"Oh no! Who needs to know?"

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VSEPS, 2015

OPHTHALMIC MUTUAL INSURANCE COMPANY
(A Risk Retention Group)

WHO IS WATCHING YOU?

Claim #____________ Insured ________________ Claim Rep____________

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832, Chantilly, Virginia 20153-0832 • www.npdb-hipdb.com

Payments by This Payer for This Practitioner

Amount of This Payment for This Practitioner (Format NNNNN.NN): $ [ ]

Date of This Payment (MMDDYYYY): [ ]

This Payment Represents: ○ A Single Final Payment ○ One of Multiple Payments

Total Amount Paid or to Be Paid by This Payer for This Practitioner (Format NNNNN.NN): $ [ ]

Payment Result of: ○ Judgment ○ Settlement ○ Payment Prior to Settlement

Date of Judgment or Settlement, if Any (MMDDYYYY): [ ]

Adjudicative Body Case Number (if Applicable): [ ]

Adjudicative Body Name (if Applicable): [ ]

Court File Number (if Applicable): [ ]

Description of Judgment or Settlement and Any Conditions, Including Terms of Payment (limit 2000 charact including spaces and punctuation)
Note: Do not reference any personal identification information about patients (e.g., names).

[ ]

Payments by This Payer for Other Practitioners in This Case

Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case (Including the Amount Specified Above for This Practitioner) (Format NNNNN.NN): $ [ ]

Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case: [ ]

Payments by Others for This Practitioner

Complete if your entity is an Insurance Company or a Self-Insured Organization.

Has a State Guaranty Fund or State Excess Judgment Fund Made a Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?: ○ Yes ○ No ○ Unknown

Amount Paid or Expected to Be Paid by the State Fund (Format NNNNN.NN): $ [ ]

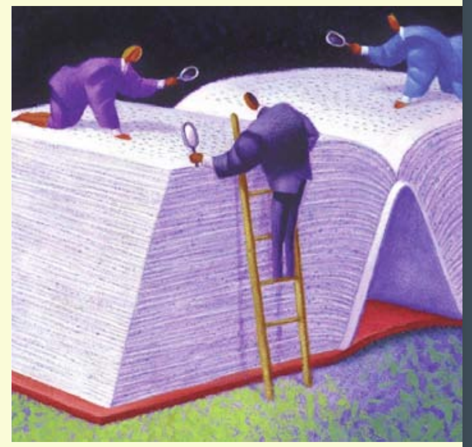
Complete if your entity is an Insurance Company, an Insurance Guaranty Fund or a State Medical Malpractic Payment Fund.

Has a Self-Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such Payment(s) Expected to Be Made?: ○ Yes ○ No ○ Unknown

Amount Paid or Expected to Be Paid by Self-Insured Organization(s) and/or Other Insurance Company/Companies (Format NNNNN.NN): $ [ ]

Page 1

Interplay between State Board Actions and MPL



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).

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.

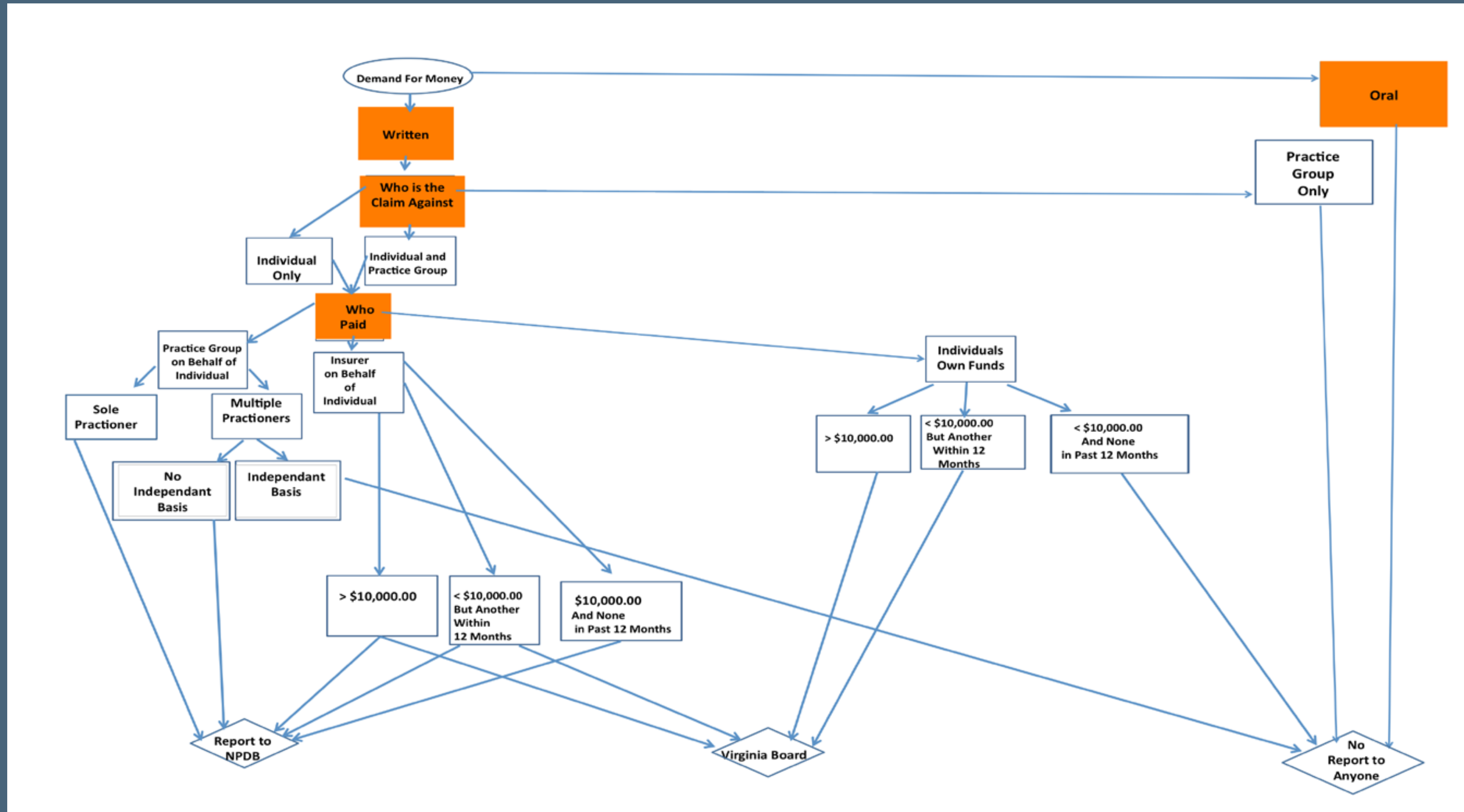
It is important to note the threshold differences between what is done in MPL lawsuits vs. what is done by state boards. With the state boards, there are no rules of evidence, no advance notice of issues under review, no advance disclosure of complaint or complainant, no statute of limitations, and no 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

Objectives

- ✓ Demand for Money
  - Oral or Written Demand?
- ✓ Who is the Claim Against
  - Doctor and/or Group Practice?
- ✓ Who Pays and How Much
  - Doctor and/or Group Practice?
  - Under $10K, over $10K, and frequency?
- ✓ Who to Report to
  - Virginia Board of Medicine, NPDB, Both?

Virginia Settlement Flow Chart



OMIC

CASE STUDIES

Case #1 - Oral v. Written Demand

- Patient seen for cataract removal OD
- Desire was for monovision (near) using a Toric IOL for additional fee
- Mistake by scribe led to patient corrected for distance
- Patient was lawyer

Case #1

- Patient verbally demanded:
  - ✓refund of all extra fees paid for Toric IOL
  - ✓free IOL exchange for placement of lens
  - ✓free surgery for 2nd eye

Case #1

- What ended up happening
  - ✓Patient opted for 2nd eye near IOL and is going to ‘wait it out’
- Doctor agreed to refund for Toric
- Release of Claims executed by Group in exchange for $2K check from doctor
- Patient happy with doctor

OMIC

Case #2 – Letter with no Demand

- 78yo male patient underwent cataract removal both eyes 2 weeks apart
- Patient was implanted with AMO Tecnis Multi-focal
- Patient expresses dissatisfaction with vision in a letter but never demands money
- Patient signed Release of Liability in exchange for $5400 refund from Doctor and Group

Case #3 – Letter with Demand

- 65yo female patient underwent cataract removal OD
- Patient was implanted with multifocal lens
- Patient had to wear glasses and complained of halo and glare at night
- Doctor reviewed chart and realized patient received wrong power lens

Case #3

- Patient given option of removal and lens exchange, remain as is and wear glasses, or wait for 2nd eye cataract removal
- Patient transferred care to another doctor
- Patient sent letter demanding refund of multifocal lens
- Patient signed Release of Liability in exchange for $2500 from Doctor and Group

Case #4 - Lawsuit

- 72yo underwent vitrectomy OS for hemorrhage, possible old CRVO noted
- 3 month post op patient developed cataract and RD OS, scleral buckle, vitrectomy, silicone oil to repair RD, bare CF, stable
- 4.5 months later elevated IOP’s (mid 50’s), referred for glaucoma consult to partner in large group practice

Case #4

- Glaucoma doctor used Timolol and Diamox to bring IOP's down to 33OD, 8OS, uveitis contributing problem
- 6 months later (11 months after 1st surgery) pt underwent Cat sx OD by 3rd MD in group
- Posterior capsule not well defined so no IOL placed, no red reflex
- F/U: whitish reflex, OD=HM

Case #4

- 3 weeks later vitrectomy, endolaser for non clearing vitreous hemorrhage by retina MD
- 2 months later RD OD with no break
- 1 month later vitrectomy, laser, cryopexy, silicone oil injection
- 2.5 months later recurrent RD OD
- 2 weeks later repair

Case #4

- Patient referred to teaching hospital due to subretinal fluid reaccumulating, new hemorrhage
- Patient underwent corneal transplant at hospital
- OS = CF
- OD went from 20/30 to HM

Case #4

- Plaintiff filed lawsuit against Retina MD and Group
- Retina MD dismissed before settlement
- Case settle on behalf of Group for $755K

STATE & FEDERAL LAW

Virginia State Law

"Medical malpractice settlement" = any **written agreement and release** entered into . . . in response to a **written claim** for money damages . . .

Va. Code Ann. § 54.1-2900.

OMIC

A. The following matters shall be reported within 30 days of their occurrence to the Board:

. . .

2. Any malpractice judgment against a person licensed under this chapter;

3. Any settlement of a malpractice claim against a person licensed under this chapter;

. . .

The reporting requirements set forth in this section shall be met if these matters are reported to the National Practitioner Data Bank . . . and notice that such a report has been submitted is provided to the Board.

Va. Code Ann. § 54.1-2909.

B. The following persons and entities are subject to the reporting requirements set forth in this section:

1. Any person licensed under this chapter who is the subject of a . . . settlement, [or] judgment . . . for which reporting is required pursuant to this section;

2. Any other person licensed under this chapter;

. . .

5. The malpractice insurance carrier of any person who is the subject of a judgment or settlement;

. . .

Va. Code Ann. § 54.1-2909.

The Board of Medicine shall require all doctors of medicine, osteopathy and podiatry to report and shall make available the following information:

C. The Board shall promulgate regulations to implement the provisions of this section, including, ... The Board's regulations shall provide for reports to include all medical malpractice judgments and medical malpractice settlements of more than $10,000 within the most recent 10-year period in categories indicating the level of significance of each award or settlement; . . . . Notwithstanding this subsection, a licensee shall report a medical malpractice judgment or medical malpractice settlement of less than $10,000 if any other medical malpractice judgment or medical malpractice settlement has been paid by or for the licensee within the preceding 12 months.

Va. Code Ann. § 54.1-2910.1.

The Board shall require an assessment of the competency of any person holding an active license under this chapter on whose behalf three separate medical malpractice judgments or medical malpractice settlements of more than $75,000 each are paid within the most recent 10-year period. The assessment shall be accomplished in 18 months or less by a program acceptable to the Board. The licensee shall bear all costs of the assessment. . . .

Va. Code Ann. § 54.1-2912.3.

C. For purposes of reporting required under this section, medical malpractice judgment and medical malpractice settlement shall have the meanings ascribed in § 54.1-2900 of the Code of Virginia. A medical malpractice judgment or settlement shall include:

. . .

2. A payment made from personal funds;
3. A payment on behalf of a doctor of medicine . . . by a corporation or entity comprised solely of that doctor of medicine, . . . ; or
4. A payment on behalf of a doctor of medicine . . . named in the claim where that doctor is dismissed as a condition of, or in consideration of the settlement, judgment or release. If a doctor is dismissed independently of the settlement, judgment or release, then the payment is not reportable.

18VAC85-20-290.

Federal Law

Reporting Medical Malpractice Payments

Each entity that makes a payment for the benefit of a health care practitioner in settlement of, or in satisfaction in whole or in part of, a claim or judgment for medical malpractice against that practitioner must report the payment information to the NPDB. A payment made as a result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) that does not identify an individual practitioner should not be reported to the NPDB.

Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a practitioner's provision of or failure to provide health care services.

NPDB Guidebook, E-16

Reporting of Payments by Individuals

Individual subjects are not required to report payments they make for their own benefit to the NPDB. Thus, if a practitioner or other individual makes a medical malpractice payment out of personal funds, the payment should not be reported. However, a professional corporation or other business entity comprised of a sole practitioner that makes a payment for the benefit of a named practitioner must report that payment to the NPDB.

NPDB Guidebook, E-17-18

Practitioner Fee Refunds

If a health care practitioner's fee is refunded by an entity (including solo incorporated practitioners), the payment must be reported to the NPDB if the conditions described in the next paragraph are met. A refund made by an individual, out of personal funds, should not be reported to the NPDB.

For purposes of NPDB reporting, medical malpractice payments are limited to exchanges of money. A refund of a fee must be reported only if it results from a **written** complaint or claim demanding monetary payment for damages.

Waiver of Debt

A waiver of a debt is not considered a payment and should not be reported to the NPDB. For example, if a patient has an adverse reaction to an injection and is willing to accept a waiver of fee as settlement, that waiver should not be reported to the NPDB.

NPDB Guidebook, E-20

Dismissal of a Defendant from a Lawsuit

If a defendant health care practitioner is dismissed from the lawsuit prior to settlement or judgment, for reasons independent of the settlement or release, a payment made to settle a medical malpractice claim or action should not be reported to the NPDB for that defendant health care practitioner.

NPDB Guidebook, E-19

Who are you going to call?

If you have ANY questions about oral or written demands, refunds, or any type of settlement - who are you going to call?

CALL YOUR MALPRACTICE COMPANY or SPEAK TO AN ATTORNEY!