SOUTH DAKOTA STATE MEDICAL ASSOCIATION
POLICY

Subject:	The Release of Physician Data
Document Number:	PS-126-0
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POLICY STATEMENT

The South Dakota State Medical Association (SDSMA) encourages the use of physician data to benefit both patients and physicians, and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The SDSMA supports the use of physician data when it is used to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments in concert with the following principles:

A. Patient Privacy Safeguards – All entities involved in the collection, use and release of claims data comply with the HIPAA Privacy and Security Rules, and disclosures made without patient authorization are generally limited to claims data, as that is generally the only information necessary to accomplish the intended purpose of the task.

B. Data Accuracy and Security Safeguards – Effective safeguards are established to protect against the dissemination of inconsistent, incomplete, invalid, or inaccurate physician-specific medical practice data, and reliable administrative, technical, and physical safeguards provide security to prevent the unauthorized use or disclosure of patient or physician-specific health care data and physician profiles.

Physician-specific medical practice data, and all analyses, proceedings, records, and minutes from quality review activities are not subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent.

C. Transparency Requirements – When data are collected and analyzed for the purpose of creating physician profiles, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure.

The limitations of the data sources used to create physician profiles are clearly identified and acknowledged in terms understandable to consumers, and the capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers.

Case-matched, risk-adjusted resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients.

D. Review and Appeal Requirements – Physicians are provided with an adequate and timely opportunity to review, respond and appeal the results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release.

When the physician and the rater cannot reach agreement, physician comments are appended to the report at the physician's request.

E. Physician Profiling Requirements – The data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians.

Data reporting programs only use accurate and balanced data sources to create physician profiles and do not use these profiles to create tiered or narrow network programs that are used to steer patients towards certain physicians primarily on cost of care factors.

When a single set of claims data includes a sample of patients that are skewed or not representative of the physicians' entire patient population, multiple sources of claims data are used.

Physician efficiency of care ratings use physician data for services, procedures, tests and prescriptions that are based on physicians' patient utilization of resources so that the focus is on comparative physicians' patient utilization and not on the actual charges for services.

Physician-profiling programs may rank individual physician members of a medical group but do not use those individual rankings for placement in a network or for reimbursement purposes.

F. Quality Measurement Requirements – The data are used to profile physicians based on quality of care provided – never on utilization of resources alone, and the degree to which profiling is based on utilization of resources is clearly identified.

Data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the Physician Consortium for Performance Improvement. These evidence-based measures are endorsed by the National Quality Forum (NQF) and/or the AQA and HQA, when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians are used to evaluate the data.

G. Patient Satisfaction Measurement Requirements – Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to better meet patient needs particularly as they relate to favorable patient outcomes and other criteria of high quality care.

Because of the difficulty in determining whether responses to patient satisfaction surveys are a result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, the use of patient satisfaction data is not appropriate for incentive or tiering mechanisms, and in physician profiling programs, it is important that programs that publicly rate physicians on patient satisfaction notify physicians of their rating and provide a chance for the physician to appeal that rating prior to its publication.

AUTHORITY

South Dakota State Medical Association Council of Physicians, 11/21/2014; Reaffirmed by South Dakota State Medical Association Board of Directors, 7/17/2021.

SOURCE

1. American Medical Association policy*, H-315972 HIPAA Business Associate Contracting, Domestic and Foreign, and Foreign Outsourcing* (BOT Rep. 17, I-06)
2. American Medical Association policy, *H-315.973 Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data* (CMS Rep. 6, I-06; Reaffirmed: BOT Rep. 17, A-13)
3. American Medical Association policy, *H-315.975 Police, Payer, and Government Access to Patient Health Information* (Res. 246, A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07)
4. American Medical Association policy, *H-315.983 Patient Privacy and Confidentiality* (BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17, A-13)
5. American Medical Association policy, *H-315.989 Confidentiality of Computerized Patient Records* (BOT Rep. F, A-93; Reaffirmation I-99; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 17, A-13)
6. American Medical Association policy, *H-285.931 The Critical Role of Physicians in Health Plans and Integrated Delivery Systems* (Res. 706, I-98; Reaffirmation A-99; Reaffirmation A-07; Reaffirmed: Res. 709, A-12; Reaffirmed: Res. 814, I-13)
7. American Medical Association policy, *H-406.993 Development and Use of Physician Profiles* (CMS Rep. J, A-93; Res. 808, A-95; CMS Rep. 10, A-96; Reaffirmation A-05)
8. American Medical Association policy, *H-406.994 Principles of Physician Profiling* (CMS Rep. J, A-93; CMS Rep. 10, A-96; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 724, A-05; Reaffirmed in lieu of Res. 729, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 824, I-10)
9. American Medical Association policy, *H-406.996 Use and Release of Physician-Specific Health Care Data* (BOT Rep. Q, I-92; BOT Rep. W, A-92; Reaffirmed: Res. 719, A-93; CMS Rep. 10, A-96; Appended: Res. 316, I-97; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 724, A-05; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10)
10. American Medical Association policy, *H-406.997 Collection and Analysis of Physician-Specific Health Care Data* (BOT Rep. Q, I-92; BOT Rep. Y, I-85; Amended: CLRPD Rep. 2, I-95; CMS Rep. 10, A-96; Reaffirmation A-01; Reaffirmation A-05; Reaffirmed in lieu of Res. 724, A-05)
11. American Medical Association policy, *H-406.998 Role of Physicians and Physician Organizations in Efforts to Collect Physician-Specific Health Care Data* (BOT Rep. Y, I-85; Reaffirmed: CLRPD Rep. 2, I-95; BOT Rep. P, A-91; BOT Rep. Q, I-92; CMS Rep. 10, A-96; Reaffirmation A-01; Reaffirmation A-05)
12. American Medical Association policy, *H-450.941 Pay-For-Performance, Physician Economic Profiling, and Tiered and Narrow Networks* (BOT Rep. 18, A-07; Reaffirmed in lieu of Res. 729, A-08; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmation I-10; Reaffirmed in lieu of Res. 808, I-10; Reaffirmed in lieu of Res. 824, I-10)

13. American Medical Association policy*, H-450.947 Pay-for-Performance Principles and Guidelines* (BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmed in lieu of Res. 808, I-10; Modified: BOT Rep. 8, I-11; Reaffirmed: Sub. Res. 226, I-13)
14. American Medical Association policy, *H-450.961 Health Plan "Report Cards"* (CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmation A-11)
15. American Medical Association policy, *H-450.982 Patient Satisfaction and Quality of Care* (CMS Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed BOT Rep. 9, A-13)