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 alphanumeric sequence 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 cost containment services. The amounts reported for an insuring entity's or self-insurer's employees should include overhead, just as an outside firm's charges would include.

(1) Defense and cost containment expenses include:

(a) Surveillance expenses;

(b) Fixed amounts for cost containment expenses;

(c) Litigation management expenses;

(d) Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in defense of a claim, and fees or salaries for rehabilitation nurses, if such cost is not included in losses;

(e) Attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and

(f) The cost of engaging experts.

(2) Defense and cost containment expenses do not include:

(a) Fees of adjusters and settling agents (but not if engaged in a contentious defense);

(b) Attorney fees incurred in the determination of coverage, including litigation between the insuring entity and the policyholder; and

(c) Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in the capacity of an adjuster.

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" means an alleged medical error or omission or a series of related errors or omissions leading to allegations of harm. A single incident may span multiple years and involve numerous named defendants.

L. "Incident identifier" means the unique alphanumeric sequence 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*.

M. "Insuring entity" means the same as in subsection 2I of the *Medical Professional Liability Closed Claim Reporting Model Law*.

N. "Medical malpractice" means the same as in subsection 2J of the *Medical Professional Liability Closed Claim Reporting Model Law*.

O. "Noneconomic damages" means the same as in subsection 2K of the *Medical Professional Liability Closed Claim Reporting Model Law*.

P. "Primary insuring entity" means the insuring entity that originates the primary layer of insurance coverage. A self-insurer is not considered to be a primary insuring entity.

Q. "Provider" means the same as in subsection 2H of the *Medical Professional Liability Closed Claim Reporting Model Law*.

R. "Reporting entity" means any person or entity required to report data under Section 4 of the *Medical Professional Liability Closed Claim Reporting Model Law*.

S. "Self-insurer" means the same as in subsection 2L of the *Medical Professional Liability Closed Claim Reporting Model Law*.

T. "User ID" is a permanent alphanumeric sequence assigned by the commissioner to each insuring entity, self-insurer, facility or provider that reports data.

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 2R 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.

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, draft, or electronic funds transfer;

(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 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.

Section 6. Responsibility for Reporting Data

A. Except as provided by subsections B through F of this section, 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) An insured 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 wholly 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) The insuring entity or self-insurer fails to report the required closed claim data.

F. An insuring entity or self-insurer may designate a third party to report closed claim data. In this case the insuring entity or self-insurer must:

(1) Obtain a user ID from the commissioner;

(2) Designate the third party as the entity that will report closed claim data on its behalf;

(3) Manage the activities of the third party with respect to the insuring entity's or self-insurer's closed claim data; and

(4) Retain responsibility for all closed claim data submitted by the third party.

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 (a self-insured retention is not a primary policy limit);

(2) Annual limit of primary policy;

(3) Excess policy limit, per occurrence;

(4) Annual limit of excess policy;

(5) Available primary policy limit; and

(6) Available excess policy limit.

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—When reporting the county in which the incident occurred, the reporting entity must report based on the location of the facility where the incident occurred. If more than one alleged medical error led to the claim, the reporting entity must choose the location where the alleged medical error leading most directly to the injury occurred. In the event that an alleged medical error occurs outside this state, but the claim is made in this state, a closed claim report must be filed in this state and the county 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 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 most severe injury.

G. Dates—All dates required by subsection 5I of the *Medical Professional Liability Closed Claim Reporting Model Law* must be reported. 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.

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 or excess insuring entity; or

(c) Anticipated subrogation recoveries.

(2) When indemnity payments 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 in excess of policy limits 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.

(b) If indemnity payments are based on a trial verdict, the reporting entity must use the apportionment resulting from the verdict.

(c) If indemnity payments are not based on a trial verdict, the reporting entity must allocate indemnity payments among facilities and providers based on an assessment of comparative fault.

(d) The reporting entity must allocate defense and cost containment expense payments based on the extent to which each facility or provider benefited from the defense services.

(e) The reporting entity is responsible for assigning incident identifiers 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 experts, 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:

(1) If indemnity payments are the amounts awarded by a court for economic and noneconomic damages, respectively, the reporting entity must report those amounts.

(2) Otherwise, if a reporting entity makes indemnity payments to a claimant, the reporting entity must report the portion of the indemnity payments related to economic damages and the portion of the indemnity payments related to noneconomic damages based on documented evidence obtained during the claim resolution process. Reporting entities may not determine these amounts using a fixed formula, such as fifty percent of total paid indemnity.

(3) The total indemnity payments must be equal to the sum of the reporting entity's best estimate of indemnity payments related to economic damages and the reporting entity's best estimate of indemnity payments related to noneconomic damages, and neither estimate may exceed the total indemnity payment.

L. Trials—Information about defendants other than the insured should be to the best of the reporting entity's knowledge at the time the claim was closed:

(1) If a trial was started, the reporting entity must report:

(a) Whether the trial was by a judge alone or by a judge and jury; and

(b) The total number of defendants, including those it insures and any other defendants.

(2) If the trial resulted in a verdict, the reporting entity must report the total number of defendants found liable.

(3) If there was a verdict and at least one defendant was found liable, the reporting entity must report:

(a) The total verdict against all defendants (this amount should reflect the award without applying any damages caps, remittiturs, additurs, interest, or other adjustments);

(b) The percentage of fault, if any, assigned to the plaintiff;

(c) The percentage of fault assigned to the reporting entity's insured;

(d) Whether liability was joint and several, or separate;

(e) A breakdown of the total verdict into the following damages categories: economic compensatory damages, noneconomic compensatory damages, and punitive damages;

(f) The amount, if any, of pre-judgment interest awarded by the court;

(g) The amount, if any, by which the court reduced the verdict as a result of caps on damages or interest; and remittitur, or any other reason;

(h) The amount, if any, by which the court increased the verdict as a result of additur; and

(i) The total judgment awarded by the court.

Drafting Note: A state's decision to include or exclude some or all of the data elements listed in Subsection 7L may be affected by the state's Freedom of Information Act or by the confidentiality provisions used in the state's enactment of the *Medical Professional Liability Closed Claim Reporting Model Law*.

PART B
MECHANISM FOR REPORTING AND COLLECTION OF DATA

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.

The state's data reporting and collection system should include controls that prevent the entry of data that are invalid or internally inconsistent. The system 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 data reporting and collection system consistent with those of other states. In order to facilitate uniformity among states, the commissioner is encouraged to share with other states any information that can be made available regarding the design and operation of the state's system.

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

Part D of this guideline 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.

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 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*. If the data are not confidential, the commissioner should make the data publicly available on a website in a standard format, within a reasonable period (not to exceed one year) after the year to which the claim report relates. 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 as 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.

Attached to this guideline as Appendix 1 is a reconciliation form that could be used to reconcile closed claim data to Schedule T. It is suggested that the form be completed in its entirety by the insurer and reviewed by the state insurance department, which would follow up as needed.

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 in a data record the reporting entity's best estimate of indemnity payments related to economic damages exceeds the total indemnity payments, 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. Closed claim databases have proven to be an important resource for legislators, insurance commissioners, and others who seek to understand the dynamics of medical professional liability insurance markets and related public policy issues. In deciding what information to make available, each state must abide by any constraints imposed by its own laws, including its Freedom of Information Act and the confidentiality provisions used in the state's enactment of the *Medical Professional Liability Closed Claim Reporting Model Law*. Each state must also balance the potential benefits of making data available against the confidentiality interests of individual claimants, providers, and facilities.

There is a continuum of disclosure options, ranging from full public disclosure of all collected information to the disclosure of only aggregate information. Full disclosure of all information (including individual identifiers) maximizes the availability of information to the public but does not protect the confidentiality interests of claimants, providers, and facilities. The disclosure of only aggregate information maximizes the protection of the privacy interests of claimants, providers, and facilities but limits the utility of the collected data because it precludes analysis by the public. Intermediate solutions balance

these interests against one another by releasing enough information to allow the data to be used effectively but not releasing so much as to create an undue risk to claimant, provider, and facility confidentiality.

States that have already created closed claim databases have opted for a range of disclosure strategies. Texas makes claim-level information available on a website in electronic format but redacts certain information, such as patient and provider names. Florida provides physician names and specialties, so that one can determine whether a particular provider has been subject to claims. Texas provides information on jury verdicts and payouts; Florida provides information only on payouts. Missouri makes available to the public individual claims data scrubbed of direct identifiers. In addition, the public data must conform to federal statistical standards that minimize disclosure risk, or the risk that identities could be inferred either directly or in conjunction with other publicly available information. Massachusetts provides information on a public website on malpractice payouts involving particular named physicians during the previous decade but does not identify claimants. Other states, including Ohio, Oklahoma, and Washington, make available only aggregate data. (The states mentioned in this paragraph are only examples; there are other states with medical professional liability closed claim databases.)

The federal government maintains a National Practitioner Data Bank ("NPDB") that contains information on closed claims and disciplinary sanctions against physicians. The NPDB makes public detailed claim-level information in electronic format but redacts patient and provider names. Hospitals, professional societies, and state medical disciplinary boards can obtain provider-specific information. The NPDB does not collect information regarding jury verdicts.

To assist individual states, this section provides three broad 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. These 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.

The 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 in more general form.

2. Release of individual-level data for limited use, subject to a confidentiality agreement.

3. Release of the data at levels of aggregation that minimize disclosure risk. This third 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. (For medical malpractice it is important to be able to identify baby cases and also to link the data to other data sources, for which common age cutoffs are 18 and 65. So the categories might be <1, 1-5, 6-10, 11-17, 18-24, 25-29, 30-34, . . ., 60-64, 65-69, 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 publicly 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 3. 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. Injury, lawsuit, settlement or trial dates might be disclosed by providing only the month and year rather than the exact day. Alternatively, the timing of events can be disclosed using "number of days from injury to report" and "number of days from report to close" in conjunction with the incident year, notice year, suit year, final indemnity payment year and close year.

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.

e. It is preferable to aggregate information – as in the county or specialty examples above – or to suppress particular fields, such as a county or specialist field, than to suppress all of the information about a particular claim. Suppressing claims entirely will distort the whole dataset, even for research for which the county or specialty was not relevant or was of secondary importance.

Option 2: Release of individual-level data, subject to a confidentiality agreement

For data fields that could result in inadvertent release of confidential information about individual claimants, providers, or facilities, additional detail could be provided only to reputable persons who sign a confidentiality agreement. This option could provide a compromise between those who favor broader public access to information, those who recognize the value of providing data for research purposes, and those who are concerned with inadvertent release of data that could be traced back to a particular claimant, provider, or facility.

Attached to this guideline as Appendix 2 is a sample confidentiality form that could be used. This form is derived from the one used by the state of Florida for access to patient-level data on hospital admissions and outcomes. The agreement has a defined term (currently one year), but Florida generally grants extensions to allow for research that exceeds this period.

Option 3: 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.

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.

[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.

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 are released only if sampled from a population of at least 250,000

Agency	**Threshold – minimum number for each data cell**	**Other threshold rules**
Department of Education: National Center for Education Statistics (NCES)	3	Data is matched with all publicly available data sources. If potential matches can be narrowed down to as few as two institutions, data is not disclosed Values are coded in ranges (for example, income between $50,000 – $75,000) Values are top- and bottom- coded to prevent identification of outliers
Department of Energy	N/A - cells with too few observations are suppressed for accuracy reasons rather than for confidentiality (suppressed when standard error > 50%)	**pq rule** – values of *p* and *q* are not published
National Center for Health Statistics	n=5	**(n,k) rule**, parameters aren't published
Department of Justice: Bureau of Justice Statistics (BJS)	n=10	The BJS does not use any of the additional rules specified above. They do take additional measures to enhance the anonymity of the data, such as publishing values in ranges
Department of Labor: Bureau of Labor Statistics	Value of *n* is not released to the public	**(n,k) rule**, parameters not published
Department of Transportation: Bureau of Transportation Statistics	No agency-wide rule; established on a case-by-case basis	No agency-wide rule; established on a case-by-case basis
Department of the Treasury: IRS, Statistics of Income Division	n=3 for data aggregated at the state level or larger geography; n=10 for data aggregated at sub-state levels	N/A
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	

III. 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.

IV. 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. (Caution: the default value for any drop-down box should be "not reported" rather than a reportable value.) 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.

Reporting Universe

As used in the *Medical Professional Liability Closed Claim Reporting Model Law,* a claim consists of a demand for payment to compensate injuries sustained during the course of medical treatment. As defined in the model law, a claim generally consists of a single claimant seeking compensation from a single provider or facility. Allegations against additional providers or facilities with respect to the same injury or injuries should be reported as separate companion claims and assigned the same *incident identifier*.

General guidelines are:

- Do not report a "medical misadventure" or poor clinical outcome unless an injured party has made a demand for payment or has made specific allegations against a particular provider or facility.
- All medical treatment associated with single provider or facility that is related to single injury or set of related injuries should be treated as a single claim. The same plaintiff could be associated with multiple claims in instances where the injuries are associated with unrelated medical conditions and treatments.
- Each defendant or insured should be treated as a separate (but related) claim.
- Multiple claimants pursuing compensation for the same series of injuries should be treated as a single claim. For example, if both a mother and father file for damages on behalf of an injured child, all defense costs and indemnity payments should be combined and filed as a single claim.
- Multiple injured parties involved in single incident or series of incidents should be treated as a single claim, as in instances where both mother and child are injured during childbirth. However, multiple injuries sustained by unrelated individuals, as is the case with most class-action lawsuits, should be treated as separate claims.
- Claims involving cases of mistaken identity, such as allegations against a provider or facility that had no relationship to an injured party, should not be reported.

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	Alphanumeric
4	IncID	Unique identifier for each incident	Alphanumeric
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)	Numeric
8	PolLim_ann_ex	Annual policy limits, all excess coverage (stacked if more than one applicable coverage – see below).	Numeric
9	PolLim_avail_prim	Available policy limits for this event, primary coverage.	Numeric
10	PolLim_avail_ex	Available policy limits for this event, excess coverage.	Numeric
11	Lic_code	NPDB field of licensure code.	Text, Left Zero Filled
12	Spec_code	NPDB medical specialty code.	Text, Left Zero Filled
13	Facility	Code for type of facility where incident occurred.	Text
14	Location	Code for the location within facility where incident occurred.	Alphanumeric
15	Allegation_group	NPDB general allegation code	Text, Left Zero Filled
16	Allegation_code	NPDB specific allegation code	Text
17	City	City in which injury occurred	Text
18	County	County in which injury occurred	Text
19	State and County FIPS Code	5-digit county Federal Information Processing Standard Code, 2-digit state code + 3 digit county code.	Text, Left Zero Filled
20	Inj_gender	Gender of injured party (M, F)	Alpha – M or F
21	Inj_Age	Age of injured party	Numeric
22	Severity	Injury severity code.	Numeric
23	Inj_date	Earliest date of act or omission that was the proximate cause of the claim.	MM/DD/YYYY
24	Rept_date	Date claim reported to insurer	MM/DD/YYYY
25	Suit_date	Date suit was filed, if applicable	MM/DD/YYYY

Item #	Data Field	Description	Format
26	Close_date	Date claim was closed	MM/DD/YYYY
27	Date_Payment	Date of final indemnity payment, if applicable.	MM/DD/YYYY
28	Disposition	Manner in which a claim is resolved.	Alphanumeric
29	Disp_time	Timing of disposition of claim.	Text
30	Indemnity	Total indemnity paid or incurred by this entity on behalf of a single medical provider.	Numeric
31	Econ_ind	Amount of total indemnity attributable to economic damages.	Numeric
32	Nonecon_ind	Amount of total indemnity attributable to non-economic damages.	Numeric
33	Defense_Costs_Counsel	Defense and costs containment expenses for legal counsel.	Numeric
34	Defense_costs_experts	Defense and cost containment expenses for experts.	Numeric
35	Defense_costs_other	Defense and cost containment expenses for other than legal counsel or experts.	Numeric
36	Defense_costs_total	Total defense and cost containment expenses.	Numeric
37	Trial_Type	If a trial was started, indicate bench or jury trial.	Text
38	Def_no	If verdict, total number of defendants found liable.	Numeric
Items 39 – 49 should be completed only if there was a verdict and at least one defendant was found liable			
39	Total_verdict	Total verdict for all defendants, prior to any adjustments due to damage caps, remittiturs, additurs, interest, or other adjustments.	Numeric
40	Fault_plaintiff	Percentage of fault assigned to plaintiff.	Percent
41	Fault_insured	Percentage of fault assigned to reporting entity's insured.	Percent
42	Liability_doctrine	Whether liability joint and several, or separate.	Text
43	Econ_verdict	Amount of verdict awarded to compensate economic damages.	Numeric
44	Nonecon_verdict	Amount of verdict awarded to compensate non-economic damages.	Numeric
45	Punitive_verdict	Amount of verdict for punitive damages.	Numeric
46	Interest	Amount of pre-judgment interest awarded.	Numeric

Item #	Data Field	Description	Format
47	Amt_reduced	Amount the verdict was reduced because of damage caps, remittitur, or any other reason.	Numeric
48	Additur	Amount the verdict was increased as a result of additur.	Numeric
49	Total	Total judgment awarded by court.	Numeric

Item Descriptions and Tables of Codes

Item 1: Entity ID Code

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

Item 2: Entity Name

Full legal name of the insuring or reporting entity.

Item 3: Claim Identifier

Each reporting entity should assign a unique identifier for each claim. This identifier should consist of a unique sequence of letters and / or numbers. Once an identifier has been assigned, 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 identifier.

Item 4: Incident Identifier

Each reporting entity should assign a unique numeric identifier for each incident or 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. Each claim submitted for providers involved in a single occurrence should be assigned the same incident identifier.

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 limits available, primary coverage.

Policy limits available for the claim being reported under the insured's primary coverage.

Item 10: Policy limits available, excess coverage.

Policy limits available for the claim being reported under the insured's excess coverage.

Item 11: NPDB Occupation / Field of Licensure Code

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

NPDB Occupation/Field of Licensure Codes	
Code	**Description**
	Chiropractor
603	Chiropractor
	Counselor
621	Counselor-Mental Health
651	Professional counselor
654	Professional counselor-alcohol
657	Professional counselor-family/marriage
660	Professional counselor-substance abuse
661	Marriage and family therapist
	Dental Service Provider
030	Dentist
035	Dentist/Resident
606	Dental assistant
609	Dental hygienist
612	Denturist
	Dietician/Nutritionist
200	Dietician
210	Nutritionist
	Emergency Med Tech (EMT)
250	EMT, Basic
260	EMT, Cardiac, critical care
270	EMT, Intermediate
280	EMT, Paramedic
	Eye and Vision Service Provider
630	Ocularist
633	Optician
636	Optometrist
	Nurse
100	Registered
110	Nurse anesthetist
120	Nurse midwife
130	Nurse practitioner

NPDB Occupation/Field of Licensure Codes	
Code	**Description**
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
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

NPDB Occupation/Field of Licensure Codes	
Code	**Description**
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 12: 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

NPDB Specialty Codes	
Code	**Description**
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
D4	Oral and maxillofacial surgery
D5	Oral and maxillofacial pathology
D6	Orthodontics and dentofacial Orthopedics
D7	Pediatric Dentistry
D8	Periodontics
D9	Prosthodontics
DA	Oral and maxillofacial radiology
DB	Unknown

Item 13: 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 14: 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 15: Allegation Group

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

Item 16: 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 ***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.**
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

NPDB Allegation Codes	
319	Patient position problem
320	Problem with appliance
321	Radiology or imaging error
322	Surgical or other foreign body retained
323	Wrong diagnosis or misdiagnosis
324	Wrong dosage administered
325	Wrong dosage dispensed
326	Wrong dosage ordered of correct medication
327	Wrong medication administered
328	Wrong medication dispensed
329	Wrong medication ordered
330	Wrong body part
331	Wrong blood type
332	Wrong equipment
333	Wrong patient
334	Wrong procedure or treatment
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 of 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, misplace, 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 3rd 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

NPDB Allegation Codes	
719	Vicarious liability
720	Wrong life/birth
899	Cannot be determined from available records.
999	Allegation not otherwise classified

Item 17: City where injury occurred

Full name of the city in which the injury is alleged to have occurred. The city should correspond to the location of the alleged error or omission identified on item 14. If the injury did not occur in a city, leave blank.

Item 18: County where injury occurred

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

Item 19: County FIPS Code

Five-digit Federal Information Processing Standard Code (FIPS) for the county in which the injury occurred. Do not omit leading zeros (001, 023, etc.). The FIPS code consists of the two-digit state code plus the three-digit county code (i.e. 26001). If the injury occurred outside of the United States, enter '99999.'

Item 20: Gender of injured person. Use M or F.

Item 21: Age of injured person at the date of injury.

Item 22: 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 23: 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 24: 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 25: Date of lawsuit

The date a lawsuit was filed for this claim.

Item 26: Date claim was closed

The date of final disposition or settlement of a claim. Payments for defense costs or indemnity may occur **after** the date of closure (as in a structured settlement).

Item 27: Date of final indemnity payment

The date of the final indemnity payment, if applicable. If the final payment is scheduled for a future date, provide this date as best as can be determined when the claim is closed.

Item 28: 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 29: 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 30: Indemnity paid by reporting entity

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

Note on items 31 and 32: Economic and noneconomic portions of total indemnity paid by all parties.

Amounts entered into items 31 and 32 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 amount**s of both categories of indemnity **should be reduced by a proportionate amount.**

Item 31: 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 32: 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.

Defense and cost containment expenses should include overhead costs allocated to each claim. Such overhead costs include salaries, benefits, and other fixed costs.

Item 33: Defense and Cost Containment Expense for Legal Counsel

The portion of defense costs associated with legal counsel, including both in-house and outside counsel.

Item 34: Defense and Cost Containment Expense for Experts

The portion of defense costs associated with experts, including both in-house and outside experts.

Item 35: Defense and Cost Containment Expense Other than Legal Counsel of Experts

The remaining portion of defense and cost containment expenses not included in items 45 and 46.

Item 36: Total Defense and Cost Containment Expense

The sum of items 33, 34, and 35.

The following items should be completed only if a claim was brought to trial.

Item 37: Trial Type

If trial was started, indicate whether it was a bench trial (B) or jury trial (J).

Item 38: Number of liable defendants

If the trial resulted in a verdict, report the number of defendants that were found liable.

Item 39: Unadjusted Verdict

The amount of the total verdict for all defendants, prior to any adjustments due to damage caps, remittiturs, additurs, interest, of other adjustments.

Item 40: Plaintiff Fault

The percentage of fault assigned to the plaintiff.

Item 41: Insured Fault

The percentage of fault assigned to the reporting entity's insured.

Item 42: Liability Doctrine

Indicate whether liability governed by the doctrine of joint and several liability (J) or whether liability was separate (S).

Item 43: Verdict for Economic Damages

The amount of the verdict that was awarded based on economic damages.

Item 44: Verdict for Non-economic Damages

The amount of the verdict that was awarded based on non-economic damages.

Item 45: Verdict for Punitive Damages

The amount of the verdict consisting of punitive damages.

Item 46: Interest

The amount of pre-judgment interest awarded.

Item 47: Verdict Reduction

The amount by which the verdict was reduced because of damage caps, remittitur, or any other reason.

Item 48: Verdict Augmentation

The amount by which the verdict was increased as a result of additur.

Item 49: Final Verdict

Total judgment award by court after all adjustments to verdict.

Appendix 1

SCHEDULE T DATA RECONCILIATION FORM

Line Number	Line	Loss paid – number of claims	Losses paid – dollar amount
1	Schedule T, Supplement A		
2	Closed claim report totals		
3	Difference (Schedule A – Closed claims)		
	Adjustments to Schedule T		
4	Sch T – payments reported in current year on claims closed in prior years		
5	Sch T – claims not reported in quarterly claims data for other reasons (claim not reportable in this state, etc. Specify in separate explanation)		
6	Correction for other discrepancies (occurrence vs. claims reporting, other accounting issues, etc. Specify in separate explanation)		
7	Adjustments to Schedule T (Line 1 – line 4 – line 5 – line 6)		
	Adjustments to Claims Data		
8	Losses to be paid in future years on claims closed in current year		
9	Losses paid in prior years on claims closed in current year [note – this was on the TX form. I would suspect this is very unusual, and may be relegated to the "other" category]		
10	Claims not reported on Schedule T for other reasons (reported for another state, etc. Specify in separate explanation)		
11	Adjustments to claims data (line 2 – line 8 – line 9 – line 10)		
	Reconciled Amounts		
12	Difference in adjusted amounts (line 7 – line 10) – this line should equal 0.		
Explanation for adjustment on line 5:			
Explanation for adjustments on line 6:			
Explanation for adjustments on line 10:			

Appendix 2

SAMPLE CONFIDENTIALITY FORM

LIMITED DATA SET DATA USE AGREEMENT

This agreement is by and between the [state insurance department], hereinafter referred to as the Commissioner, and _____, hereinafter referred to as Requester.

This agreement addresses the conditions under which the Commissioner will disclose and Requester will obtain and use the limited data set specified herein. Requester agrees to abide by the provisions of this agreement in the use of the limited data set obtained from the Commissioner.

1. Description of Data. The following limited data set may be disclosed or used pursuant to this agreement:
   _____
   _____

2. Purpose of Agreement. Requester represents and, in furnishing the limited data set specified in this agreement, the Commissioner relies upon such representation that the limited data set will be used solely for the following purpose(s):
   _____
   _____

3. Point of Contact. The Commissioner designates the following individual as the Commissioner's point of contact for this agreement:

   _____
   Name of Point of Contact

   _____
   Street address

   _____
   City/ State/ Zip code

   _____ _____
   Phone number Fax

   _____
   E-mail

   All correspondence regarding this agreement, including, but not limited to, notification of change of custodianship, uses or disclosures of the limited data set not provided for by this agreement, disposition of the limited data set, and termination of this agreement, shall be addressed to the point of contact.

4. Custodial Responsibility. Requester names the following individual custodian of the designated record set on behalf of the Requester:

_____
Name of custodian

_____
Name of company or organization

_____
Street address

_____
City/ State/ Zip code

_____ __ _____
Phone number Fax

_____
E-mail

The custodian shall be responsible for the observance of all conditions of use and for the establishment and maintenance of safeguards as specified in this agreement to prevent unauthorized use. Requester shall notify the Commissioner in writing within fifteen (15) days of any change of custodianship. Notification of change of custodianship shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

5. Permissible Uses and Disclosures. Requester shall not use or further disclose the limited data set specified in this agreement except as permitted by this agreement or as required by federal law. Requester shall establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of and to prevent unauthorized use or access to the limited data set.

Requester shall not release or allow the release of the limited data set specified in this agreement to any persons or entities other than as permitted by this agreement.

Requester shall restrict disclosure of the limited data set to the minimum number of individuals who require the information in order to perform the functions of this agreement. Requester shall instruct individuals to whom the limited data set is disclosed of all obligations under this agreement and shall require the individuals to maintain those obligations.

Requester shall secure the limited data set when the data is not under the direct and immediate control of an authorized individual performing the functions of this agreement.

Requester shall not attempt to use the limited data set to track or link an individual's data, determine real or likely identities, gain information about an individual, or contact an individual.

Requester shall make a good faith effort to identify any use or disclosure of the limited data set not provided for by this agreement. Requester shall notify the Commissioner by certified mail, return receipt requested, or in person with proof of delivery within seventy-two (72) hours of discovery of any use or disclosure of the limited data set not provided for by this agreement of which Requester is aware. If applicable, the Requester shall return any record or records that become identified to the Commissioner by certified mail, return receipt requested, or in person with proof of delivery within seventy-two (72) hours of identification. All other copies of an identified record including a modified, hybrid or merged record shall be immediately destroyed.

A violation of this section shall constitute a material breach of this agreement.

6. Disclosure to Agents. Requester shall ensure that any agents of Requester, including, but not limited to, a contractor or subcontractor, to whom Requester provides the limited data set specified in this agreement agree to the same terms, conditions, and restrictions that apply to Requester with respect to the limited data set.

7. Release of Statistical and Research Results. Subject to the conditions of this agreement, aggregated statistical tabulations and research results derived from the limited data set specified in this agreement may be released or published; however, statistical tabulations or research results that may reveal information about an individual's record or lead to the identification of individuals shall not be published or released.

8. Penalties. Requester acknowledges that failure to abide by the terms of this agreement may subject Requester to penalties for wrongful disclosure of protected health information under federal law. Requester shall inform all persons with authorized access to the limited data set specified in this agreement of the penalties for wrongful disclosure of protected health information.

9. Indemnification. Requester agrees to indemnify, defend, and hold harmless the Commissioner from any or all claims and losses accruing to any person, organization, or other legal entity as a result of violation of this agreement by Requester or agents of Requester to the extent permitted by federal and state law.

10. Disposition of Data. Requester may retain the limited data set specified in this agreement until _____, hereinafter referred to as the retention date. Unless otherwise agreed to in writing, Requester shall destroy the limited data set and any information derived from its contents, including all copies, modified data, or hybrid or merged databases containing the limited data set, upon the retention date. Requester shall provide the Commissioner with written confirmation of the destruction of the limited data set information. If both parties agree in writing to amend the retention date, Requester shall extend the protections of this agreement and maintain the confidentiality of the limited data set until the amended retention date.

11. Term of Agreement. This agreement shall be effective upon execution by both parties and shall remain in effect until _____or until terminated by one of the parties. The Commissioner may, by no less than twenty-four (24) hours written notice to Requester, terminate this agreement upon material breach of this agreement. This agreement may be terminated by either party without cause upon thirty (30) days written notice. Notice of termination shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

The terms of this agreement may not be waived, altered, modified, or amended except by written agreement of both parties.

This agreement supersedes any and all agreements between the parties with respect to the use of the limited data set specified in this agreement.

In witness whereof, the Commissioner and Requester have caused this agreement to be signed and delivered by their duly authorized representatives as of the date set forth below.

For the Requester	**For the Commissioner**
Signature:_____	Signature: _____
Print name:_____	Print name: _____
Title: _____	Title: _____
Date:_____	Date: _____

_____

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2010 Proc. 2nd Quarter, Vol. I 130, 111, 124, 129, 317-388, 432 (adopted).