

Guide and Codebook

This guide is intended to assist state regulators in compiling claims data pursuant to the NAIC **Medical Professional Liability Closed Claim Reporting Model Law**. It is designed to promote uniformity and to ensure that data can be seamlessly aggregated across states. In addition, it is recommended that each state develop formal data verification procedures to ensure that data are as accurate and complete as possible. Data verification methods are discussed below. Lastly, for states that desire to make data available to researchers or other interested parties, methods of minimizing the risk of disclosure of confidential or sensitive information are presented.

I. Data verification

In recent years, data verification processes have evolved into highly sophisticated, rigorous, and organized systems for ensuring the integrity and accuracy of data. A variety of data problems can introduce serious statistical biases and distortions into any subsequent analysis. All states should develop formal processes to ensure that data are as accurate and complete as possible. Some of the following material is taken from the NAIC **Market Regulation Handbook**, which provides a good overview of data verification issues.

The most frequently used data verification procedures are related to completeness, validity, internal consistency, missing records, and reasonability. If a data problem cannot be remedied, procedures should be adopted to minimize the risk of statistical bias.

Completeness

Data should be complete as possible. Underreporting can introduce significant biases into an analysis of claims data, particularly if a state lacks corresponding exposure and premium data. Without procedures to ensure completeness, it may be difficult to differentiate between meaningful patterns and reporting errors.

To ensure completeness, malpractice claims should be reconciled with control totals, if available. All states can obtain statewide data from the “state page” of the financial annual statement, including aggregate annual premiums written and earned, losses paid and incurred, and additional expense items. In addition, insurers report the number of paid claims on Supplement A to Schedule T. Unfortunately, due to different accounting standards, amounts reported on the financial annual statement may not closely reconcile with the individual-level claims data. For example, the number of paid claims on the annual statement may include payments made on claims closed on prior years. However, very large discrepancies between amounts should be noted, and states should contact insurers to provide a satisfactory explanation for such discrepancies. In at least some instances, underreporting can be detected, even though the method is imperfect.

Analogous data for some reporting entities do not exist in most states. For example, most state insurance departments will have only limited information about self-insured entities. States should carefully review their surveillance and enforcement authority with respect to all relevant entities to ensure full compliance with reporting requirements.

Validity

Data fields should be systematically checked to determine that all values are valid and that all codes used correspond to the reporting specifications. Validity is generally determined in a prima facie sense: values are wrong “on their face” in that the true value cannot logically be as reported. For example, data that include codes that are not specified on the reporting protocols are simply “wrong,” and must be recoded. Other examples include reported policy limits below legally required minimums, or payments for non-economic damages that exceed statutory caps.

Internal consistency

States should identify ways to ensure that each data record is internally consistent, such that values reported in different data fields are not logically contradictory. Similar to validity, inconsistency is determined on a prima facie basis: a data record is internally inconsistent when two or more values cannot logically be simultaneously correct. For example, if a data record reported policy limits of \$1,000,000 per occurrence, but the paid loss amount is reported as \$1,500,000, the necessary conclusion is that one or both of these values are incorrect.

Missing Data Elements (including values coded as “unknown”)

Missing data elements can potentially bias analyses. Bias will occur if the relevant characteristics of the subset of items for which the information is missing differs on average from the overall population. Since both the likelihood and degree of such potential differences are generally unknown, potential bias cannot be ruled out in a non-arbitrary way.

Ideally, no relevant data elements should be missing, though some small amount is often tolerated in many data quality control systems. States should develop procedures that specify the tolerable percentage of missing data.

Reasonability

Reasonability standards are relatively subjective compared to the other verification standards identified in this section. Reasonability checks identify anomalous data values that deviate significantly from averages, or “what one would expect to see.” Reasonability checks can be performed by examining the upper and lower extreme values for each data element, and comparing these values to the average value for the entire dataset. In addition, values within a single record should be compared to identify anomalous relationships. Values that appear unreasonable should be investigated to determine that they are correct. For example, a claim payment of \$5,000,000 on an injury with a severity level of 1 (emotional only) ought to be verified. While not strictly invalid, such a discrepancy is anomalous to such an extent as to merit further investigation.

II. Confidentiality

The NAIC model law affords states significant flexibility with respect to whether, and in what form, data may be made available to the public. This section provides two options designed to produce data that are analytically useful while at the same time minimizing the probability that sensitive information will be disclosed. Of greatest concern to most states is what statisticians call “disclosure risk,” or the risk that data could enable end-users to identify individuals or entities involved in a malpractice action. Privacy concerns should be weighed against potential benefits of public data, such as enabling independent analyses or replicating results – two hallmarks of the scientific method.

There is a continuum of available options with respect to public release, ranging from full public disclosure to strict confidentiality. The two alternatives presented here are:

1. release of individual-level “anonymized” data, in which certain characteristics associated with particular individuals or entities are either scrubbed from the data or released on more general form, and
2. release of the data at levels of aggregation that minimize disclosure risk. This second alternative conforms to guidelines governing most federal agencies in possession of sensitive data.

Option 1: Release of individual-level records

Individual-level records can be released in a way that makes it unlikely, if not impossible, that individual identities can be inferred. In general, demographic characteristics, such as age, should be released in general categories (such as ages 1-5, 6 -10, etc). In addition, care should be taken to ensure that no data records correspond too closely to unique circumstances of a case, whereby an individual could combine the data with other publically available information in such a way as to ascertain an identity with some degree of certainty. For example, a dataset containing only a single claim against a neurosurgeon for an injury occurring on a given date within a specified geographic location may allow one to easily identify the practitioner. The following guidelines are intended as suggestions for states that wish to preserve anonymity while releasing data in its most usable form.

- a. References to small geographic units should be suppressed, though such data may be released in aggregate form as described on option 2. For individual claims records, geographic units may be denoted with a more general identifier. For example, the county of injury might be replaced with a new field that represents regions in a state composed of multiple counties.
- b. Dates, such as report date or close date, should be no more precise than a year. States may insert their own calculations derived from the dates to more securely preserve confidentiality. For example, rather than releasing the opening and closing dates, a “time to close” variable may be derived from these dates.

c. The specific identify of the reporting entity may be kept confidential in individual records. However, variables describing the type of reporting entity (such as insurer, self-insured, etc) may be released without significant disclosure risk if there are a sufficient number of such entities provided malpractice coverage in a state.

d. Data records that specify fairly unique characteristics of events or individuals should be suppressed, or aggregated into broader categories. For example, states might want to consider suppression of records that identify a particular medical specialty unless there are a minimum of four additional claims during an annual period against practitioners of the same medical specialty for each identifiable unit of geography. For cases failing to meet this rule, specialties may be aggregated into a new more general specialty code to attain the minimum five records.

Option 2: Release of aggregate data

The *Federal Committee on Statistical Methodology*, under the authority of the Office of Management and Budget, has developed general guidelines to preserve the confidentiality of information collected by numerous federal agencies. These rules govern the properties that publicly released data must possess to minimize the possibility that a user could, either directly or indirectly in conjunction with other public information:

1. discover the identity of individuals or entities;
2. infer with some precision the value of some attribute (say, a person's income).

The standards can be found in **Federal Committee on Statistical Methodology. Office of Management and Budget.** Statistical Policy Working Paper 22 (Revised 2005) – Report on Statistical Disclosure Limitation Methodology. At the time of writing, this paper is available on the internet at: <http://www.fcsm.gov/working-papers/spwp22.html>

The most common rule type governs the statistical properties of data cells in aggregate data. The most straightforward guideline is the *threshold rule*, which is simply the requirement that a minimum number of observations appear within a data cell. Obviously, a cell count of 1 possesses a high disclosure risk. For example, assume the release of a record in which exactly one medical malpractice payment was made in 2007 on behalf of a neurosurgeon practicing in a sparsely populated county. Very likely, the individual could be identified from other publicly available information, since only a single neurosurgeon may practice in a given county.

A data cell consisting of only two observations would also pose a high risk of revealing private information. Assume that two payments were made on behalf of two physicians by two different insurers, and the data are released in aggregate. In this instance, each insurer could identify the payment amount of the other insurer simply by subtracting their payment from the total.

Obviously, the more individuals that make up the aggregate figure, the safer are the identities and of each. It is not uncommon for federal agencies to release data cells consisting of as few as *three* observations. A threshold of five or more may be used if the data are particularly sensitive. The threshold rule is usually supplemented by additional rules that afford greater privacy protections.

For data consisting of magnitudes (income, malpractice payments, etc), it is likely that some cells will be highly skewed toward high-end values (incomes or malpractice payments greater than \$1 million, say). Highly skewed distributions pose a high risk that an individual could identify the highest values with a reasonable degree of certainty. A cell consisting of the sum of one very large payment and several much smaller payments would itself constitute a reasonable high-end estimate of the largest value. Knowledge of the highest value case could also permit an identification of the individual associated with the case. For example, one could search court records within a county for all cases with payouts of between \$1 million and \$2 million. As such, the Committee on Statistical Methodology has urged government agencies to adopt at least some following “sensitivity rules” in *addition to any threshold criterion*.

(n,k) rule (also called the “dominance rule”) – this rule is designed to limit access to data cells in which one or two high value observations contribute a substantial portion to the overall cell total, as in the example above. The rule is violated if some number of observations (n) exceeds (k) percent of the cell total. Commonly, n is assigned a value of one or two.

P-Percent Rule (or the “p-percent estimation equivocation level”) – This rule contemplates a “coalition” of individuals (c) pooling knowledge to estimate the largest contributor to a cell total.¹ Such individuals could be physicians represented in a cell, their insurers, or plaintiff attorneys that have knowledge of cases represented in a cell. For example, if a single law firm represented two of three cases that comprise a cell total, the firm could easily identify the value of the third contributor by simply subtracting their two cases from the total.

The rule makes the rather generous assumption that, based solely on general knowledge, estimates can be made to within 100% of the true value of each observation that comprises a cell total. In cases where “general knowledge” is less reliable, the rule will afford significantly *greater* confidentiality protections.

To limit the ability of coalitions to pool information to reliably estimate the value of subcomponents of a total, the p-percent rule constrains the percent distribution across cases that make up the total. Specifically, the rule states that any estimates derived from the data should be imprecise (or not come with *p* percent of the actual value). The limiting case is where the second and third largest contributors to a cell pool knowledge to estimate the largest contributor.

While the mathematical derivation and proofs of the rule are somewhat complex, the rule itself is not. It simply specifies that the sum of the remaining contributors to a cell total (everyone but the three largest contributors) must be larger than *p* percent of the largest observation:

$$\sum_{i=c+2}^N x_i \geq \frac{p}{100} \times x_1$$

Where

c+2 represents all observations but the largest three;

N is the total number of observations in a data cell;

X_i = the value being tested, such as claim payment amounts; and

p represents a percent less than 100 to be determined by the commissioner.

In practice, the rule means that anyone with knowledge of the second and third largest observations will be able to estimate the highest value only with *p*-percent accuracy.

pq rule – This rule is derived from the p-percent rule, but assumes that a potential “coalition” could have greater knowledge than assumed in the p-percent rule. That is, the pq rule assumes that estimates of true values could be made that are much more precise than “within 100% of the true value.” This rule is not in general use, nor recommended by the Committee on Statistical Methodology. As such, it is not furthered discussed here. More information can be obtained from the working paper cited above.

The parameters in each of the above rules (*c*, *p*, *n*, etc) are specified by each agency on a case-by-case basis. **Importantly, the committee recommends that the values that an agency adopts *not* be made public, since knowledge of the parameters can aid end-users in making various estimates.**

Cells that fail a test can be collapsed into other observations. For example, data at the county level can be combined with other counties or aggregated at some other higher level of geography.

The following table is derived from the Statistical Working Paper 22, and describes the practices of various federal agencies with respect to the public release of sensitive information.

| Agency | Threshold – min number for each data cell | Other threshold rules |
|--------|---|-----------------------|
|--------|---|-----------------------|

¹ It has been shown mathematically that if the value of the largest contributor cannot be estimated with accuracy, then no other subcomponent of a total can be estimated.

| Agency | Threshold – min number for each data cell | Other threshold rules |
|--|--|---|
| Department of Agriculture – Economic Research Service | 3 | (n,k) rule –No single observation can represent more than 60% of a given cell total (see explanation of the (n,k) rule above. In this case, (n,k) = (1,.6) |
| Department of Agriculture – National Agricultural Statistics Service | 3 | (n,k) rule , the parameter values are administratively determined and vary |
| Department of Commerce – Bureau of Economic Analysis | N/A | P-percent rule , value of p is administratively determined and varies across datasets |
| Bureau of the Census | Threshold varies, though the most common rule is that a cell must represent a minimum of 3 individuals from separate households | p-percent rule ; value of p is not published Some (sampled or micro-) data is not released on a geographic unit with a population of less than 100,000; and the most detailed micro-data the population must be at least 250,000 |
| Department of Education: National Center for Education Statistics (NCES) | 3 | Data is matched with all publicly available data sources. If potential matches can be narrowed down to as few as two institutions, data is not disclosed Values are coded in ranges (for example, income between \$50,000 – \$75,000) Values are top- and bottom- coded to prevent identification of outliers |
| Department of Energy | N/A - cells with too few observations are suppressed for accuracy reasons rather than for confidentiality (suppressed when standard error > 50%) | Pq rule – values of p and q are not published. |
| National Center for Health Statistics | n=5 | (n,k) rule, parameters aren't published |
| Department of Justice: Bureau of Justice Statistics (BJS) | n=10 | The BJS does not use any of the additional rules specified above. They do take additional measures to enhance the anonymity of the data, such as publishing values in ranges |
| Department of Labor: Bureau of Labor Statistics | Value of n is not released to the public | (n,k) rule, parameters not published |
| Department of Transportation: Bureau of Transportation Statistics | No agency-wide rule; established on a case-by-case basis | No agency-wide rule; established on a case-by-case basis |
| Department of the Treasury: IRS, Statistics of Income Division | N=3 for data aggregated at the state – level or larger geography; n=10 for data aggregated at sub-state levels | The division does not use any of the additional rule |
| National Science Foundation | Does not generally rely on a threshold rule | Either (n,k) rule or the p-percent rule |
| Social Security Administration | N=3 at state level, n=10 at county level | |

Internal Policies and Procedures

If data are confidential, each department should adopt reasonable policies and procedures to limit unauthorized access to files. Most agencies with sensitive files limit access to departmental employees who have a reasonable business or job related purpose to do so. A sample confidentiality form is printed on the following page. Each employee with access to confidential materials should sign the form.

Example Confidentiality Form

Each individual granted access to the raw or "unit level" medical malpractice data collected pursuant to [enter appropriate statutory citation] must sign this confidentiality form, and initial each of its provisions.

Only employees who have a job related purpose to access the data may do so. Access to all other employees is prohibited. _____ (initial)

Description of duties related to data (to be completed by employee's supervisor):

An individual who has signed this confid

entiality agreement has no authority to grant unit level access to any other individual who has not been granted such access. _____ (initial)

All electronic copies of data must be password protected and otherwise secured against unauthorized access. This password must not be disclosed to others who have not been granted access to the data. _____ (initial)

Paper copies of data must be stored in a secure location (locked filing cabinets, etc). _____ (initial)

Data may be released to the public only in the form prescribed by applicable departmental rules, and only pursuant to written permission obtained by the director. _____ (initial)

The process by which data are prepared for public release should be documented. A copy of the computer programs used to process the data and any resulting logs shall constitute appropriate documentation. Documents shall be retained for a minimum period of five years, as should a copy of the data that was released. _____ (initial)

Any breach of security or other disclosure must be reported immediately to your section supervisor or division director. It is the duty of the supervisor to take all appropriate steps to minimize the risks associated with a security breach. _____ (initial)

If data are stored on your hard drive, the computer must be locked and password protected when it is left unattended. _____ (initial)

Any data removed from the premises in a laptop or other electronic media should be logged, and should remain secure from unauthorized access. _____ (initial)

Authorization to access the data is automatically revoked when an individual in a position granted access leaves that position _____ (initial).

Signature _____ Date _____

A signed copy of this form shall be placed in the employees personnel file.

III. Sharing data with other state insurance departments

Confidentiality concerns should not deter interstate data sharing. All states are signatories to the NAIC global confidentiality agreement. This agreement ensures that a recipient state will treat data according to the originating state’s legal standards and rules. In essence, the legal disclosure provisions of the originating state “travel with the data.”

Codebook

Each claim represents each named individual or entity alleged to have contributed to an injury, and from whom compensation was sought. **All data elements for each claim pertain to the named individual or entity on whose behalf the claim is filed.** For example, the injury date should reflect the date that the individual or entity is alleged to have contributed to an injury, regardless of whether other parties are alleged to have also contributed to the injury at different times and places. Close dates should reflect the date on which a claim was closed for the individual or entity, regardless of whether other parties negotiate independent settlements at different times.

Table of Data Fields

| Item # | Data Field | Description | Format |
|--------|------------------|---|------------------------|
| 1 | Ins_Code | Unique identifier assigned by the commissioner for each reporting entity. | Alphanumeric |
| 2 | Entity Name | Name of reporting entity | Alpha |
| 3 | ClaimID | Unique identifier for each claim | Numeric |
| 4 | IncID | Unique identifier for each incident | Numeric |
| 5 | PolLim_Occ_prim | Policy limits, primary coverage, per occurrence | Numeric |
| 6 | PolLim_Ann_prim | Annual policy limits, primary coverage | Numeric |
| 7 | PolLim_Occ_Ex | Policy limits, all excess coverage, per occurrence (stacked if more than one applicable coverage-see below) | |
| 8 | PolLim_occ_ex | Annual policy limits, all excess coverage (stacked if more than one applicable coverage – see below). | |
| 9 | Lic code | NPDB field of licensure code | Text, Left Zero Filled |
| 10 | Spec code | NPDB medical specialty code | Text, Left Zero Filled |
| 11 | Facility | Code for type of facility where incident occurred | Text |
| 12 | Location | Code for the location within facility where incident occurred | Alphanumeric |
| 13 | Allegation_group | NPDB general allegation code | Text, Left Zero Filled |
| 14 | Allegation_code | NPDB specific allegation code | Text |
| 15 | City | City in which injury occurred | Text |
| 16 | County | County in which injury occurred | Text |
| 17 | County FIPS Code | 3-digit county Federal Information Processing Standard Code | Text, Left Zero Filled |
| 18 | Zip Code | Five digit Zip code for place of injury. | Text, Left Zero Filled |
| 19 | Inj_gender | Gender of injured party (M, F) | Alpha – M or F |
| 20 | Inj_Age | Age of injured party | Numeric |
| 21 | Severity | Injury severity code. See Table X | Text |
| 22 | Inj_date | Earliest date of act or omission that was the proximate cause of the claim | MM/DD/YYYY |
| 23 | Rept_date | Date claim reported to insurer | MM/DD/YYYY |
| 24 | Suit_date | Date suit was filed, if applicable | MM/DD/YYYY |
| 25 | Close_date | Date claim was closed | MM/DD/YYYY |
| 26 | Disposition | Manner in which a claim is resolved | Alphanumeric |

| Item # | Data Field | Description | Format |
|--------|------------------|---|---------|
| 27 | Disp_time | | Text |
| 28 | Indemnity | Total indemnity paid by this entity | Numeric |
| 29 | Other_Indemnity | All other indemnity paid by all other parties | Numeric |
| 30 | Econ_ind | Economic indemnity paid by all parties | Numeric |
| 31 | Nonecon_ind | Non-economic indemnity paid by all parties | Numeric |
| 32 | Punitive damages | Punitive damages paid by all parties | Numeric |
| 33 | LAE_Defense | Loss adjustment expenses paid for legal costs | Numeric |
| 34 | LAE_Other | All other loss adjustment expenses paid | Numeric |

Item Descriptions and Tables of Codes

Item 1: Entity ID Code

A unique identifier assigned by the commissioner for each reporting entity. Where applicable, a reporting entity's five-digit NAIC code may be used.

Item 2: Entity Name

Full legal name of the insuring or reporting entity.

Item 3: Claim ID

Each reporting entity should assign a unique identifier for each claim. This identifier should consist solely of numbers. Once a number has been used, it should not be repeated for any future claim. One claim record should be reported for each name individual or entity formally alleged to have contributed to an injury or grievance, and from whom a malpractice payment is being sought. Note that the claim identifier need not be the company's internal claim id.

Item 4: Incident Identifier

Each reporting entity should assign a unique numeric identifier for each occurrence. An occurrence is an event or series of events leading to an allegation of malpractice, and which may involve allegations against multiple individuals and entities. An occurrence is defined causally, and may or may not be constrained in time. For example, multiple failures to diagnose a given illness may occur over years. Such a series of events would be considered a single occurrence.

Item 5: Per occurrence policy limits, primary coverage

The maximum amount a primary insurer will pay for a single malpractice claim under the terms of the policy.

Item 6: Annual policy limits, primary coverage

The maximum amount a primary insurer will annually pay under the terms of a policy for one or more malpractice claims. The reported policy limit should reflect all policies in effect for a given claim (see above).

Item 7: Per occurrence policy limits, all excess coverage combined

The combined maximum amount all excess insurers will pay for a single malpractice claim under the terms of the policy. Policy limits should reflect the cumulative limits of all policies other than the primary coverage in effect for a given claim. For example, if a policy was issued with a \$1 million limit, and an additional excess policy had a \$5 million limit, a total limit of \$6 million should be reported.

Item 8: Annual policy limits, all excess coverage combined

The combined maximum amount all excess insurers will annually pay under the terms of their respective policies or contracts. The reported policy limit should reflect all excess policies in effect for a given claim (see above).

Item 9: NPDB Occupation / Field of Licensure Code

Enter the field of licensure code from the following table for individuals named in a malpractice action. If an institution is named in the claim, enter 999.

| NPDB Occupation/Field of Licensure Codes | |
|--|--|
| Code | Description |
| Chiropractor | |
| 603 | Chiropractor |
| Counselor | |
| 621 | Counselor-Mental Health |
| 651 | Professional counselor |
| 654 | Professional counselor-alcohol |
| 657 | Professional counselor-family/marriage |
| 660 | Professional counselor-substance abuse |
| 661 | Marriage and family therapist |
| Dental Service Provider | |
| 030 | Dentist |
| 035 | Dentist/Resident |
| 606 | Dental assistant |
| 609 | Dental hygienist |
| 612 | Denturist |
| Dietician/Nutritionist | |
| 200 | Dietician |
| 210 | Nutritionist |
| Emergency Med Tech (EMT) | |
| 250 | EMT, Basic |
| 260 | EMT, Cardiac, critical care |
| 270 | EMT, Intermediate |
| 280 | EMT, Paramedic |
| Eye and Vision Service Provider | |
| 630 | Ocularist |
| 633 | Optician |
| 636 | Optometrist |
| Nurse | |
| 100 | Registered |
| 110 | Nurse anesthetist |
| 120 | Nurse midwife |
| 130 | Nurse practitioner |
| 140 | Licensed practical |
| 141 | Clinical nurse specialist |
| Nurse aides, Home health aide, and other aide | |
| 148 | Certified nurse aide/assistant |
| 150 | Nurses aide |
| 160 | Home health aide |
| 165 | Health care aide/direct care worker |
| 175 | Certified or qualified medication aide |
| Pharmacy Service Provider | |
| 050 | Pharmacist |

| NPDB Occupation/Field of Licensure Codes | |
|--|--|
| Code | Description |
| 055 | Pharmacy intern |
| 060 | Pharmacist, nuclear |
| 070 | Pharmacy assistant |
| 075 | Pharmacy technician |
| Physician | |
| 010 | Physician (MD) |
| 015 | Physician inter/resident (MD) |
| 020 | Osteopathic Physician (DO) |
| 025 | Osteopathic Physician Intern/Resident (DO) |
| Physician Assistant | |
| 642 | Physician assistant, allopathic |
| 645 | Physician assistant, osteopathic |
| Podiatric Service Provider | |
| 350 | Podiatrist |
| 648 | Podiatric assistant |
| Psychologist/Psychological Asst. | |
| 371 | Psychologist |
| 372 | School psychologist |
| 373 | Psychological assistant, associate, examiner |
| Rehabilitative, respiratory, and restorative service provider | |
| 402 | Art/Recreation therapist |
| 405 | Massage therapist |
| 410 | Occupation therapist |
| 420 | Occupational therapy assistant |
| 430 | Physical therapist |
| 440 | Physical therapy assistant |
| 450 | Rehabilitation therapist |
| 663 | Respiratory therapist |
| 666 | Respiratory therapy technician |
| Social worker | |
| 300 | Social worker |
| Speech, language, and hearing service provider | |
| 400 | Audiologist |
| 460 | Speech/language pathologist |
| 470 | Hearing aid/hearing instrument specialist |
| Technologist | |
| 500 | Medical technologist |
| 505 | Cytotechnologist |
| 510 | Nuclear medicine technologist |
| 520 | Radiation therapy technologist |
| 530 | Radiologist technologist |
| Other Health Care Practitioner | |
| 600 | Acupuncturist |
| 601 | Athletic trainer |
| 615 | Homeopath |
| 618 | Medical assistant |
| 624 | Midwife, Lay (non-nurse) |
| 627 | Naturopath |
| 639 | Orthotics/ Prosthetics Fitter |

| NPDB Occupation/Field of Licensure Codes | |
|--|---|
| Code | Description |
| 170 | Psychiatric Technician |
| 699 | Other health care practitioner-not classified |
| Health Care Facility Administrator | |
| 752 | Adult care facility administrator |
| 755 | Hospital administrator |
| 758 | Long-term care administrator |
| 999 | Not an individual defendant. |

Item 10: NPDB Medical Specialty Codes

Select the most relevant specialty code from the following table.

| NPDB Specialty Codes | |
|-----------------------|-------------------------------------|
| Code | Description |
| Physician Specialties | |
| 01 | Allergy and immunology |
| 03 | Aerospace medicine |
| 05 | Anesthesiology |
| 10 | Cardiovascular diseases |
| 13 | Child Psychiatry |
| 20 | Dermatology |
| 23 | Diagnostic Radiology |
| 25 | Emergency medicine |
| 29 | Forensic pathology |
| 30 | Gastroenterology |
| 33 | General / Family Practice |
| 35 | General preventive medicine |
| 37 | Hospitalist |
| 39 | Internal medicine |
| 40 | Neurology |
| 43 | Neurology, clinical neurophysiology |
| 45 | Nuclear medicine |
| 50 | Obstetrics & Gynecology |
| 53 | Occupational medicine |
| 55 | Ophthalmology |
| 59 | Otolaryngology |
| 60 | Pediatrics |
| 63 | Psychiatry |
| 65 | Public health |
| 67 | Clinical pharmacology |
| 69 | Physical medicine & rehabilitation |
| 70 | Pulmonary diseases |
| 73 | Anatomic/clinical pathology |
| 75 | Radiology |
| 76 | Radiation oncology |
| 80 | Colon and rectal surgery |
| 81 | General surgery |
| 82 | Neurological surgery |

| NPDB Specialty Codes | |
|-----------------------------|--|
| Code | Description |
| 83 | Orthopedic surgery |
| 84 | Plastic surgery |
| 85 | Thoracic surgery |
| 86 | Urological surgery |
| 98 | Other specialty-not classified |
| 99 | Unspecified |
| Dental specialties | |
| D1 | General dentistry (no specialty) |
| D2 | Dental: Public Health |
| D3 | Endodontics |
| D4 | Oral and maxillofacial surgery |
| D5 | Oral and maxillofacial pathology Orthodontics and dentofacial |
| D6 | Orthopedics |
| D7 | Pediatric Dentistry |
| D8 | Periodontics |
| D9 | Prosthodontics |
| DA | Oral and maxillofacial radiology |
| DB | Unknown |

Item 11: Type of facility Code

| Code | Description |
|--------------------------|--|
| Group or Practice | |
| 361 | Chiropractic Group / Practice |
| 362 | Dental Group / Practice |
| 363 | Optician / Optometric Group / Practice |
| 364 | Podiatric Group / Practice |
| 365 | Medical Group / Practice |
| 366 | Mental health / Substance Abuse Group / Practice |
| 393 | Home health Agency / Organization |
| 383 | Hospice / Hospice Care Provider |
| Hospital | |
| 301 | General/Acute Care Hospital |
| 302 | Psychiatric hospital |
| 303 | Rehabilitation Hospital |
| 304 | Federal Hospital |
| Hospital Unit | |
| 307 | Psychiatric Unit |
| 308 | Rehabilitation Unit |
| 310 | Laboratory/CLIA Laboratory |
| 389 | Nursing Facility/Skilled Nursing Facility |
| 370 | Research Center/Facility |

| Other Health Care Facility | |
|---|---|
| 381 | Adult Day Care Facility |
| 383 | Intermediate Care Facility for Mentally Retarded/Substance Abuse |
| 386 | Residential Treatment Facility/Program |
| 388 | Outpatient Rehabilitation Center/Comprehensive Outpatient Rehabilitation Center |
| 391 | Ambulatory Surgical Center |
| 392 | Ambulatory Clinic/Center |
| 394 | Health Center/Federally Qualified Health Center/Community Health Center |
| 395 | Mental Health Center/Community Mental Health Center |
| 396 | Rural Health Clinic |
| 397 | Mammography Service Provider |
| 398 | End Stage Renal Disease Facility |
| 399 | Radiology/Imaging Center |
| Managed Care Organization | |
| 331 | Health Maintenance Organization |
| 335 | Preferred Provider Organization |
| 336 | Provider Sponsored Organization |
| 338 | Religious, Fraternal Benefit Society Plan |
| 320 Health Insurance Company/Provider | |
| Health Care Supplier/Manufacturer | |
| 342 | Blood Bank |
| 343 | Durable medical Equipment Supplier |
| 344 | Eyewear Equipment Supplier |
| 345 | Pharmacy |
| 346 | Pharmaceutical Manufacturer |
| 347 | Biological Products manufacturer |
| 348 | Organ Procurement Organization |
| 349 | Portable X-Ray Supplier |
| 351 | Fiscal/Billing/Management Agency |
| 352 | Purchasing Service |
| 353 | Nursing/Health Care Staffing Service |
| 390 Ambulance Service/Transportation Company | |
| 999 Other not specified | |

Item 12: Location within facility where incident occurred

| Code | Description |
|-----------------------------|------------------------------|
| Inpatient Facilities | |
| 1 | Catheterization lab |
| 2 | Critical care unit |
| 3 | Dispensary |
| 4 | Emergency department |
| 5 | Labor and delivery room |
| 6 | Laboratory |
| 7 | Nursery |
| 8 | Operating room |
| 9 | Outpatient department |
| 10 | Patient room |
| 11 | Pharmacy |
| 12 | Physical therapy department |
| 13 | Radiation therapy department |

| NPDB Allegation Codes | |
|-------------------------------------|---|
| | <i>Excludes</i> misdiagnoses (323), and delay in diagnosis (200). Use code only to indicate instances of a conclusion that no condition worthy of follow-up or treatment existed, when it in fact did exist. |
| 102 | Failure to delay case when indicated |
| 103 | Failure to identify fetal distress |
| 104 | Failure to treat fetal distress |
| 105 | Failure to medicate |
| 106 | Failure to monitor |
| 107 | Failure to order appropriate medication |
| 108 | Failure to order appropriate test |
| 109 | Failure to perform preoperative evaluation |
| 110 | Failure to perform procedure |
| 111 | Failure to perform resuscitation |
| 112 | Failure to recognize a complication |
| 113 | Failure to treat |
| Delay in Performance | |
| 200 | Delay in diagnosis |
| 201 | Delay in performance |
| 202 | Delay in treatment |
| 203 | Delay in treatment of identified fetal distress |
| Error / Improper Performance | |
| 300 | Administration of blood or fluid problems |
| 301 | Agent use or selection error |
| 302 | Complimentary or alternative medication problem |
| 303 | Equipment utilization problem |
| 304 | Improper choice of delivery method |
| 305 | Improper management |
| 306 | Improper performance |
| 307 | Improperly performed C-Section |
| 308 | Improperly performed vaginal delivery |
| 309 | Improperly performed resuscitation |
| 310 | Improperly performed test |
| 311 | Improper technique |
| 312 | Intubation problem |
| 313 | Lab error |
| 314 | Pathology error |
| 315 | Medication administered via the wrong route |
| 316 | Patient history |
| 317 | Problems with patient monitoring in recovery |
| 318 | Patient monitoring problem |
| 319 | Patient position problem |
| 320 | Problem with appliance |
| 321 | Radiology or imaging error |
| 322 | Surgical or other foreign body retained |
| 323 | Wrong diagnosis or misdiagnosis |
| 324 | Wrong dosage administered |
| 325 | Wrong dosage dispensed |
| 326 | Wrong dosage ordered of correct medication |
| 327 | Wrong medication administered |
| 328 | Wrong medication dispensed |
| 329 | Wrong medication ordered |
| 330 | Wrong body part |
| 331 | Wrong blood type |
| 332 | Wrong equipment |
| 333 | Wrong patient |
| 334 | Wrong procedure or treatment |

| NPDB Allegation Codes | |
|--|---|
| Unnecessary/Contraindicated Procedure | |
| 400 | Contraindicated procedure |
| 401 | Surgical or procedural clearance contraindicated |
| 402 | Unnecessary procedure |
| 403 | Unnecessary test |
| 404 | Unnecessary treatment |
| Communication/Supervision | |
| 500 | Communication problem between practitioners |
| 501 | Failure to instruct or communicate with patient or family |
| 502 | Failure to report on patient condition |
| 503 | Failure to respond to patient |
| 504 | Failure to supervise |
| 505 | Improper supervision |
| Continuity of Care / Management | |
| 600 | Failure/delay in admission to hospital |
| 601 | Failure/delay in referral or consultation |
| 602 | Premature discharge from institution |
| 603 | Altered, misplaced, or prematurely destroyed records |
| Behavioral / Legal | |
| 700 | Abandonment |
| 701 | Assault and Battery |
| 702 | Breach of contract or warranty |
| 703 | Breach of patient confidentiality |
| 704 | Equipment malfunction |
| 705 | Breach of regulation |
| 706 | Failure to ensure patient safety |
| 707 | Failure to obtain consent / lack of informed consent |
| 708 | Failure to protect 3 rd party |
| 709 | Failure to test equipment |
| 710 | False imprisonment |
| 711 | (Legal, ethical, or moral) improper conduct |
| 712 | Inadequate utilization review |
| 713 | Negligent credentialing |
| 714 | Practitioner with communicable disease |
| 715 | Product liability |
| 716 | Religious issues |
| 717 | Sexual misconduct |
| 718 | Third party claimant |
| 719 | Vicarious liability |
| 720 | Wrong life/birth |
| 899 | Cannot be determined from available records. |
| 999 | Allegation not otherwise classified |

Item 15: City where injury occurred

Full name of the city in which the alleged injury occurred. The city should correspond to the alleged error or omission identified on item 14.

Item 16: County where injury occurred

Full name of the county in which the injury is alleged to have occurred. The county should correspond to the alleged error or omission identified on item 14.

Item 17: County FIPS Code

Three digit Federal Information Processing Standard Code (FIPS) for the county in which the injury occurred. Do not omit leading zeros (001, 023, etc).

Item 18: Five digit **Zip Code** of the location where injury occurred.

Item 19: Gender of injured person. Use M or F.

Item 20: Age of injured person.

Item 21: Severity of injury code

| Code | Severity Description | Examples |
|---------------------------------------|----------------------|--|
| Temporary Injuries (Codes 1-4) | | |
| 1 | Emotional injury | Fright, no physical injury |
| 2 | Insignificant | Lacerations, contusions, minor scars or rash, no delay in recovery |
| 3 | Minor | Infection, fracture set improperly, fall in hospital. Recovery is delayed but complete |
| 4 | Major | Burns, surgical material left, drug side effect or brain injury. Recover is delayed but complete |
| Permanent Injuries | | |
| 5 | Minor | Loss of fingers, loss or damage to minor organs. Injury is not disabling |
| 6 | Significant | Deafness, loss of limb, loss of eye, loss of one kidney or lung |
| 7 | Major | Paraplegia, blindness, loss of two limbs, or brain damage |
| 8 | Grave | Quadriplegia, severe brain damage, life-long care or fatal prognosis |
| 9 | Death | |

Item 22: Date of injury

Report the date of the earliest alleged error or omission that was the first necessary if not sufficient cause of the alleged medical injury. This date should correspond to the error or omission code identified on item 14.

Item 23: Date claim was reported

The date that an insurer received a formal demand for payment for injuries arising out of alleged medical negligence. If no insurance coverage is available, use the date that the medical provider or facility received such notice.

Item 24: Date of lawsuit

The date a lawsuit was filed for this claim.

Item 25: Date claim was closed.**Item 26: Claim Disposition Code**

| Claim Disposition Codes | |
|--------------------------------------|---|
| Code | Description |
| 1 | Claim is abandoned by the claimant. |
| 2 | Claim is settled by the parties. |
| Claims disposed of by a court | |
| 3a | Directed verdict for the plaintiff |
| 3b | Directed verdict for the defendant |
| 3c | Judgment notwithstanding verdict for the plaintiff (judgment for the defendant) |
| 3d | Judgment notwithstanding verdict for the defendant (judgment for the plaintiff) |
| 3e | Involuntary dismissal |

| | |
|--|--|
| 3f | Judgment for the plaintiff |
| 3f | Judgment for the defendant |
| 3f | Judgment for the plaintiff after appeal |
| 3f | Judgment for the defendant after appeal |
| Claims settled by an alternative dispute resolution process | |
| 4a | Arbitration |
| 4b | Mediation |
| 4c | Private judging or private trial |
| 4d | Other type of alternative dispute resolution process |

Item 27: Timing of Disposition Code

| Timing of Disposition | |
|------------------------------|---|
| 1 | Before filing suit or requesting arbitration or a mediation hearing |
| 2 | Before trial, arbitration or mediation |
| 3 | During trial, arbitration or mediation |
| 4 | After trial or hearing, but before judgment or award |
| 5 | After judgment or decision, but before appeal |
| 6 | During an appeal |
| 7 | After an appeal; or |
| 8 | During review panel or non-binding arbitration |

Item 28: Indemnity paid by reporting entity

The amount of indemnity paid by the insurer reporting the claim, exclusive of any other amounts paid by any other insurer or party.

Item 29: All other indemnity paid

The total amount paid by all other insurers or parties for this claim.

Note on items 30 and 31: Economic and noneconomic portions of total indemnity paid by all parties.

Amounts entered into items 28 and 29 should reasonably reflect available documentation obtained during the course of adjudicating a claim regarding actual economic costs incurred by the injured party due to the alleged medical negligence. Economic damages should reflect the reporting entity's best estimate of current and future lost wages, current and future medical costs, and any other pecuniary costs arising from the alleged act of malpractice. Arbitrarily apportioning economic and non-economic damages 50%-50% or via some other heuristic rule is not acceptable.

For costs that are not documented, each reporting entity should develop a reasonable methodology for imputing values. For example, lost life-time wages of a minor who lacks any employment history may be estimated via generally accepted econometric or actuarial methods that would be accepted in a court of law.

Noneconomic damages should not exceed any tort limitations such as damage caps that exist in the relevant jurisdiction. Within such constraints, noneconomic damages should bear a reasonable relationship to the nature and severity of the injury in terms of limitations on major life activities formerly enjoyed by the injured party, physical pain and suffering, loss of consortium, psychological or mental consequences of the injury, and any other reasonable non-pecuniary losses.

Reporting entities should be prepared to document and justify allocation methodologies upon request of the insurance commissioner. **If the sum of estimated economic and non-economic damages exceed total indemnity, the amount allocated to non-economic damages should be reduced by a proportionate amount.**

Item 30: Economic Indemnity. Portion of total indemnity designed to compensation an injured party for pecuniary losses, such as lost wages and medical costs attributable to the iatrogenic injury.

Item 31: Non-economic indemnity. Portion of the total indemnity designed to compensate an injured party for other than pecuniary losses, such as pain and suffering, diminished quality of life, or loss of consortium.

Item 32: Punitive damages. Amounts awarded for purposes other than compensation, such as awards designed to punish or deter grossly negligent conduct.

Item 33: Loss Adjustment Expense (LAE) paid for legal defense. Include amounts paid to legal staff, expert witnesses, court costs, and any other amounts directly related to legal costs associated with this claim.

Item 34: Loss Adjustment Expense (LAE) for other than legal defense. All other costs incurred during the course of adjudicating this claim, but excluding legal costs.