

Chapter 4

Physician Profile Databases

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Unintended Consequences

Databases that compile information on physicians and other health care providers have been in existence for some time. The first of these databases reflected the interest that the federal and state governments had in fulfilling their role in maintaining public health. Hospitals and other employers also maintained an interest in assuring physician accountability, with emphasis on clinical competence and economic efficiency. Increasingly, consumers too are demanding physician and health care facility accountability—a reflection of the fact that an individual's health, and the health of his or her family, are among an individual's greatest concerns. It is against this backdrop of government, employer, and consumer interests that various factors have combined to allow consumer access to physician databases. The most controversial information provided by databases is physician malpractice history, information concerning adverse events, and patient-physician relationships.

GROUPING OF DATABASES

When grouping databases, a number of methods can be used. They can be grouped according to the entity that creates the database, according to the entity that has access to it, or according to the entities that maintain the highest interest in the operation of the database. The latter of these provides the most insight into the database itself and is the method chosen by these authors.

State and Federal Government Interest

The interest of state and federal governments in health care databases has traditionally focused on limiting inappropriate prescribing and dispensing of narcotics, and in reducing the incidence of fraud and abuse in the Medicare/Medicaid and other federal and state insurance programs. That these interests are ongoing is evidenced by the continuing existence of the Drug Enforcement Administration's Controlled Substances Data Base, and the more recent development of the Healthcare Integrity and Protection Data Bank (HIPDB). HIPDB contents include final adverse actions such as both civil judgments and federal and state criminal convictions that are related to the delivery of a health care

item or service. Increasingly, governments have been creating databases designed to improve the quality—as well as to limit the costs—of medical care.

Employer Interest

The marked growth in physician and health care provider databases reflects not only an increase in government demand for physician and other health care professional accountability, but an increase in demand on the part of employers for accountability as well. The interest of employers, including hospitals, clinics, managed care organizations, and other provider networks, largely mirrors that of the federal and state governments: compiling and maintaining access to information on individual health care providers' clinical performance, and the provider's licensing, disciplinary and malpractice history.

Consumer Interest

A number of factors have combined to increase consumers' access to physician database information:

- The existence of databases maintained by the government, especially state governments.
- Regarding disciplinary action taken against licensed professionals.
- The high incidence of fraud in government-sponsored health insurance on the part of physicians, hospitals, and health-related equipment suppliers, which has resulted in the creation of antifraud databases such as the HIPDB.
- The rise of managed care organizations and other like-minded health provider entities whose orientation is on making a profit, which has resulted in their use of commercial databases to profile physicians and other health care providers as a means to this end.
- The frustration on the part of the government and consumers regarding the perceived lack of discipline meted out by state disciplinary boards.
- The perception among those in government and on the part of consumers that there is a national crisis of medical malpractice.

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Demographic, Complementary, and Related Information

American Medical Association (<http://www.ama-assn.org>)
 American Board of Medical Specialties
 (<http://certifieddoctor.org.verify>)
 Cigna Health Care Company (<http://www.cigna.com>)
 Medicine Online (<http://www.medicinonline.com>)
 MyDoctor.com (<http://www.mydoctor.com>)
 Wellpoint Health Networks (<http://www.wellpoint.com>)

Clinical Performance

Best Doctors (<http://www.bestdoctors.com>)

Disciplinary and/or Malpractice History

Association of State Medical Board Executive Directors—
 Administrators in Medicine (AIM)
 (<http://www.docboard.org/docfinder>)
 Consumer Info Central (a fee is required) (<http://www.ConsumerInfoCentral.com>)
 Federation of State Medical Boards (a fee is required)
 (<http://www.docinfo.org>)
 HealthGrades (<http://www.healthgrades.com>)
 HealthScope (<http://www.healthscope.org>)
 WebMD (<http://www.webmd.com>)

Table 4-1 Consumer-accessed databases

- The consumer's access to the capabilities of the Internet.
- The emerging patient safety and error reduction movement.

The end result is that information that was once restricted to use by federal and state governments, and health care provider entities such as hospitals and clinics, increasingly has been put into the hands of the consumer (Tables 4-1 and 4-2).

CATEGORIES OF INFORMATION

Clinical Performance Data

A physician's clinical performance, that is, clinical outcomes and economic efficiency, is determined by collecting information on clinical encounter and billing claim data specific to individual providers. Indicators of clinical performance are arrived at through a process of "profiling." The purpose of provider profiling is to collect data in order to compare individual physicians with others practicing in a particular hospital or region. Profiling databases are used to gather information concerning quality assurance, utilization review, and assessment of physician performance. These data often include physician information relating

Alaska, Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, and Wyoming.

Table 4-2 Consumer-accessed, state-sponsored databases

to mortality, complications, morbidity, drug use variances, blood utilization, infection control, and the like.

The data may then be merged with routine practice data such as number of hospital admissions, lengths of patient stay, and numbers of external reviews. Computer analysis is then used to identify variations in a particular physician's performance, based on application of various clinical and economic thresholds. By adjusting for differences in physician case mix and patient severity, employers and other entities may make valid comparisons of resource use, costs, and medical outcomes by physician, network, business unit, and employer.

The purpose in releasing these profiles to the public was to allow consumers to better understand those characteristics of individual patients that adversely affect outcomes; to improve the results of treatment of disease; to improve the provision of health care; and to provide information to consumers to allow them to make better-informed decisions when selecting a physician.

A consumer's having access to information regarding clinical competence, although helpful, has limited value. For example, data concerning a physician's outcomes for selected surgical or other procedures are too specific and are of value only to those consumers with both the need for such a procedure and in a position to select among a group of physicians that perform it.

Licensing and Disciplinary History Data

The second category of data compiled includes information relating to licensing status and disciplinary actions taken by state medical boards or other entities. Because of the government's role as *parens patriae*, some of the first professional databases that were created by states were those that collected information on professionals who had been sanctioned by state licensing boards.

Theoretically this information has always been available to consumers as this is generally considered public information. However, as a practical matter this information, until recently, has been far from the reach of consumers. In order to locate information on individual professionals, the consumer was required either to contact the regulatory office directly, or to locate those mostly obscure state professional publications that chose to report the names of the professionals who were sanctioned.

A number of state medical boards or departments of health through their websites are increasingly providing licensing and disciplinary information to the public free of charge. Both state and private organizations have begun to

Box 4-1. Medical-Legal Pearl

Federal regulations for unique "National Provider Identifiers," required by the simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA), will make it easier to access information related to individual physicians across organizations and websites.

incorporate a wide variety of health-related information, along with licensing and disciplinary data, on websites available to consumers without charge.

Data concerning licensing and disciplinary history, although they may allow consumers to discover those among the profession that most would consider the “least desirable,” have limited value because this information is relevant to only those few professionals who have had licensing problems or have been disciplined. They provide no information on the large majority of providers of the health care services.

Malpractice History Data

The third, and most controversial, category of information collected is that related to a physician’s malpractice history. Reacting to what Congress described as a nationwide rise in medical malpractice, and a need to improve the quality of medical care, the National Practitioner Data Bank (NPDB) was created as part of the Health Care Quality Improvement Act (HCQIA) of 1986. This database became operational in 1990. The purpose of the NPDB is to remedy the perceived nationwide crisis in medical malpractice by collecting information relating to the professional competency of physicians and other health care professionals. Information, such as malpractice payments and disciplinary actions against providers by state licensing boards and adverse actions by health care entities, such as occurs through the peer review process, must be reported to the data bank. Hospitals are then required to query the data bank before granting clinical privileges.

The NPDB was unique in that it did not restrict the database information to use by government entities, as had been the case with previous databases. Rather, it not only allowed, but required, that hospitals and other health care entities access this information. For other health care provider entities, access is allowed, but not required. Although one purpose of the database was to improve the quality of health care, it is important to note that consumers have not been allowed access to the NPDB. Whether this should occur has been the subject of Congressional debate. However, beginning primarily in 1996 in Massachusetts, and since then in an increasing number of other states, consumers have been allowed access to other databases that compile information on malpractice.

CONSUMER-ACCESSED DATABASES

Databases that provide information to consumers generally are sponsored by government bodies (e.g., state medical boards), self-regulatory agencies (e.g., medical societies), and private organizations (e.g., consumer advocacy groups). For the latter of these, information reported may be culled from various sources including state medical boards, insurance companies, government agencies, including the courts, from physician self-reporting, and, more recently, from reports on individual physicians made by consumers themselves.

For any database, and particularly those accessed by consumers, there are a number of concerns, both operational and informational. Operational concerns relate to cost of operating the database, the format in which the information is presented, and the method by which it is accessed: phone, fax, letter, or by the Internet. Informational concerns relate to the extent that the data are:

- Complete (is the information missing important data fields?).
- Current (information that is not up-to-date limits the value of the database).
- Accurate (was the information independently verified?).
- Unbiased (is the source of the information the physician or a public interest group?).
- Meaningful and relevant (does the goal in providing the information achieve its purpose?).

Information Disseminated

Demographic Information

Information relating to a physician’s demographics is the most neutral of the information provided to consumers. This information includes the address of the physician’s practice location, the name of the school the physician attended, graduate education, any specialty board certifications that are held, the availability of translating services that are provided at the practice location, and whether the physician participates in the Medicaid program.

Complementary Information

Reporting of complementary information provides a means for the physician to balance any negative information reported with information that reflects more positively. In what may be described as a concession to physicians, in many databases physicians are allowed to include such information as appointments to medical school faculties, responsibilities for graduate medical education, publications in peer-reviewed medical literature, and professional or community service activities and awards.

Disciplinary Information

Reporting disciplinary information provides to the consumer what is potentially the most damaging to physicians. This information is culled from various sources including the criminal courts, the state medical board, and hospital disciplinary bodies. As to criminal matters, information may include descriptions of any criminal convictions for felonies and serious misdemeanors, as well as descriptions of any charges to which the physician pleads *nolo contendere* or where sufficient facts of guilt were found. As to state medical board disciplinary actions, information may include descriptions of any state’s final board disciplinary actions. Finally, as to hospital disciplinary matters, there may be disseminated descriptions of revocation or involuntary restriction of hospital privileges for reasons related to competence or character, and descriptions of the restriction of privileges at a hospital in lieu of or in settlement of a pending disciplinary case related to competence and character in any hospital.

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PUBLISHING MALPRACTICE INFORMATION

In addition to demographic, complementary, and disciplinary information, consumers are increasingly allowed access to malpractice information. Publication of this information presents a number of concerns relating to competing interests of public versus provider, and involves issues of accessibility, format, and context of the information.

Competing Interests

The issues that arise in regard to the creation and operation of any database, but become more acute in relation to consumer-accessed databases, include:

1. On whom is information to be collected.
2. Who is to have access to the information.
3. What information is to be collected.
4. For what purpose is the information to be used.

As it is recognized that consumers have a legitimate right to data on health care providers, the competing interests involved in the health care provider database do not come down to the consumer's right to access versus the provider's right of privacy, but rather, the consumer's right to access versus the provider's right to control the extent and manner in which the provider information is to be disseminated.

Accessibility

Those entities that maintain websites will either provide consumers with malpractice information on individual physicians directly on the site, or will instruct consumers in how to obtain this information in another way. For example, and perhaps most onerous, some states require consumers to make direct requests for malpractice information on an individual physician by telephone or in writing to the appropriate state agency. In these instances consumers generally are then sent a summary report listing the amount of payment and a brief description of the injury. But increasingly, the trend is for states to provide malpractice history information on individual physicians as part of the website itself. In those states, for consumers with access to the Internet and the ability to locate the appropriate website, this represents a convenient source of physician malpractice information.

Format

Consumers are provided with malpractice information on individual physicians in one of three ways.

Box 4-2. Medical-Legal Pearl

The Administrators in Medicine (AIM) Docfinder website is maintained by the Association of State Medical Board Executive Directors and provides the most important Internet portal to physician profile databases operated by individual states: <http://www.docboard.org/docfinder>.

Graduated Categories

Dissemination according to graduated categories: below, at, and above average. This allows for comparing an individual licensee's medical malpractice judgment awards and settlements to the experience of other physicians within the same specialty.

Payment Amounts

Dissemination in raw form according to actual payment amounts.

Expanded Malpractice Information

Dissemination of *pending* malpractice claims to the public. In some states, potential plaintiffs in a medical malpractice suit must notify potential defendants, as well as the state department of health, of their intention. This information may be made available to the public. Medical groups object to the release of this information to consumers by the state agency because it involves allegations of malpractice for which probable cause has not been determined. The medical groups' concern is that release of unfounded accusations would unfairly identify physicians who may be threatened with frivolous and unfounded lawsuits.

Context

Part of the publication of malpractice information involves the placing of that information in context. Consequently, consumers are advised of a number of factors, many of which overlap:

1. An individual physician's malpractice information should be compared to the experience of other physicians who perform procedures and treat patients with a similar degree of risk.
2. Physicians treating certain patients and performing certain procedures are more likely to be the subject of litigation than others.
3. The number of years a physician has been practicing may impact the data.
4. Paid malpractice claims may involve incidents that took place years before the payment was made.
5. Treating high-risk patients may affect a physician's malpractice history.
6. Malpractice cases may be settled for reasons other than liability and cases may be settled without the physician's consent.

Information regarding settlements is believed to be the most easily misunderstood by consumers and so is often accompanied by a disclaimer.

Box 4-3. Medical-Legal Pearl

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 physician. 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 Standard Settlement Disclaimer.

RELIABILITY OF MALPRACTICE INFORMATION

Although for almost any database there are concerns for accuracy, scope, and cost, other concerns are particularly apparent. For example, the issue of database reliability—the degree to which the database is able to fulfill the purpose for which it was created—is particularly important. Because the purpose of the consumer-accessed physician profile database is to provide information to consumers regarding individual physicians to allow consumers to determine at least the worst, if not the best, among the group, the question becomes whether the information provided to consumers actually allows this determination.

By knowing that a particular physician has been disciplined by a licensing board or has been convicted of a crime, consumers could, perhaps fairly reliably, conclude that the physician is among the worst of those in the profession. By knowing that a physician is board certified and has a number of awards, honors, and publications, consumers could, perhaps fairly reliably, conclude that the individual is among the best of the professional group. But reporting only this information does not allow more informed selection of those who are neither among the worst nor best, that is, those who are somewhere in between. Consequently, the strength of the database that reports a physician's malpractice history is in its presumably giving the consumer the opportunity to choose the most, and to avoid the least, competent among a group of *average* physicians, for these, by chance alone, are the ones most likely to be providing services to the consumer. The weakness of these databases is that consumers may not be able to determine the average physician's competence reliably.

Perception of Malpractice

The central issue regarding a physician's adverse malpractice judgment is consumer perception of the degree to which a past adverse judgment is predictive of future lack of ability necessary to provide quality patient care. Do consumers perceive that an instance of malpractice, even when it conforms to its proper definition, that is, "negligence," under tort law (as opposed to "negligence" as determined by a sympathetic jury or in settlement of a "frivolous" claim) equates with lack of quality? In other words, to what extent do consumers perceive that a physician who has a history of making a legitimate mistake should be avoided?

Box 4-4. Medical-Legal Pearl

The value that consumers place on having access to malpractice information depends upon their perception of how a history of malpractice claims is predictive of future lack of ability to provide quality medical care. Consumers will face the most difficulty in choosing whether to receive care from a physician who has a single, perhaps remote-in-time, adverse medical negligence judgment, but who has otherwise good qualifications.

In weighing the value of malpractice information as a possible indicator of lack of quality, consumers are likely to get mixed messages. Both messages will be received indirectly as consumers are not likely to have personal experience with physicians whom they know to have a malpractice history. On the one hand, consumers in some states may get physician profile information that goes to great lengths when reporting malpractice information to put a physician's malpractice history in the best light. In other words, consumers will be provided with contextual information that downplays the significance of claims. On the other hand, some consumer advocacy groups will provide consumers with health-related information that puts malpractice information in the worst light. For example, instead of providing information regarding the extent and nature of malpractice claims as it relates to the average physician, that is, a physician with malpractice history that includes a settlement or two, some consumer groups discuss malpractice claims as on par with such conduct as traditionally requiring discipline by a medical board—conduct such as substance abuse, gross negligence, and others.

Many studies strongly suggest that quality of care is not a major determinant of whether a patient initiates a malpractice claim, but studies do show that a history of malpractice claims is, in fact, indicative of a physician's interpersonal skills. Consequently, consumers may be encouraged to consider more heavily a primary care physician's malpractice history, because of the relative importance of the interpersonal aspects of the physician-patient relationship, such as communication skills and rapport. Conversely, they may be encouraged to consider less heavily a surgeon's malpractice history, and the malpractice history of other specialists who perform invasive procedures, because of the relative importance of technical skill, which is less predictive by claim history.

EMERGING TYPES OF INFORMATION

The type and volume of information contained in databases, including those accessible to consumers, continues both to increase and to reflect the general focus of information contained in previous databases: quality and competence of the physician.

Adverse Events Information

To assure the highest quality of care requires a commitment to identify, analyze, and to some extent report adverse medical events. Examples of databases that compile information on adverse medical events include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Sentinel Event Program and the New York Patient Occurrence Reporting and Tracking System (NYPORTS) (<http://www.rapiddevelopers.com/nyports>). Examples of national reporting systems of adverse events related to medications and medical products are the Federal Drug

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Administration's "Safety Information and Adverse Event Reporting Program" (<http://fda.gov/medwatch>), and the MedMARx (<http://www.medmarx.com>) databases.

Although data collection of adverse events has been in existence for some time, newer developments allow for hospitals and other health care facilities both to obtain feedback on their own patterns of reporting and to compare them with other facilities. Use of Internet-based systems allows for data entry, and may allow for limited reporting to consumers of results of aggregate analysis of data. An important limitation in the value of adverse event reporting systems is that reporting may be voluntary and, if required, may still be subject to underreporting. Evidence of institutional underreporting may be based on wide regional variations and low hospital reporting rates.

The general rule in adverse event reporting systems is that data regarding specific events be nonidentifiable, i.e., no patient or physician names are used. Disclosure of such information may be prevented under law. In the case of NYPORTS, for example, New York State Public Health Law prevents disclosure of incident reports under the Freedom of Information Law.

There is a narrow exception to the rule that consumers are prevented from obtaining information about specific adverse events. Medicare beneficiaries who file written complaints are required to be informed of whether their care met professionally recognized standards of care and of the final disposition of the complaint. This may include being informed of any actions that are taken against the physician or hospital. This information could presumably be used in lawsuits and other action against physicians and health facilities.

Patient–Physician Relational Information

Databases that rely on patient ratings of the physician and facility quality are among the newest sources of information available to consumers. The value of these databases is severely limited, not only because they rely exclusively on the subjective perception of individual patients, but also by the limited number of participants in patient satisfaction or experience surveys and the exceedingly few physicians who are included in the database.

UNINTENDED CONSEQUENCES

Compiling a broad range of information on physicians, particularly their malpractice history, may have harmful consequences beyond simply providing to consumers unreliable data.

Access to Physicians

When the physician database reports malpractice information to allow the consumer to select the best among a group of physicians, the effect may be to actually limit the consumer's ability to gain access to those physicians. In knowing that data will be recorded and disseminated,

even the best physicians may be discouraged from performing those services that may carry higher risks of being sued. For example, physicians may be discouraged from taking high-risk patients or performing highly technical procedures for fear that their record will be tarnished if there is a bad outcome. As a result, consumers who most need those physicians whose practices involve stretching the limits of what the profession and technology have to offer will be deprived of this benefit. Another result may be a "chilling effect" on research into new therapies and procedures.

Defense Costs

When physicians know that an adverse legal or disciplinary board finding will not only be recorded, but disseminated to state and federal governments, employers, third-party payors, and especially to consumers, they may be less willing to settle a case, in hopes of having the case dismissed or getting a favorable judgment at trial or on appeal. This will result in increased burdens on the legal system, as well as to hospital and state disciplinary boards, in the form of increased time and resources spent on attorneys preparing cases, experts preparing to provide opinions and testifying, judges and disciplinary board members reviewing and hearing cases, and by others involved in the legal and disciplinary process.

Use by Attorneys

Regardless of the database, information may be obtained for use in ways that were not intended. That this occurs is the result of database information having a value in addition to that which allows the goal of the database to be fulfilled. Those whose interest in the physician profiling database lies apart from its intended use may include both plaintiff and defense attorneys.

Plaintiff Attorneys

The plaintiff attorney's interest in these data may be the result of its value in allowing an attorney to decide whether to pursue a case against a particular physician, preparing for a case already taken, and, possibly, using the information as evidence of a physician's lack of character or competence.

Defense Attorneys

Database information has the potential of being used by database subjects as a shield in defending a negligence claim. For example, a plaintiff's case against a physician may be weakened if the physician can show that, by having access to database information—information suggesting that the physician is a provider of inferior services—the plaintiff assumed the risk in seeking his or her services. This is similar to the way in which hospitals, and other health care entities, are legally presumed to have knowledge, through the National Practitioner Data Bank, of disciplinary and medical negligence data regarding any health care professional whom they employ.

Peer Reporting

At least some of what would appear in a physician profile, such as licensing and disciplinary information, may be generated by the physician's peers—whether one's partner, colleague, or coworker—or by those in agencies responsible for administering and investigating consumer or other complaints. Having information on a physician's licensing and disciplinary actions available to consumers may sufficiently raise the stakes so that a physician's peers and others are reluctant to make reports and investigate incidents of possible substandard care or inappropriate behavior.

Consumer Privacy

As more information concerning the health care system is obtained, its value in improving clinical treatment, providing for more informed patient choice of health care provider, and providing for advances in health research and public health surveillance is enhanced. The value of data used for profiling a physician is particularly enhanced, for example, as a way to measure the physician's ability to efficiently and economically provide a service, when it is placed in the context of an aggregate of individual clinical encounters. However, data on these clinical encounters often are tied with information on individual patients, thereby raising concerns for patient privacy.

Acknowledgment

An earlier version of this chapter appeared in the Journal of Legal Medicine [Mark J. Greenwood, *The Physician Profile Database: Publishing Malpractice Information on the Internet*, 21 J. Legal Med. 477 (2000)].

General References

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