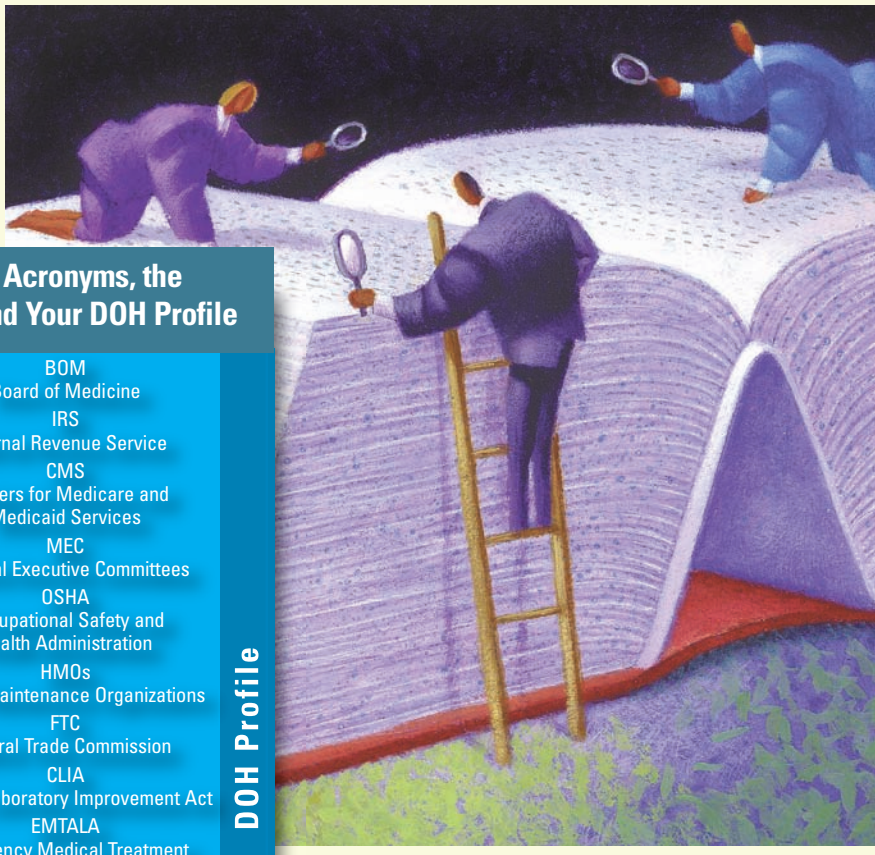
By Michael J. Schoppmann

Interplay between State Board Actions and MPL

Shared Risk and Potential Implications



There is an extensive list of government entities and laws that can potentially harm physicians. Better known by their acronyms, these include: BOM, IRS, CMS, MEC, OSHA, HMOs, FIC, CLIA, EMTALA, DEA, HIPAA, OIG, FBI, AG, and FCA (Figure 1).

The National Practitioner Data Bank (NPDB) collects information on healthcare practitioners including medical professional liability (MPL) actions, hospital actions, and licensing actions, as well as information from insurance companies and managed care companies. This data is managed by the Bureau of Health Professions, Health Resources and Services Administrations, U.S. Department of Health and Human Services, under a legal notion of "informed consent." All the acronyms listed previously have access to both the NPDB and your state's Department of Health (DOH) Profile, reiterating the importance of physicians' compliance with the NPDB and the DOH.

MPL is interwoven into every adverse action. In the past, the review of medical records was done according to this procedure: patient, hospital, and government actions were filtered through state boards, which were consequently interlaced with reviews by the U.S. attorney (fraud and abuse), the attorney general (licensing actions), and the district attorney (criminal charges).

Figure 1 Acronyms, the NPDB, and Your DOH Profile

The National Practitioner Data Bank / DOH Profile

- BOM — Board of Medicine
- IRS — Internal Revenue Service
- CMS — Centers for Medicare and Medicaid Services
- MEC — Medical Executive Committees
- OSHA — Occupational Safety and Health Administration
- HMOs — Health Maintenance Organizations
- FTC — Federal Trade Commission
- CLIA — Clinical Laboratory Improvement Act
- EMTALA — Emergency Medical Treatment and Active Labor Act
- DEA — Drug Enforcement Agency
- HIPAA — Health Insurance Portability and Accountability Act
- OIG/FBI — Office of Inspector General/Federal Bureau of Investigation
- AG/FCA — Attorney General/False Claims Act

But now, medical records go through review by the hospital, patient, and insurance company. At this point, state boards and their components (district attorney, U.S. attorney, and the attorney general) are in charge of compliance and regulation.

It is important to note the threshold differences between what is done in MPL lawsuits vs. what is done by state boards. With the state boards, there are no rules of evidence, no advance notice of issues under review, no advance disclosure of complaint or complainant, no statute of limitations, and no damages are required. In addition, physicians are often denied access to records, and the same agency that decided a physician's fate at a hearing decides the appeal.

To better illustrate the role of the Federation of State Medical Boards (FSMB) in the total number of actions initiated by state

Michael J. Schoppmann, Esq, *is Managing Partner, Kern Augustine Conroy & Schoppmann, P.C.*

boards, I would like to reference the FSMB's 2014 report, "U.S. Medical Regulatory Trends and Actions" (Table 1). In 2012, a total of 14,487 disciplinary alerts were issued by the FSMB to state boards; of these, 9,219 state board actions were initiated as a result of the FSMB alerts. The results of these board actions ranged from license restrictions (most often) to license suspension to license denial (less often).

State board actions are an increasing trend; the numbers of actions initiated, reprimands, license restrictions, probation, surrender of license, and revocation of same from 2008 and 2012 are shown in Table 2.

Information sources

State boards gather their complaints from diverse sources, including patients, documents from MPL actions, hospital actions, and other state licensing actions; and insurance companies and managed care companies. The tactics that state boards use in order to obtain these complaints include investigations of employee contacts, comprehensive record reviews, queries to physician witnesses, pharmacy sweeps, and hospital staff-file reviews.

This state board process begins with a request for medical records. At this point, they begin the information-gathering process, including a demand for a written reply to all allegations. A notice of investigative hearing is sent, at which point a preliminary evaluation committee is set in place. The committee is in charge of determining what, if any, action to take, based on the recent trends of the committee in working on other, recent cases. Unless charges are filed or the case is settled, the investigation remains confidential. Otherwise, if charges are filed, this information will become public. Sample forms for the documentation of "professional misconduct" that led to actions include failing to show "cultural sensitivity," "disruptive" behavior, errors created by office staff, failure to wear an identification tag, poor documentation or treatment—even if rendered by another physician.

Table 1 State Medical Board Actions, 2012

State Medical Board Actions	2012
Total state medical board actions	9,219
Board actions by category*	
License restricted	1,480
Reprimand	1,224
Fine	995
Administrative action	949
Probation	913
License suspended	907
CME required	819
License surrendered	511
Conditions imposed	465
License revoked	299
License denied	170
Other	487
Reciprocal actions taken by state boards	**1,306**
Number of disciplinary alerts issued by the FSMB	**14,487**
Number of physicians disciplined	**4,479**
Physicians put on probation	857
Physicians with a license suspension	739
Physicians with a license revocation	275

Source: Federation of State Medical Boards
*The total number of board actions is higher than the total number of disciplined physicians because physicians may have had more than one action taken against them.

Table 2 State Board Actions, 2007/2008 and 2012*

	2007	2012
Actions initiated (total)	8,222	9,219
Breakdown of actions	**2008**	**2012**
Reprimands	892	1,067
License restrictions	859	1,012
Probation	785	913
Surrender of license	377	511
Revocation of license	256	299

*Note: The total here compares 2007 and 2012; the breakdown of numbers compares 2008 and 2012.

Beware of the state board

The issue of possible dire effects from state board materials, during an MPL case, should be addressed by carefully considering and avoiding any "state board" admissions in pleadings, as well as in letters to the court, depositions, and trial testimony. In addition, during this interplay between an MPL action and the state board and state DOH, it is wise to challenge any request for information or documents, because state board investigations are confidential, the fact that an investigation is neither an action nor a disciplinary proceeding, and, lastly, the fact the physician's quality assurance file is typically not discoverable.

Subsequent to any interaction with the state board after the MPL case, it is advised that your legal counsel review the client's physician profile obligations, advise the physician to contact his or her insurance provider if any type of state board investigation is begun, and preserve any information and evidence that was inadmissible or not used at trial but may be useful before a state board.

In addition to consolidating the NPDB and the Healthcare Integrity and Protection Data Bank, by Section 6403, the Affordable Care Act is better known for providing insurance for previously uninsured people. The mere presence of more insureds will increase the number of MPL claims. These newly insured individuals, who are largely unfamiliar with the healthcare system, will likely give rise to an increase in state board actions as well. Accordingly, there may be a disproportionately higher increase in state board than in MPL actions.

The Golden Rule I would like physicians to take away from all this is: Never speak to any media representative, investigator, and—especially—to some other attorney who is not your direct legal counsel. PIAA

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