

GUIDELINE FOR IMPLEMENTATION OF MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING

Table of Contents

Section 1.	Statement of Purpose
Section 2.	Definitions
Section 3.	Applicability and Scope
Section 4.	Claims Required to Be Reported
Section 5.	Assignment of Claim and Incident Identifiers
Section 6.	Responsibility for Reporting Data
Section 7.	Reporting of Specific Data Elements
Section 8.	Mechanism for Reporting and Collection of Data
Section 9.	Data Analysis and Annual Reports by the Commissioner
Section 10.	Further Distribution of Data

Section 1. Statement of Purpose

This Guideline is intended to specify and promote uniform best practices for states implementing the *Medical Professional Liability Closed Claim Reporting Model Law*.

Section 2. Definitions

As used in this Guideline:

- 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) Expenses or costs associated with external or internal claims adjusting staff.
- 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.

Section 3. Applicability and Scope

This Guideline is intended to apply to any state that enacts the *Medical Professional Liability Closed Claim Reporting Model Law* or has similar data reporting requirements.

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.

- B. 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.

- C. 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) Issues the final payment to the claimant in the form of a check or draft;
 - (2) 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.

- D. If a closed claim is reopened to update data, 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.
 - (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.
- 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 facility or provider is responsible to report the required closed claim data if:
- (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*.

Section 7. Reporting of Specific Data Elements

- A. Medical specialty—When reporting medical specialties, reporting entities must use the *Specialty Codes* published by the National Practitioner Data Bank. The commissioner may expand the list of medical specialties to include other types of medical providers, such as:
 - (1) Chiropractor;
 - (2) Nurse;
 - (3) Physical therapist;
 - (4) Physician’s assistant; or
 - (5) Other types of medical providers who commonly provide medical services.
- B. 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.
- C. 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.

D. City—When reporting the 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 incident leading most directly to the injury occurred.

E. 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 but 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 injury.
- F. 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:
- (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.
- G. 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.

H. Timing of disposition—When reporting the timing of the claim disposition, the reporting entity must report whether the claim is settled:

- (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.

I. 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 on behalf of the insured, including:
 - (a) The amount paid by the insuring entity. 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.
 - (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:
 - (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.

J. Estimation of economic and noneconomic damages

- (1) If a reporting entity makes indemnity payments to a claimant, the reporting entity must report economic damages based on documented evidence obtained during the claim resolution process. Reporting entities may not determine economic damages using a fixed formula, such as fifty percent of total paid indemnity.
- (2) When a reporting entity makes a best estimate of economic damages, the reporting entity must use reasonable judgment to estimate the following elements of loss:
 - (a) Medical expenses;
 - (b) Loss of earnings;
 - (c) Burial costs;
 - (d) Loss of use of property;

- (e) Cost of replacement or repair;
 - (f) Cost of obtaining substitute domestic service; and
 - (e) Loss of business or employment opportunities.
- (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
 - (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.

Section 8. Mechanism for Reporting and Collection of Data

- A. The commissioner will establish a web-based reporting site to be used by reporting entities to report the required closed claim data.
- B. The state's reporting site should include controls that prevent the entry of illogical or self-contradictory data.
- C. 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.

Section 9. Data Analysis and Annual Reporting by the Commissioner

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.

- A. Before data are summarized and analyzed, the commissioner will check the reasonableness of the data collected and work with reporting entities to ensure that any needed corrections are made.
- B. By June 30 of each year, the commissioner will:
 - (1) Summarize and analyze the data submitted on claims closed in preceding years, using sound statistical methods; and
 - (2) Issue a report including the data, the analysis, and any conclusions that are drawn. This report will be made available to the public on the commissioner's website.
- C. To the extent that data are confidential, the commissioner will 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*.

Section 10. Further Distribution of Data

If applicable, the commissioner will make data available to other parties 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*.