/Medicaid Exclusions	10	13.5%	100.0%	9	15.8%	-11.1%	10	11.9%	10.0%
Medical Malpractice Payment Reports	53	41.7%	30.2%	29	33.7%	-82.8%	35	29.4%	17.1%
Total	127	100.0%	9.4%	86	100.0%	-47.7%	119	100.0%	27.7%

Category	2003			2004			Cumulative	
	Number	Percent	% Change 2002-2003	Number	Percent	% Change 2003-2004	Number	Percent
Adverse Action Reports	49	92.5%	-71.4%	50	78.1%	2.0%	1079	63.55%
State Licensure Actions	13	26.5%	-30.8%	10	20.0%	-23.1%	329	30.5%
Clinical Privileges Actions	33	67.3%	-72.7%	39	78.0%	18.2%	701	65.0%
Professional Society Actions	2	4.1%	100.0%	0	0.0%	--	18	1.7%
Medicare/Medicaid Exclusions	1	2.0%	-900.0%	1	2.0%	0.0%	31	2.9%
Medical Malpractice Payment Reports	4	7.5%	-775.0%	14	21.9%	250.0%	619	36.5%
Total	53	100.0%	-124.5%	64	100.0%	20.8%	1,698	100.0%

Table 28: Distribution of Requests for Secretarial Review by Type of Outcome, Last Five Years and Cumulative Through 2004
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)

Outcome	2000			2001			2002		
	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests
Request Closed by Intervening Action	13	0.0%	0.0%	5	5.8%	5.9%	14	11.8%	12.2%
Request Closed: Practitioner Did Not Pursue Review*	0	0.0%	0.0%	0	0.0%	0.0%	1	0.8%	0.9%
Request Outside Scope of Review (No Change in Report)	72	0.1%	0.1%	51	59.3%	60.0%	39	32.8%	33.9%
Secretary Changes Report	63700	99.8%	99.8%	2	2.3%	2.4%	0	0.0%	0.0%
Secretary Maintains Report as Submitted	35	0.1%	0.1%	25	29.1%	29.4%	57	47.9%	49.6%
Secretary Voids Report	5	0.0%	0.0%	2	2.3%	2.4%	4	3.4%	3.5%
Unresolved as of December 31, 2004	1	0.0%	n/a	1	1.2%	1.2%	4	3.4%	n/a
Total	63826	100.0%	100.0%	86	100.0%	100.0%	119	100.0%	100.0%

Outcome	2003			2004			Cumulative		
	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests
Request Closed by Intervening Action	14	26.4%	27.5%	13	20.3%	37.1%	125	7.4%	7.5%
Request Closed: Practitioner Did Not Pursue Review*	1	1.9%	2.0%	0	0.0%	0.0%	42	2.5%	2.5%
Request Outside Scope of Review (No Change in Report)	10	18.9%	19.6%	6	9.4%	17.1%	663	39.0%	39.9%
Secretary Changes Report	0	0.0%	0.0%	0	0.0%	0.0%	18	1.1%	1.1%
Secretary Maintains Report as Submitted	26	49.1%	51.0%	16	25.0%	45.7%	670	39.5%	40.4%
Secretary Voids Report	0	0.0%	0.0%	0	0.0%	0.0%	142	8.4%	8.6%
Unresolved as of December 31, 2004	2	3.8%	n/a	29	45.3%	n/a	38	2.2%	n/a
Total	53	100.0%	100.0%	64	100.0%	100.0%	1,698	100.0%	100.0%

This table shows, as of December 31, 2004, the outcomes of Secretarial Review requests based on the dates of requests for review. For undated requests, the date they were received by the Practitioner Data Banks Branch was used.

* "Request Closed: Practitioner Did Not Pursue Review" refers to cases which were closed because (1) the practitioner withdrew the request for Secretarial Review or (2) failed to submit required documentation after the case was elevated to Secretarial Review status. If the required documentation was not submitted prior to being elevated to Secretarial Review status, the case is not included in this table.

**Table 29: Resolved Requests for Secretarial Review by Report and Outcome Types, Cumulative Through 2004
National Practitioner Data Bank (September 1, 1990 - December 31, 2004)**

Outcome	Malpractice Payments		Licensure Actions		Clinical Privileges Actions	
	Number	Percent of Requests	Number	Percent of Requests	Number	Percent of Requests
Request Closed by Intervening Action	36	5.8%	33	10.0%	52	7.4%
Request Closed: Practitioner Did Not Pursue Review*	16	2.6%	11	3.3%	14	2.0%
Request Outside Scope of Review (No Change in Report)	349	56.4%	75	22.8%	215	30.7%
Secretary Changes Report	6	1.0%	8	2.4%	3	0.4%
Secretary Maintains Report as Submitted	176	28.4%	156	47.4%	323	46.1%
Secretary Voids Report	31	5.0%	40	12.2%	68	9.7%
Unresolved as of December 31, 2004	5	0.8%	6	1.8%	26	3.7%
Total	619	100.0%	329	100.0%	701	100.0%

Outcome	Professional Society Actions		Medicare/Medicaid Exclusions		Total	
	Number	Percent of Requests	Number	Percent of Requests	Number	Percent of Requests
Request Closed by Intervening Action	3	16.7%	1	3.2%	125	7.36%
Request Closed: Practitioner Did Not Pursue Review*	1	5.6%	0	0.0%	42	2.47%
Request Outside Scope of Review (No Change in Report)	5	27.8%	19	61.3%	663	39.05%
Secretary Changes Report	0	0.0%	1	3.2%	18	1.06%
Secretary Maintains Report as Submitted	6	33.3%	9	29.0%	670	39.46%
Secretary Voids Report	3	16.7%	0	0.0%	142	8.36%
Unresolved as of December 31, 2004	0	0.0%	1	3.2%	38	2.24%
Total	18	100.0%	31	100.0%	1,698	100.0%

This table represents the outcomes of Secretarial Review requests based on the dates of the requests. For undated requests, the date they were received by the Practitioner Data Banks Branch was used.

* "Request Closed: Practitioner Did Not Pursue Review" refers to cases which were closed because (1) the practitioner withdrew the request for Secretarial Review or (2) failed to submit required documentation after the case was elevated to Secretarial Review status. If the required documentation was not submitted prior to being elevated to Secretarial Review status, the case is not included in this table.