Virginia Regulatory Town Hall

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Proposed Regulation
Agency Background Document

Agency name	Board of Medicine, Department of Health Professions
Virginia Administrative Code (VAC) citation	18VAC85-20-10 et seq.
Regulation title	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry and Chiropractic
Action title	Reporting of paid claims on the physician profile
Document preparation date	12/28/05

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 21 (2002) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

In a short paragraph, please summarize all substantive changes that are being proposed in this regulatory action.

The Board has proposed amendments to section 290, which sets out the requirements for reporting of malpractice paid claims and board actions. The changes are intended to clarify ambiguous provisions and specify more clearly the timing of a malpractice report, the definition of a malpractice paid claim and the conditions under which a report is required.

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

Regulations are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Section 54.1-2400, which provides the Board of Medicine the authority to promulgate regulations to administer the regulatory system:

§ 54.1-2400 -General powers and duties of health regulatory boards
The general powers and duties of health regulatory boards shall be:
…
6. To promulgate regulations in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ 54.1-100 et seq.) and Chapter 25 (§ 54.1-2500 et seq.) of this title. …

The statutory requirements for paid malpractice claims to be reported on the Practitioner Profile System are found in § 54.1-2910.1:

§ 54.1-2910.1. Certain data required.

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

1. The names of the schools of medicine, osteopathy, or podiatry and the years of graduation;

2. Any graduate medical, osteopathic, or podiatric education at any institution approved by the Accreditation Council for Graduation Medical Education, the American Osteopathic Association or the Council on Podiatric Medical Education;

3. Any specialty board certification as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association, the American Board of Multiple Specialties in Podiatry, or the Council on Podiatric Medical Education of the American Podiatric Medical Association;

4. The number of years in active, clinical practice as specified by regulations of the Board;

5. Any hospital affiliations;

6. Any appointments, within the most recent 10-year period, of the doctor to the faculty of a school of medicine, osteopathy or podiatry and any publications in peer-reviewed literature within the most recent five-year period and as specified by regulations of the Board;

7. The location and telephone number of any primary and secondary practice settings and the approximate percentage of the doctor's time spent practicing in each setting. For the sole purpose of expedited dissemination of information about a public health emergency, the doctor shall also provide to the Board any e-mail address or facsimile number; however, such e-mail address or facsimile number shall not be published on the profile database and shall not be released or made available for any other purpose;

8. The access to any translating service provided to the primary and secondary practice settings of the doctor;

9. The status of the doctor's participation in the Virginia Medicaid Program;

10. Any final disciplinary or other action required to be reported to the Board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§ 54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment or a final order of the Board relating to disciplinary action;

11. Conviction of any felony; and

12. Other information related to the competency of doctors of medicine, osteopathy, and podiatry, as specified in the regulations of the Board.

B. In addition, the Board shall provide for voluntary reporting of insurance plans accepted and managed care plans in which the doctor participates.

C. The Board shall promulgate regulations to implement the provisions of this section, including, but not limited to, the release, upon request from a consumer, of such information relating to a specific doctor. ***The Board's regulations shall provide for reports to include all paid claims in categories indicating the level of significance of each award or settlement; however, the specific numeric values of reported paid claims shall not be released in any individually identifiable manner under any circumstances.***

In addition, § 54.1-2909 of the *Code of Virginia* requires any settlement or judgment of a malpractice claim be reported within 30 days of its occurrence:

§ 54.1-2909. Further reporting requirements; civil penalty; disciplinary action.

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

1. Any disciplinary action taken against a person licensed under this chapter in another state or in a federal health institution or voluntary surrender of a license in another state while under investigation;

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; and

4. Any evidence that indicates a reasonable probability that a person licensed under this chapter is or may be professionally incompetent; has engaged in intentional or negligent conduct that causes or it likely to cause injury to a patient or patients; has engaged in unprofessional conduct; or may be mentally or physically unable to engage safely in the practice of his profession.

The reporting requirements set forth in this section shall be met if these matters are reported to the National Practitioner Data Bank under the Health Care Quality Improvement Act, 42 U.S.C. § 11101 et seq., and notice that such a report has been submitted is provided to the Board.

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 disciplinary action, settlement, judgment or evidence for which reporting is required pursuant to this section;

2. Any other person licensed under this chapter, except as provided in the protocol agreement entered into by the Medical Society of Virginia and the Board for the Operation of the Impaired Physicians Program;

3. The presidents of all professional societies in the Commonwealth, and their component societies whose members are regulated by the Board, except as provided for in the protocol agreement entered into by the Medical Society of Virginia and the Board for the Operation of the Impaired Physicians Program;

4. All health care institutions licensed by the Commonwealth;

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

6. Any health maintenance organization licensed by the Commonwealth.

C. No person or entity shall be obligated to report any matter to the Board if the person or entity has actual notice that the matter has already been reported to the Board.

D. Any report required by this section shall be in writing directed to the Board, shall give the name and address of the person who is the subject of the report and shall describe the circumstances surrounding the facts required to be reported. Under no circumstances shall compliance with this section be construed to waive or limit the privilege provided in § 8.01-581.17.

E. Any person making a report required by this section, providing information pursuant to an investigation or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability or criminal prosecution resulting therefrom unless such person acted in bad faith or with malicious intent.

F. The clerk of any circuit court or any district court in the Commonwealth shall report to the Board the conviction of any person known by such clerk to be licensed under this chapter of any (i) misdemeanor involving a controlled substance, marijuana or substance abuse or involving an act of moral turpitude or (ii) felony.

G. Any person who fails to make a report to the Board as required by this section shall be subject to a civil penalty not to exceed $5,000. The Director shall report the assessment of such civil penalty to the Commissioner of the Department of Health or the Commissioner of Insurance at the State Corporation Commission. Any person assessed a civil penalty pursuant to this section shall not receive a license, registration or certification or renewal of such unless such penalty has been paid.

H. Disciplinary action against any person licensed, registered or certified under this chapter shall be based upon the underlying conduct of the person and not upon the report of a settlement or judgment submitted under this section.

Purpose

Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal and the problems the proposal is intended to solve.

The intent of the Practitioner Profile System is to make information available to the public that will assist them in choosing appropriate practitioners who can safely deliver health care. Since the payment of a malpractice claim is not always an indicator of a practitioner's ability to practice with skill and safety, the following disclaimer is displayed before a consumer can scroll down to the malpractice information on the Profile.

When considering malpractice paid claims data, please keep in mind:

Some studies have shown little correlation between the existence of a malpractice paid claims history and the practitioner's competence to provide care.

Malpractice paid claims histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation.

Some doctors work primarily with high-risk patients. These doctors may have malpractice paid claims histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.

Settlement of a claim may occur for a variety of reasons, which do not necessarily reflect negatively on the professional competence or conduct of the practitioner. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

The incident causing the malpractice paid claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.

Presentation of Required Data:

Practitioners are required to report all paid claims in the last 10 years. For doctors practicing less than 10 years, the data covers their total years of practice.

To provide perspective regarding the reported data, the Board displays information about the paid claims experience of the practitioner's specialty along with the practitioner's history of paid claims. In reporting the data in this manner, each practitioner is seen relative to other practitioners in the specialty, rather than to all practitioners in all specialties.

Paid claims are not expressed in dollar amounts. Each paid claim has been analyzed and assigned to one of three statistical categories: below average, average, or above average. This analysis was made relative to the other claims in the specialty in which the claim occurred.

The information provided, in the manner provided, should offer perspective about this aspect of medical practice. You could miss an opportunity for high quality care by excluding a doctor based solely on the presence of a malpractice history. You may wish to discuss information provided in this report, and malpractice generally, with your doctor.

With a disclaimer about paid claims in general and about the characterization of such claims on the Profile, the Board believes the malpractice information that is presented is an important

element for informed patients in making health care decisions that affect their health and safety and should be inclusive of all paid claims regardless of the method of payment.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (More detail about these changes is requested in the "Detail of changes" section.)

The amended regulations would accomplish the following:

1) In subsection A, the Board proposes to repeat the statutory requirement in § 54.1-2909 for reporting of a paid malpractice claim within 30 days. However, claims are sometimes paid through structured settlements or in installments, so an additional amendment will clarify that the report must be made within 30 days *of the initial payment* rather than after completion of the settlement.

2) Subsection C is added to specify the definition and requirements for a malpractice paid claim. By doing so, the Board will clarify provisions for practitioners who have raised questions about what is considered a paid claim and therefore is required to be reported.

The Board will specify that, for purposes of reporting required under this section, a malpractice paid claim is a payment for the benefit of a doctor of medicine, osteopathic medicine, or podiatry in satisfaction in whole or in part of a settlement or a judgment based on the provision of or failure to provide healthcare services by that practitioner. A claim is considered a paid claim when a lump sum payment is made or when the first payment of multiple payments is made and must be reported at that time. A claim is reportable even if payment is made from personal funds or if a payment was made on behalf of a doctor of medicine, osteopathic medicine, or podiatry by a corporation or entity comprised only of the doctor of medicine, osteopathic medicine, or podiatry.

The regulations should also specify that when a doctor of medicine, osteopathic medicine or podiatry who was named in the claim is dismissed independently of the settlement, judgment or release, then the payment is not reportable. However, if the doctor is dismissed as a condition of, or in consideration of the settlement, judgment or release, then the payment is reportable.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.

If the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.

1) The primary advantage to the public is the availability of malpractice information on the patient's current doctors or in seeking a doctor to provide medical care. With a more explicit definition of what constitutes a paid claim, there should be more consistency in reporting and more valid information. While the practitioners would argue that reporting of paid claims is not of benefit to them, the specificity should create a level playing field so all doctors are reporting the same occurrences. Without such specificity, some practitioners are penalized by full reporting while others are choosing to limit reporting to an individual interpretation of a "paid claim." There are no disadvantages to the public in having more complete information about a doctor's malpractice history.

2) The primary advantage to the agency is consistency and clarity in the rules; it may alleviate the number of calls received by the Board asking for interpretations of the law and regulations. There are no disadvantages.

3) There are no other pertinent matters of interest.

Economic impact

Please identify the anticipated economic impact of the proposed regulation.

Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source / fund detail, and (b) a delineation of one-time versus on-going expenditures	a) As a special fund agency, the Board must generate sufficient revenue to cover its expenditures from non-general funds, specifically the renewal and application fees it charges to practitioners for necessary functions of regulation; b) The agency will incur some one-time costs (less than $1,000) for mailings to the Public Participation Guidelines mailing lists, conducting a public hearing, and sending notice of final regulations to regulated entities. Every effort will be made to incorporate those into anticipated mailings and Board meetings already scheduled. There are no on-going expenditures.
Projected cost of the regulation on localities	None
Description of the individuals, businesses or other entities likely to be affected by the regulation	The entities that are likely to be affected by these regulations would be doctors of medicine, osteopathic medicine or podiatry.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	The number of entities impacted by this regulation would be: 26,982 active doctors of medicine 816 active doctors of osteopathic medicine 414 active doctors of podiatric medicine It is not known how many of doctors practice within a large medical center or as an employee of a governmental or other entity. To the extent a doctor practices independently or within a group

	practice, he would be included as a small business.
All projected costs of the regulation for affected individuals, businesses, or other entities. Please be specific. Be sure to include the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses.	There is no cost of the regulation on the affected entities. Reporting on the profile is usually accomplished electronically or with the assistance of a staff person at the DHP call center.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action.

As alternatives to the promulgation of regulations, Board staff will continue to advise practitioners or their attorneys about the Board's definition of a "paid claim" and when that claim must be reported. However, that does not obviate the need for amendments because the interpretation of "paid claim" will continue to be subjective and not definitive for some practitioners. Those who inquire will receive the Board's interpretation but others may fail to report a paid claim if their definition of "paid claim" differs. While the Board could adopt the interpretation as a guidance document that is not enforceable as a law or regulation, so any enforcement of failure by a practitioner to report a paid malpractice would be challengeable. The proposed amendments will provide a consistent and level standard for practitioners who will be better able to comply with requirements of law and regulations that are more descriptive and enforceable.

Regulatory flexibility analysis

Please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

The *Code of Virginia* requires reporting of specified information on a practitioner profile for doctors of medicine, osteopathic medicine and podiatry. In § 54.1-2910.1, the Board is required to promulgate regulations "***for reports to include all paid claims in categories indicating the level of significance of each award or settlement; however, the specific numeric values of reported paid claims shall not be released in any individually identifiable manner under any circumstances.***" Therefore, there is no regulatory flexibility consistent with health, safety and welfare that would achieve the objectives of the applicable law. In addition, § 54.1-2909 mandates that a judgment or settlement of a malpractice paid claim be reported within 30 days of its occurrence, so there is a statutory schedule for making such a report.

In response to public comment, the Board did eliminate inclusion in the definition of a malpractice paid claim "a payment in the form of refund of fees or waiver of debt" as too broad and problematic for practitioners seeking to be in compliance with law and regulation.

Public comment

Please summarize all comments received during public comment period following the publication of the NOIRA, and provide the agency response.

The Notice of Intended Regulatory Action was published in the Register on July 11, 2005 and sent to the Public Participation Guidelines list with comment requested until August 10, 2005. There were two comments on the NOIRA:

1) The President of the Medical Society of Virginia supported changes in subsection A, but objected to inclusion of claims that are paid from personal funds rather than by an insurer. MSV also expressed concerns about the language in the NOIRA in which the claim is not reportable if the doctor is dismissed independently of the settlement, judgment or release; MSV suggested tracking the language from the National Practitioner Data Bank (NPDB). Finally, MSV objected to a requirement for reporting if a fee refund or waiver of debt is made due to a claim of malpractice.

2) The counsel for the Virginia Podiatric Medical Association expressed concern about the language of the NOIRA in which a report would be required if a fee refund or waiver of debt was made due to a claim of malpractice. VPMA was concerned that a practitioner would need to report refund or waivers to settle billing disputes or resolve dissatisfaction by patients and requested that the language be stricken from the proposal.

Agency response:

The Legislative Committee and the full board discussed the comments and modified the initial draft of the proposal to clarify several provisions. A definition of a malpractice paid claim was given as a "payment" in "satisfaction in whole or in part of a settlement or a judgment in response to a written demand for monetary payment for damages based on the provision of health care or professional services rendered." The Board also eliminated the requirement for reporting if a fee refund or waiver of debt was made due to a claim of malpractice. Therefore, a paid claim could not be interpreted as resolution of a billing dispute or a refund to dismiss a dissatisfied patient.

However, the Board did not eliminate the requirement for reporting of a paid claim made from personal funds because that would undermine the intent of the *Code of Virginia* to require reporting of all paid claims without regard to the source of the payment. In addition, the intent of the profile is to provide patients with sufficient information on which to make informed choices about physicians. The source of the payment is not as relevant as the fact that there was a paid claim against the doctor.

Finally, the Board has followed the guidance of the NPDB in describing that a report does not need to be made if a doctor is dismissed "independently" of the settlement, judgment or release. The NPDB Guidebook of September 2001, under "Dismissal of a Defendant from a Lawsuit" states "In the first instance, there is no payment for the benefit of the health care practitioner *because the individual has been dismissed from the action independently of the settlement or release."*

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability.

There is no impact on the institution of the family and family stability.

Detail of changes

Please detail all changes that are being proposed and the consequences of the proposed changes. Detail all new provisions and/or all changes to existing sections.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
290	n/a	Subsection A require reporting of all paid claims in the most recent 10-year period. Subsection B specifies the methodology for displaying the claims on the profile by a comparison with other doctors in the same specialty.	Subsection A: A timeframe for reporting is added (within 30 days) for consistency with other data elements that must be entered on the profile and with § 54.1-2909 of the Code of Virginia. Since some paid claims are structured settlements with payments over a period of time, it was necessary to specify that the report is made upon the occurrence of the initial payment. B. A change in terminology is proposed for consistency with the term used in law and regulation. C. A new section is added to define and specify what constitutes a paid claim as a payment for the benefit of a doctor of medicine, osteopathic medicine, or podiatry in satisfaction in whole or in part of a settlement or a judgment. It must be a monetary payment in response to a written demand based on the provision of health care or professional services rendered, or which should

			have been rendered. The language adopted by the Board as a definition of a paid claim is consistent with § 60.7 CFR for reporting to the National Practitioner Data Bank (NPDB). The Board has added that the payment must be in response to a written demand based or professional services that were rendered or should have been rendered. There was concern that a verbal threat of a lawsuit resulting in some sort of refund for services could be construed as a paid claim, but that was not the intent nor is the waiver of an outstanding debt considered a malpractice payment in federal rules. The definition in this regulation is consistent with the definition in § 60.3 CFR for a "medical malpractice action or claim." Regulations specify that a malpractice paid claim includes: 1. A lump sum payment or the first payment of multiple payments; 2. A payment made from personal funds; 3. A payment on behalf of a doctor of medicine, osteopathic medicine, or podiatry by a corporation or entity comprised solely of that doctor of medicine, osteopathic medicine, or podiatry; or 4. A payment on behalf of a doctor of medicine, osteopathic medicine or podiatry named in the claim where that doctor is dismissed as a condition of, or in consideration of the settlement, judgment or release. If the doctor is dismissed independently of the settlement, judgment or release, then the payment is not reportable. Since the Code requires reporting of <u>all</u> paid claims, neither the method of payment nor the entity making the payment can obviate the responsibility for reporting. However, if a

			doctor is dismissed independently of the action, then the payment is not reportable.