

**GUIDELINE FOR IMPLEMENTATION OF
MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING**

**PART A
SUGGESTED REGULATION ON REPORTING REQUIREMENTS**

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Section 1. Statement of Purpose

This regulation establishes detailed reporting requirements that are consistent with the NAIC *Medical Professional Liability Closed Claim Reporting Model Law*.

Section 2. Definitions

As used in this regulation:

- A. “Claim” means the same as in subsection 2A of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- B. “Claim identifier” means the unique number assigned to a claim by the reporting entity as required by subsection 5A(1) of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- C. “Claimant” means the same as in subsection 2B of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- D. “Closed claim” means the same as in subsection 2C of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- E. “Commissioner” means the same as in subsection 2D of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- F. “Companion claims” means the same as in subsection 2E of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- G. “Defense and cost containment expenses” means expenses paid or incurred for defense, litigation and medical cost containment services. Either internal staff, such as in-house counsel or professional medical staff, or external staff, such as defense counsel or expert witnesses, may provide defense and cost containment services.

- (1) Defense and cost containment expenses and services include:

- (a) Defense services provided by attorneys, expert witnesses, private investigators, hearing representatives and fraud investigators;
 - (b) Cost containment activities and services performed by external or internal experts to defend the claim, including case evaluation, risk assessment, case preparation and management, medical record review and settlement negotiations; and
 - (c) Specific case-related expenses, such as surveillance expenses, court costs, medical examination fees, the costs of laboratory, X-ray and other medical tests, autopsy expenses, stenographic expenses, fees associated with witnesses and summonses and the costs of obtaining copies of documents.
- (2) Defense and cost containment expenses do not include:
- (a) Expenses incurred to determine whether coverage is available; and
 - (b) General Expenses or costs associated with external or internal claims adjusting staff that cannot reasonably be allocated to a specific occurrence. [note – I’m concerned that G2(b) may contradict G1 above. My feeling is that costs should include all amounts which can be attributed to a specific claim.]
- H. “Economic damages” means the same as in subsection 2F of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- I. “Excess insuring entity” means an insuring entity that provides insurance coverage above the limits of primary insurance or a self-insured retention.
- J. “Facility” means the same as in subsection 2G of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- K. “Incident identifier” means the unique number assigned by the reporting entity to a series of closed claims that result from a single incident or related series of incidents of medical malpractice, as required by subsection 5A(2) of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- L. “Insuring entity” means the same as in subsection 2I of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- M. “Medical malpractice” means the same as in subsection 2J of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- N. “Noneconomic damages” means the same as in subsection 2K of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- O. “Primary insuring entity” means the insuring entity that originates the primary layer of insurance coverage.
- P. “Provider” means the same as in subsection 2H of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- Q. “Reporting entity” means any person or entity required to report data under Section 4 of the *Medical Professional Liability Closed Claim Reporting Model Law*.

- R. “Self-insurer” means the same as in subsection 2L of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- S. “User ID” is a permanent number assigned by the commissioner to each insuring entity, self-insurer, facility or provider that reports data.
- T. “Economic loss” means the actual monetary costs borne by an injured party as a result of an instance of alleged malpractice, and may vary from the amount of economic indemnity paid to compensate for such loss.
- U. “Occurrence” means a medical incident or series of incidents leading to an allegation of harm. A single occurrence may span multiple years and involve numerous named defendants.

Section 3. Applicability and Scope

This regulation is intended to implement this state’s medical professional liability closed claim reporting requirements in a manner that is consistent with the NAIC *Medical Professional Liability Closed Claim Reporting Model Law*. It applies to all reporting entities as defined in Subsection 2Q of this regulation.

Section 4. Claims Required to Be Reported

- A. The types of closed medical professional liability claims that must be reported to the commissioner include:
 - (1) Claims closed with an indemnity payment;
 - (2) Claims closed with paid defense and cost containment expenses; and
 - (3) ~~Claims closed with both indemnity payments and paid defense and cost containment expenses~~ which were opened pursuant to a formal demand for payment or receipt of a lien letter or for which a lawsuit was filed. [note: this makes the definition consistent with the model law, which defines a claim as a “demand for monetary damages...” Also, this should eliminate reporting inconsistencies attributable to different reserve practices between reporting entities]
 - (4) Claims should not be reported
 - a. in cases of mistaken identity;
 - b. in instances in which individuals may have contacted an attorney or requested medical records but have made no formal demand for payment; or
 - c. instances in which a reporting entity is aware of an adverse medical outcome but no demand for payment has been made.
- B. A separate claim should be filed for each individual or entity formally alleged to have contributed to an incident or adverse outcome and from whom a demand for payment has been made, regardless of whether they are the name insured on the policy or covered employees or agents of a corporation, association or trust.
- CB. If a self-insurer, facility or provider waives copayments, forgives bills or deductibles, or makes other similar accommodations to a client, it is not a claim under subsection 2A of the *Medical Professional Liability Closed Claim Reporting Model Law*. Reporting entities are not required to report these types of accommodations to the commissioner.

~~DC.~~ A claim is closed on the date the reporting entity ~~takes final administrative action to close the claim. Final administrative action occurs after the reporting entity:~~

- ~~(1) If applicable, issues the final payment to the claimant in the form of a check, draft, or electronic funds transfer or finalizes arrangements to make future periodic payments; and [note – this is necessary to ensure that claims with periodic payments are reported in a timely fashion. Otherwise, the report may not be required until many years after a claim has been settled];~~
- ~~(2) Determines the final amounts for Pays all outstanding bills for defense and cost containment expenses; and~~
- ~~(3) If applicable, receives all indemnity and defense and cost containment expense payment data needed for reporting from a facility, provider or excess insuring entity.~~

~~ED.~~ If a closed claim is reopened to update data or due to a claimant renewing a claim, the reporting entity must report the updated data to the commissioner after it updates and closes the claim file.

Section 5. Assignment of Claim and Incident Identifiers

A. The reporting entity must assign a different claim identifier to each closed claim report.

- ~~(1) The claim identifier must consist solely of numbers.~~ The commissioner will combine the reporting entity's user ID with the claim identifier to create a unique record identifier for each claim.
- (2) The commissioner may use the record identifier to trace the claim for auditing purposes.

B. If a claimant makes claims against more than one facility or provider insured by an insuring entity or self-insurer, the insuring entity or self-insurer must report each claim separately and include an incident identifier common to all such providers.

- ~~(1) The incident identifier must consist solely of numbers.~~
- ~~(2) The insuring entity or self-insurer is responsible to report claims only if it provides insurance coverage for a facility or provider and defends the claim.~~

Section 6. Responsibility for Reporting Data

A. Primary insuring entities are principally responsible for reporting closed claim data required under the *Medical Professional Liability Closed Claim Reporting Model Law*.

- (1) The primary insuring entity must report the total amounts paid to settle the claim, including any indemnity or defense and cost containment expense payments made by:
 - (a) A facility or provider;
 - (b) An excess insuring entity; or
 - (c) Any other person or entity on behalf of the facility or provider.

- (2) Facilities or providers insured by the primary insuring entity must cooperate and assist the primary insuring entity in the reporting process.
 - (3) If a primary insuring entity and one or more excess insuring entities combine to pay a claim:
 - (a) The primary insuring entity must report all paid indemnity and defense and cost containment expenses; and
 - (b) The excess insuring entity must cooperate and assist the primary insuring entity in the reporting process. If the excess insurer fails to render such cooperation and assistance, it will be subject to the same penalties as those of a primary insurer that fails to file.
- B. If an excess insuring entity insures a self-insurer and makes indemnity payments or incurs defense and cost containment expenses, the excess insuring entity is principally responsible to report the required closed claim data.
- (1) Self-insurers must report all claim payments and defense and cost containment expenses to the excess insuring entity for reporting purposes; and
 - (2) The excess insuring entity must report data on behalf of itself and the self-insurer.
 - (3) An excess insuring entity is not responsible to report closed claim data reported by a primary insuring entity under subsection 6A of this Guideline.
- C. If a closed claim payment falls within its self-insured retention, the self-insurer must report the required closed claim data.
- D. A self-insurer may designate itself to be the principal reporting entity and report closed claim data on behalf of itself and any excess insuring entity. If the self-insurer designates itself to be the principal reporting entity, the self-insurer must:
- (1) Notify the commissioner in writing of this arrangement;
 - (2) Report the required closed claim data on behalf of itself and the excess insuring entity; and
 - (3) Accept responsibility for compliance with the requirements of subsection 4A of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- E. A medical facility or provider is responsible to report the required closed claim data if an insuring entity or self-insurer fails to report the claim; [makes this provision consistent with the model changes adopted by plenary at the September mtg].
- ~~(1) — There is no insurance coverage available from an insuring entity or self-insurer to defend or pay the claim; or~~
- ~~(2) — A court of competent jurisdiction determines that the self-insurer, risk retention group or unauthorized insurer is exempt from the *Medical Professional Liability Closed Claim Reporting Model Law*; or~~

~~(3) — The commissioner grants a waiver under subsection 4A(4)(b) of the *Medical Professional Liability Closed Claim Reporting Model Law*. [Note: This section may be unenforceable. If a self-insured entity is exempt from reporting as per Section 4(4), it can't then be made to report in its alternative role as medical facility.]~~

Section 7. Reporting of Specific Data Elements

- A. Policy limits—When reporting the policy limits of the medical professional liability insurance policy covering the claim, reporting entities must report the following, if applicable:
- (1) Primary policy limit, per occurrence;
 - (2) Annual limit of primary policy;
 - (3) Excess policy limit, per occurrence; and
 - (4) Annual limit of excess policy.
- B. Medical specialty—When reporting medical specialties, reporting entities must use the *Field of Licensure Codes* and *Medical Specialty Codes* published by the National Practitioner Data Bank.
- C. Type of health care facility—When reporting the type of health care facility, the reporting entity must use the *Type of Organization Codes* published by the National Practitioner Data Bank (NPDB). Public facilities, such as prisons and universities, must review the NPDB *Type of Organization Codes* and enter the most similar classification.
- D. Primary location within a facility—When reporting the primary location within a facility where the incident occurred, the reporting entity must use the incident locations published by the Physician Insurers Association of America in conjunction with its data-sharing project. The reporting entity must report one of these locations:
- (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;
- (14) Radiology department;
- (15) Recovery room;
- (16) Rehabilitation center;
- (17) Special procedure room;
- (18) Location other than an inpatient facility:
 - (a) Clinical support center, such as a laboratory or radiology center;
 - (b) Office;
 - (c) Walk-in clinic; or
 - (d) Other;
- (19) Other department in hospital;
- (20) Unknown; and
- (21) Other.

- E. County, City, and ZIP Code—When reporting the geographic location ~~city~~ where the incident occurred, the reporting entity must report based on the location of the facility where the incident occurred. If more than one incident led to the claim, the reporting entity must choose the location where the initial incident that was the first necessary if not sufficient cause of the leading-most directly to the injury occurred. In the event that an injury occurs outside this state, but the claim is made in this state, a closed claim report must be filed in this state and the city shown as “Location out of state.”
- F. Severity of injury—When reporting the severity of injury, the reporting entity must use the National Practitioner Data Bank severity scale. This scale shows the medical outcome for temporary and permanent injuries.

- (1) Temporary injuries include:
 - (a) Emotional injury only, such as fright, where no physical damage occurred;
 - (b) Insignificant injury, such as lacerations, contusions, minor scars or rash, where no delay in recovery occurs;
 - (c) Minor injury, such as infection, fracture set improperly or a fall in the hospital, where recovery is complete but delayed; and
 - (d) Major injury, such as burns, surgical material left, drug side effect or brain damage, where recovery is complete buy delayed.
- (2) Permanent injuries include:

- (a) Minor injury, such as loss of fingers or loss or damage to organs, where the injury is not disabling;
 - (b) Significant injury, such as deafness, loss of limb, loss of eye or loss of one kidney or lung;
 - (c) Major injury, such as paraplegia, blindness, loss of two limbs or brain damage;
 - (d) Grave injury, such as quadriplegia, severe brain damage, life-long care or fatal prognosis; and
 - (e) Death.
- (3) If several injuries are involved, the reporting entity should report the principal most severe injury.
- G. Date of notice—When reporting the date of notice to the insuring entity, self-insurer, facility or provider, the reporting entity ~~must report the date on which~~ has received a formal demand for payment:
- ~~(1) — The insured notifies the primary insuring entity or self insurer of a claim if insurance coverage is available; or~~
 - ~~(2) — The claimant notifies the facility or provider of a claim if insurance coverage is not available.~~
- H. Claim disposition—When reporting the method of claim disposition, the reporting entity must describe the method of claim disposition using one of the following descriptions:
- (1) Claim is abandoned by the claimant.
 - (2) Claim is settled by the parties.
 - (3) Claim is disposed of by a court when the court issues a:
 - (a) Directed verdict for the plaintiff;
 - (b) Directed verdict for the defendant;
 - (c) Judgment notwithstanding verdict for the plaintiff (judgment for the defendant);
 - (d) Judgment notwithstanding verdict for the defendant (judgment for the plaintiff);
 - (e) Involuntary dismissal;
 - (f) Judgment for the plaintiff;
 - (g) Judgment for the defendant;
 - (h) Judgment for the plaintiff after appeal; or
 - (i) Judgment for the defendant after appeal.

- (4) Claim is settled by an alternative dispute resolution process, whether resolved by:
 - (a) Arbitration;
 - (b) Mediation;
 - (c) Private judging or private trial; or
 - (d) Other type of alternative dispute resolution process.

- I. Timing of disposition—When reporting the timing of the claim disposition, the reporting entity must report whether the claim is settled:
 - (1) Before requesting arbitration, mediation, or private trial;
 - (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.

- J. Indemnity payments and defense and cost containment expenses
 - (1) When reporting indemnity payments, the reporting entity must report payments on a gross basis and provide the total amount paid to the claimant to settle the claim. The reporting entity must not deduct the value of offsets or recoverables, such as:
 - (a) Reimbursement by the insured for a deductible;
 - (b) Reimbursement by a reinsurer for claim payments; or
 - (c) Anticipated subrogation recoveries.

 - (2) When damages exceed the facility’s or provider’s policy limits, the reporting entity must report the total amount paid by all parties on behalf of the insured, including:
 - (a) The amount paid by all the insuring entities. The actual amount paid may be higher or lower than the policy limit, depending on the settlement agreement.
 - (b) Additional payments made by the insured facility or provider to the claimant.

 - (3) Subrogation between insuring entities or self-insurers may occur if there is a dispute over which entity should respond to a lawsuit. If an insuring entity or

self-insurer receives a subrogation payment, it must report subrogation proceeds and any defense and cost containment expenses paid to obtain those proceeds. If necessary, the reporting entity may reopen the claim to report this information.

- (4) Structured settlements
 - (a) If a claim is paid with a structured settlement agreement, the reporting entity must report the lump-sum payment for the purchase of the annuity.
 - (b) If a claim is paid with a combination of a lump-sum payment to the claimant and a structured settlement, the reporting entity must report the sum of both payments.
- (5) If more than one claim is filed with a reporting entity due to an incident of medical malpractice, the reporting entity must report companion claim payments in this manner:
 - (a) Indemnity payments and defense and cost containment expenses paid to defend and settle each claim must be reported separately for each facility or provider. The reporting entity must allocate indemnity payments between defendants based on an assessment of comparative fault. The reporting entity must allocate defense and cost containment expense payments based on the extent to which each defendant benefited from the defense services.
 - ~~(b) If the reporting entity makes payments in the absence of clear legal liability, it may allocate indemnity payments and defense and cost containment expenses equally among all defendants. [unnecessary and possibly confusing. Payments normally are assigned to particular parties in the course of settlement or adjudication].~~
 - (c) The reporting entity is responsible for reporting incident-level data only for its own claims.
- (6) When reporting defense and cost containment expenses, the reporting entity must ~~report~~ itemize costs for:
 - (a) Defense and cost containment expenses paid for defense counsel, including both in-house and outside counsel;
 - (b) Defense and cost containment expenses paid for expert witnesses, including both in-house and outside experts;
 - (c) All other defense and cost containment expenses; and
 - (d) Total defense and cost containment expenses.
- (7) When an insuring entity or self-insurer uses company employees, including professional medical staff and in-house legal counsel, to defend claims, the reporting entity:
 - (a) Must include in defense and cost containment expenses the salary, benefits and an allocation of overhead for those employees; and

- (b) May use average salaries and the results of time studies when calculating these defense and cost containment expenses.
- K. Estimation of economic and noneconomic damages for claims settled without a court judgment.
- (1) If a reporting entity makes indemnity payments to a claimant, the reporting entity must report the economic portion of total indemnity damages based on documented evidence obtained during the claim resolution process. Reporting entities may not determine economic damages amounts using a fixed formula, such as fifty percent of total paid indemnity.
 - (2) Estimates of ~~When a reporting entity makes a best estimate of economic damages, the reporting entity must use reasonable judgment to estimate the following elements of actual losses incurred by the injured party should include:~~
 - (a) Medical expenses incurred, and estimated future medical expenses;
 - (b) Past and projected ~~Loss~~ of earnings;
 - (c) Burial costs;
 - (d) Loss of use of property;
 - (e) Cost of replacement or repair;
 - (f) Cost of obtaining substitute domestic or other necessary services; and
 - (e) Loss of business or employment opportunities, and
 - ~~(f) Any other identifiable pecuniary loss.~~
 - ~~(3) If a reporting entity makes indemnity payments to a claimant that include compensation for future economic damages, the reporting entity must estimate these future economic damages in the following manner:~~
 - ~~(a) Project the elements of loss listed in subsection H(2) of this section for the duration of the injury or disability or, in the event of death, for the anticipated life span of the injured person;~~
 - ~~(b) Discount damages to present value using reasonable discount factors; and [Note: unless there is an unambiguous required methodology for all reporting entities, this will result in reporting inconsistencies].~~
 - ~~(c) Consider related factors, such as issues of negligence and liability, the relative strength of the defense, and the component of the indemnity payment driven by economic damages.~~
 - (4) The total indemnity payment must be equal to the sum of the reporting entity's best estimate of economic damages and the reporting entity's best estimate of noneconomic damages, ~~and neither estimate may exceed the total indemnity payment.~~

- (5) Economic indemnity amounts may vary from the actual economic losses incurred by the injured party as estimated in section K(2).
- (6) Noneconomic indemnity should bear a reasonable relationship to the nature and degree of injury.
- (7) If the sum of both economic and noneconomic losses incurred by the injured party exceed the amount of indemnity paid to compensate such losses, indemnity amounts from both economic and noneconomic categories should be reduced proportionately such that

$$\frac{\text{economic indemnity}}{\text{actual economic losses}} = \frac{\text{noneconomic indemnity}}{\text{actual noneconomic losses}}$$

(L) For claims subject to a court judgment, the amounts awarded by the court for economic and noneconomic damages should be reported.

PART B MECHANISM FOR REPORTING AND COLLECTION OF DATA

A. The commissioner will prescribe the method to be used by reporting entities to report the required data. In developing this method, the commissioner should consider electronic transfer mechanisms, such as web-based applications or batch submissions via email, that facilitate the timely and efficient transfer of data between reporting entities and the insurance department.

~~If it is feasible, the commissioner will establish a web-based reporting site to be used by reporting entities to report the required closed-claim data.~~

B. Each The state's reporting site should develop include data editing and verification protocols controls that identify prevent the entry of data that are invalid, or internally inconsistent, or anomalous data. The site should be designed to meet the needs of various types of reporting entities, many of which have not been accustomed to reporting any kind of information to the commissioner.

~~The commissioner should also consider the feasibility of providing for electronic transfer of batch data from reporting entities that report a substantial number of claims each year, provided that these reporting entities can incorporate into their data collection and reporting processes business rules that ensure the accuracy of the reported data.~~

~~To promote efficiency of reporting and quality of data, the commissioner will, to the extent that it is feasible, make the operation and format of the state's reporting site consistent with the sites of other states.~~

PART C INSURANCE DEPARTMENT OUTREACH EFFORTS

The commissioner is responsible for collecting data from entities that are not traditionally regulated by insurance departments. To ensure timely compliance with the reporting law, the commissioner should engage in outreach and training initiatives. These are some of the groups that typically must be contacted during the outreach effort.

Sector Lobbyists

State medical associations

State hospital associations

Health care organizations, such as health maintenance organizations

Medical professional liability insurers
Nursing home associations
Surplus lines association
Risk retention group associations

Other State Agencies

Risk management agencies
University and college medical centers that provide medical services
Correctional agencies that provide medical services to inmates
Health agencies that provide public health services

Local Government

Some cities and counties provide medical services to the public or inmates residing in local correctional facilities.

Risk Management Associations

Some states have risk management associations related to health care risk management issues.

The organizations listed above can help the commissioner make reporting entities aware of the state's closed claim reporting requirements. Training programs presented by insurance department staff and accessible to members of these organizations are likely to improve the timeliness and quality of the closed claim data submitted by reporting entities.

**PART D
COMPILING, VERIFYING, AND RELEASING DATA**

The commissioner has a responsibility to ensure that the data collected are complete and accurate, to analyze the data using sound statistical methods, and to provide summary reports and data analyses for the legislature and the public.

Before data are summarized and analyzed, the commissioner should check the reasonableness of the data collected and work with reporting entities to ensure that any needed corrections are made.

~~As early as practical~~ By June 30 of each year, the commissioner should:

- (a) Summarize and analyze the data submitted on claims closed in preceding years, using sound statistical methods; and
- (b) Issue a report including the data, the analysis, and any conclusions that are drawn. This report should be made available to the public on the commissioner's website.

To the extent that data are confidential, the commissioner must protect the data in a manner consistent with provisions used in the state's adoption of Section 6 of the *Medical Professional Liability Closed Claim Reporting Model Law*.

This guide is intended to assist state regulators in compiling claims data pursuant to the *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's *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 of the data reported by insurers, medical professional liability 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. To the extent that it's possible, the state's mechanism for collecting closed claim data should be designed to prevent the entry of invalid data. 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, if codes are used, 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. To the extent that it's possible, the state's mechanism for collecting closed claim data should be designed to prevent the entry of data that are internally inconsistent. 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 paid pursuant to the policy 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 cause analyses to be biased. Bias will occur if the relevant characteristics of the subset of items for which the information is missing differ 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 *Medical Professional Liability Closed Claim Reporting 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 the data released 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 providing medical professional liability 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 (for example, 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*. As of August 2008, 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 within *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 percentage less than 100 to be determined by the commissioner.

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.

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 is it recommended by the Committee on Statistical Methodology. As such, it is not further 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 – minimum 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) = (1,0.6)
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	pq rule – values of p and q are not published

Agency	Threshold – minimum number for each data cell	Other threshold rules
	confidentiality (suppressed when standard error > 50%)	
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 <i>n</i> 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.

Sample Confidentiality Form

Each individual granted access to the raw or “unit level” medical professional liability closed claim 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 confidentiality 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 employee’s 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’s 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.”

PART E 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.

Coding of data may not be necessary or appropriate at every step of the process. For example, if a state uses a web-based reporting site, drop-down boxes may be more user-friendly than a requirement that the reporting entity convert the data to codes before entering it. On the other hand, if a state is receiving batch data transferred electronically from reporting entities, the codes in this guideline provide an appropriate format for data reporting. For sharing raw data with other state insurance departments, coding is necessary in order to provide data that can be aggregated across states.

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	Policy type code	Primary coverage type, occurrence, claims made, etc	
10	Coverage code	Type of coverage primary policy – individual, group, employee coverage, etc	
119	Lic code	NPDB field of licensure code	Text, Left Zero Filled
129	Spec code	NPDB medical specialty code	Text, Left Zero Filled
134	Facility	Code for type of facility where incident occurred	Text
142	Location	Code for the location within facility where incident occurred	Alphanumeric
153	Allegation_group	NPDB general allegation code	Text, Left Zero Filled
164	Allegation_code	NPDB specific allegation code	Text

Item #	Data Field	Description	Format
175	City	City in which injury occurred	Text
168	County	County in which injury occurred	Text
197	County FIPS Code	3-digit county Federal Information Processing Standard Code	Text, Left Zero Filled
1820	Zip Code	Five digit Zip code for place of injury.	Text, Left Zero Filled
219	Inj_gender	Gender of injured party (M, F)	Alpha – M or F
220	Inj_Age	Age of injured party	Numeric
234	Severity	Injury severity code. See Table X	Text
242	Inj_date	Earliest date of act or omission that was the proximate cause of the claim	MM/DD/YYYY
253	Rept_date	Date claim reported to insurer	MM/DD/YYYY
264	Suit_date	Date suit was filed, if applicable	MM/DD/YYYY
275	Close_date	Date claim was closed	MM/DD/YYYY
286	Disposition	Manner in which a claim is resolved	Alphanumeric
297	Disp_time	Timing of disposition of claim	Text
30a	<u>Econ_Ind</u>	<u>Economic indemnity paid by primary insurer or payee</u>	
30b	<u>Nonecon_ind</u>	<u>Noneconomic indemnity paid by primary insurer or payee</u>	
2830c	<u>Tot_Indemnity</u>	Total indemnity paid by <u>this entity primary insurer or payee</u>	Numeric
29	<u>Other_Indemnity</u>	<u>All other indemnity paid by all other parties</u>	<u>Numeric</u>
31a30	<u>Oth_Econ_ind</u>	Economic indemnity paid by all <u>other parties on behalf of this defendant</u>	Numeric
31b34	<u>Oth_Nonecon_ind</u>	Non-economic indemnity paid by all <u>other parties on behalf of this defendant</u>	Numeric
31c	<u>Oth_tot_ind</u>	<u>All other indemnity paid by all other parties on behalf of this defendant</u>	
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
35	Current wage loss	Injured person's incurred wage loss	Numeric
36	Anticipated future wage loss	Injured person's anticipated future wage loss	Numeric
37	Current medical expense	Medical expense incurred by injured party as a result of the malpractice	Numeric
38	Anticipated future medical expense	Medical expense the injured party is expected to pay in the future as a result of the injury	Numeric
39	All other incurred and future monetary expenses	All other expenses incurred as a result of the alleged incident(s) of malpractice.	Numeric
40	Narrative	Brief narrative describing the nature of the allegation and injury	Text

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 as a component of the identifier.

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 a period of 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: Policy type code

_____ Indicate type of policy for primary coverage of this defendant

Policy type codes	
Code	Description
10	Occurrence
20	Claims made
30	Extended reporting period (tail policy or DDR policy)
40	Prior acts coverage, if written as a separate policy

Item 10: Coverage type code

_____ Type of coverage extended to the named defendant

Code	Description
215	Hospital professional liability, including physicians, surgeons, dentists and other health care professionals insured as employees under a hospital policy.
225	Other healthcare facilities, including physicians, surgeons, dentists or other healthcare professionals insured under a facility other than a hospital, such as a blood bank or diagnostic testing laboratory.
235	Solo physicians and surgeons. Physicians, surgeons, and dentists not insured as a group practice and not insured as employees of a facility.
236	Group physicians and surgeons. Physicians, surgeons, and dentists insured as a group practice and not insured under a healthcare facility policy.
245	Solo other healthcare professional, not insured as a group practice and not insured as employees of a healthcare facility.
246	Group other healthcare professionals, insured as a group practice and not insured as employees of a healthcare facility.
275	All composite rated risks
285	All other

Item 119: 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

NPDB Occupation/Field of Licensure Codes	
Code	Description
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
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

NPDB Occupation/Field of Licensure Codes	
Code	Description
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
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 120: 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
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

NPDB Specialty Codes	
Code	Description
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 131: 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 124: 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
14	Radiology department
15	Recovery room
16	Rehabilitation center
17	Special procedure room
Location other than inpatient facility	
18a	Clinical support center, such as a laboratory or radiology center
18b	Office
18c	Walk-in clinic
18d	Other

Other and Unknown	
19	Other department in hospital
20	Unknown
21	Other

Item 135: Allegation Group

- | | |
|-----------------------------------|-----------------------------------|
| 001 = Diagnosis related | 060 = Treatment related |
| 010 = Anesthesia related | 070 = Monitoring related |
| 020 = Surgery Related | 080 = Equipment / Product Related |
| 030 = Medication Related | 090 = Other / Miscellaneous |
| 040 = IV & Blood Products Related | 100 = Behavioral Health |
| 050 = Obstetrics related | |

Item 164: NPDB Allegation Code

Instructions

1. Select the code that is *most descriptive* of the alleged error or omission.

Example 1: Select “wrong dosage administered” (324) for dosage errors rather than the more generic “improper performance” (306).

Example 2: Select “delay in treatment of identified fetal distress” (203) if appropriate, rather than “delay in performance” (201).

More generic categories should be used only when a specific category that adequately describes the allegation does not exist.

2. This is taxonomy of *allegations* made by the claimants. If the claimant alleges that an infection is the result of a surgery, select the code *failure to use aseptic technique*, even if there is no specific known, proven, or identified performance failure.

3. Identify the *most accurate* code.

Example 1: Do not conflate codes such as a failure to treat fetal distress (104) with a failure to identify fetal distress (103) with delay in treatment of fetal distress (203).

Example 2: Do not conflate a failure to order appropriate medication (107) with instances in which the wrong medication is ordered (329).

4. Select the *most causally relevant* code. If numerous errors are alleged to have contributed to an injury, identify the first error that was necessary to occur to have produced the sequence of actions ultimately leading to an adverse outcome. For example, if an illness is misdiagnosed, and the misdiagnosis leads to the prescription of improper medication, the “cause” of the injury is the initial misdiagnosis. The initial action is the first “necessary” but not necessarily “sufficient” condition that ultimately led to harm. In the absence of this initial event (misdiagnosis), the most proximate cause of harm (improper prescription) would not have occurred.

NPDB Allegation Codes	
Failure to Take Appropriate Action	
100	Failure to use aseptic technique
101	Failure to diagnose <i>Excludes 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.</i>

NPDB Allegation Codes	
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

NPDB Allegation Codes	
334	Wrong procedure or treatment
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 157: 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 186: 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 197: 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 1820: Five-digit Zip Code of the location where injury occurred.

Item 219: Gender of injured person. Use M or F.

Item 202: Age of injured person.

Item 234: 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 242: 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 253: 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 264: Date of lawsuit

The date a lawsuit was filed for this claim.

Item 275: Date claim was closed

Item 286: 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
3g	Judgment for the defendant
3h	Judgment for the plaintiff after appeal
3i	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 297: 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 30a: Economic indemnity paid by primary coverage or payee on behalf of specified defendant, exclusive of amounts paid by any other insurer or party. Include amounts intended to compensate an injured party for pecuniary losses resulting from a medical misadventure, such as medical costs and lost wages.

Item 30b: Noneconomic indemnity paid by primary coverage or payee on behalf of specified defendant, exclusive of amount paid by any other insurer or party. Include amounts intended as compensation for other than pecuniary losses, such as diminished quality of life or loss of consortium.

Item 30c28: Total Indemnity paid by reporting entity

The amount of indemnity paid by primary coverage or payee on behalf of specified defendant, the insurer reporting the claim, exclusive of any other amounts paid by any other insurer or party. Item 30c should equal the sum of items 30a and 30b.

Item 29: All other indemnity paid

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

Item 31a: Economic indemnity paid by other parties on behalf of this defendant, including excess coverage and out-of-pocket payments made by a medical provider. I

Item 31b: Noneconomic indemnity paid by other parties on behalf of this defendant.

Item 31c: Total indemnity paid by other parties on behalf of this defendant. Item 31c should equal to the sum of items 31a and 31b.

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

Amounts entered into items ~~3028~~ and ~~3129~~ 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 exceeds total indemnity, the amounts of both categories of indemnity 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.

Item 35: Current wage loss

Wages lost by the injured party as a result of the alleged incident(s) of malpractice. This amount should reflect available documentation and employment history.

Item 36: Anticipated future wage loss

Estimate of the amount of wage loss that will be incurred in the future. This amount should be based on reasonable expectations about what an individual would have earned in the future absent the alleged

incident of malpractice. In those instances where no employment history exists, such as for a minor child, the amount should reflect reasonable estimates using valid econometric and actuarial methods.

Item 37: Current medical expense

Medical expenses incurred by the injured party as a result of the alleged incident(s) of malpractice. This amount should reflect available documentation about all medically related expenses incurred as a result of the injury.

Item 38: Anticipated future medical expense

An estimate of the expenses that may be expected to be incurred in the future as a result of the alleged incident(s) of malpractice. In the event that expenses are expected to extend for the life of the injured party, this amount should reflect such life-long care based on generally accepted actuarial tables.

Item 39: All other incurred and anticipated future expenses

All other monetary losses incurred by the injured party as a result of the alleged incident(s) of malpractice.

Item 40: Narrative of allegation

The narrative should contain a minimum of four elements, descriptive of 1) the condition for which treatment was sought, 2) the procedure(s) and conditions leading to the alleged medical error or adverse outcome, 3) the specific alleged medical error or improper or incorrect performance, and 4) the specific outcome. Partial narratives will be rejected.

1. The original condition for which treatment was sought. This element excludes complications or conditions that developed while under treatment. For example, if a patient underwent spinal surgery and subsequently developed an infection, fields 18 - 20 should reflect the initial spinal condition and not the subsequent infection. In addition, the condition should be reported even if it was unknown (say, an allegation of misdiagnosis) at the time of the medical treatment or procedure.
2. A description of the procedures or conditions that are associated with an allegation of malpractice.
3. A description of the alleged errors that led to an adverse medical outcome. The narrative should provide a reasonable depiction of all relevant or “necessary if not sufficient” events that contributed to an error. This section should include any allegations that an omission or failure to act contributed to an injury.
4. A description of outcomes or injuries. The narrative should specify the severity and specific type of injury (or injuries) sustained, and indicate whether the injury is permanent or is likely to result in a permanent impairment of biological or physical function even if some improvement might be expected over time.

Narratives need not be overly detailed or lengthy, but they do need to be specific. For example, specific diagnostic tests or surgical or medical procedures should be described.

Examples:

Example 1: *Patient presented for preterm labor. The delivery was complicated by shoulder dystocia, resulting in mild hypoxia. The infant was subsequently discovered to have sustained permanent brachial plexus injuries. In addition, the infant suffered neurological deficits due to hypoxia, impacting primarily motor coordination. These injuries are expected to be permanent, though may diminish somewhat over time. The patient alleges that the physician should have taken steps to diminish the likelihood of preterm labor, should have diagnosed disproportion, and performed a Cesarean. The patient further alleges that the physician failed to recognize fetal distress and timely respond in an appropriate manner.*

Example 2: *Patient presented with fractured ulna sustained in a motor vehicle accident. Surgery was performed without incident. Patient subsequently developed a staph infection at the surgery site. While under care, the patient complained of swelling and pain, which was later discovered to be compartment syndrome. The allegation is that the physician failed to properly close the surgical site, failed to use appropriate sterile precautions, failed to properly monitor patient in recovery, and failed to timely diagnose compartment syndrome. Patient underwent corrective surgery, and is expected to recover with minor but permanent nerve damage.*

Example 3: *Patient presented with complaints of respiratory difficulties. Physician ordered x-ray, which revealed a questionable mass on the lungs. The x-ray was forwarded to specialist for further consideration. Meanwhile, the patient was discharged with treatment consisting of antibiotics. In subsequent days, the x-rays were switched with those of another patient, and as a result lung cancer was ruled out. Six months later, patient was diagnosed by a different physician with lung cancer. The patient is alleging lost opportunity for survival.*

If unsure about whether a piece of information is relevant, reporting entities should err on the side of comprehensiveness.