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COMMISSIONER OF INSURANCE

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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

April 28, 2005

To: All Companies Writing Medical Malpractice Insurance in Virginia

Re: Reporting of Medical Malpractice Closed Claims Pursuant to Virginia Code § 38.2-2228.2

During its 2005 session, the General Assembly of Virginia enacted House Bill 2659. Effective July 1, 2005, § 38.2-2228.2 is added to the Code of Virginia to require that all medical malpractice claims settled or adjudicated to final judgment against a person, corporation, firm, or entity providing health care, and any such claim closed without payment during each calendar year shall be reported annually to the Commission by the insurer of the health care provider.

Each insurer's submission must be made electronically and must contain individual closed claim reports and a statistical summary of the entire submission. The initial report with data for calendar years 2002, 2003, and 2004 must be filed by September 1, 2005. All future reports must be filed by July 1 of the year following the applicable calendar year.

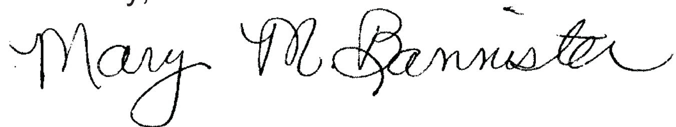
The reporting form's content and format requirements are attached and will be made available in a Microsoft Excel file located in the "Company" section of the Commission's Bureau of Insurance web site. The Internet address for the web site is as follows: http://www.scc.virginia.gov/boi/co/

All submissions must be emailed to Andrew.Iverson@SCC.Virginia.gov or submitted to the following address on a data formatted CD or a 3.5" floppy disk.

Virginia Bureau of Insurance
Attn: Andrew Iverson
Research Department, P&C Division
P.O. Box 1157
Richmond, VA 23218

If you have any questions concerning this matter, please contact Andrew Iverson at 804.371.9851 or at the email address noted above.

Sincerely,



Mary M. Bannister
Deputy Commissioner of Insurance
Property & Casualty Division

Attachment: Code of Virginia § 38.2-2228.2 – Reporting of medical malpractice closed claims, file format requirements, and field definitions

VIRGINIA ACTS OF ASSEMBLY -- 2005 SESSION

CHAPTER 649

An Act to amend and reenact §§ 8.01-399 and 8.01-581.1 of the Code of Virginia, to amend the Code of Virginia by adding sections numbered 8.01-20.1, 8.01-50.1, 8.01-52.1, by adding in Article 2 of Chapter 21.1 of Title 8.01 a section numbered 8.01-581.20:1, and by adding sections numbered 16.1-83.1, 38.2-2228.2, and 54.1-2912.3, relating to medical malpractice.

[H 2659]

Approved March 23, 2005

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-399 and 8.01-581.1 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding sections numbered 8.01-20.1, 8.01-50.1, 8.01-52.1, by adding in Article 2 of Chapter 21.1 of Title 8.01 a section numbered 8.01-581.20:1, and by adding sections numbered 16.1-83.1, 38.2-2228.2, and 54.1-2912.3 as follows:

§ 8.01-20.1. Certification of expert witness opinion at time of service of process.

Every motion for judgment, counter claim, or third party claim in a medical malpractice action, at the time the plaintiff requests service of process upon a defendant, shall be deemed a certification that the plaintiff has obtained from an expert witness whom the plaintiff reasonably believes would qualify as an expert witness pursuant to subsection A of § 8.01-581.20 a written opinion signed by the expert witness that, based upon a reasonable understanding of the facts, the defendant for whom service of process has been requested deviated from the applicable standard of care and the deviation was a proximate cause of the injuries claimed. This certification is not necessary if the plaintiff, in good faith, alleges a medical malpractice action that asserts a theory of liability where expert testimony is unnecessary because the alleged act of negligence clearly lies within the range of the jury's common knowledge and experience.

The certifying expert shall not be required to be an expert witness expected to testify at trial nor shall any defendant be entitled to discover the identity of the certifying expert or the nature of the certifying expert's opinions. Should the certifying expert be identified as an expert expected to testify at trial, the opinions and bases therefor shall be discoverable pursuant to Rule 4:1 of the Rules of Supreme Court of Virginia with the exception of the expert's status as a certifying expert.

Upon written request of any defendant, the plaintiff shall, within 10 business days after receipt of such request, provide the defendant with a certification form that affirms that the plaintiff had obtained the necessary certifying expert opinion at the time service was requested or affirms that the plaintiff did not need to obtain a certifying expert witness opinion. If the plaintiff did not obtain a necessary certifying expert opinion at the time the plaintiff requested service of process on a defendant as required under this section, the court shall impose sanctions according to the provisions of § 8.01-271.1 and may dismiss the case with prejudice.

§ 8.01-50.1. Certification of expert witness opinion at time of service of process.

Every motion for judgment, counter claim, or third party claim in any action pursuant to § 8.01-50 for wrongful death against a health care provider, at the time the plaintiff requests service of process upon a defendant, shall be deemed a certification that the plaintiff has obtained from an expert witness whom the plaintiff reasonably believes would qualify as an expert witness pursuant to subsection A of § 8.01-581.20 a written opinion signed by the expert witness that, based upon a reasonable understanding of the facts, the defendant for whom service of process has been requested deviated from the applicable standard of care and the deviation was a proximate cause of the injuries claimed. This certification is not necessary if the plaintiff, in good faith, alleges in his wrongful death action a medical malpractice theory of liability where expert testimony is unnecessary because the alleged act of negligence clearly lies within the range of the jury's common knowledge and experience.

The certifying expert shall not be required to be an expert expected to testify at trial nor shall any defendant be entitled to discover the identity of the certifying expert or the nature of the certifying expert's opinions. Should the certifying expert be identified as an expert expected to testify at trial, the opinions and bases therefor shall be discoverable pursuant to Rule 4:1 of the Rules of Supreme Court of Virginia with the exception of the expert's status as a certifying expert.

Upon written request of any defendant, the plaintiff shall, within 10 business days after receipt of such request, provide the defendant with a certification form which affirms that the plaintiff had obtained the necessary certifying expert opinion at the time service was requested or affirms that the plaintiff did not need to obtain a certifying expert opinion. If the plaintiff did not obtain a necessary certifying expert opinion at the time the plaintiff requested service of process on a defendant, the court shall impose sanctions according to the provisions of § 8.01-271.1 and may dismiss the case with prejudice.

§ 8.01-52.1. Admissibility of expressions of sympathy.

In any wrongful death action brought pursuant to § 8.01-50 against a health care provider, or in any arbitration or medical malpractice review panel proceeding related to such wrongful death action, the portion of statements, writings, affirmations, benevolent conduct or benevolent gestures expressing sympathy or general sense of benevolence, which are made by a health care provider or an agent of a health care provider to a relative of the patient, or a representative of the patient about the death of the patient as a result of the unanticipated outcome of health care, shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest. A statement of fault that is part of or in addition to any of the above shall not be made inadmissible by this section.

For purposes of this section, unless the context otherwise requires:

"Health care" has the same definition as provided in § 8.01-581.1.

"Health care provider" has the same definition as provided in § 8.01-581.1.

"Relative" means a decedent's spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half-brother, half-sister, or spouse's parents. In addition, "relative" includes any person who had a family-type relationship with the decedent.

"Representative" means a legal guardian, attorney, person designated to make decisions on behalf of a patient under a medical power of attorney, or any person recognized in law or custom as a patient's agent.

"Unanticipated outcome" means the outcome of the delivery of health care that differs from an expected result.

§ 8.01-399. Communications between physicians and patients.

A. Except at the request or with the consent of the patient, or as provided in this section, no duly licensed practitioner of any branch of the healing arts shall be required to testify in any civil action, respecting any information that he may have acquired in attending, examining or treating the patient in a professional capacity.

B. If the physical or mental condition of the patient is at issue in a civil action, the ~~diagnosis~~ *diagnoses, signs and symptoms, observations, evaluations, histories,* or treatment plan of the practitioner, *obtained or formulated* as *contemporaneously* documented ~~in the patient's medical record,~~ during the ~~time~~ *course* of the practitioner's treatment, together with the facts communicated to, or otherwise learned by, such practitioner in connection with such attendance, examination or treatment shall be disclosed but only in discovery pursuant to the Rules of Court or through testimony at the trial of the action. In addition, disclosure may be ordered when a court, in the exercise of sound discretion, deems it necessary to the proper administration of justice. However, no order shall be entered compelling a party to sign a release for medical records from a health care provider unless the health care provider is not located in the Commonwealth or is a federal facility. If an order is issued pursuant to this section, it shall be restricted to the medical records that relate to the physical or mental conditions at issue in the case. No disclosure of diagnosis or treatment plan facts communicated to, or otherwise learned by, such practitioner shall occur if the court determines, upon the request of the patient, that such facts are not relevant to the subject matter involved in the pending action or do not appear to be reasonably calculated to lead to the discovery of admissible evidence. Only diagnosis offered to a reasonable degree of medical probability shall be admissible at trial.

C. This section shall not (i) be construed to repeal or otherwise affect the provisions of § 65.2-607 relating to privileged communications between physicians and surgeons and employees under the Workers' Compensation Act~~,~~*;* (ii) apply to information communicated to any such practitioner in an effort unlawfully to procure a narcotic drug, or unlawfully to procure the administration of any such drug~~,~~*;* or (iii) prohibit a duly licensed practitioner of the healing arts, or his agents, from disclosing information as required by state or federal law.

D. Neither a lawyer nor anyone acting on the lawyer's behalf shall obtain, in connection with pending or threatened litigation, information concerning a patient from a practitioner of any branch of the healing arts without the consent of the patient, except through discovery pursuant to the Rules of ~~the~~ *Supreme* Court as herein provided. However, the prohibition of this subsection shall not apply to:

1. Communication between a lawyer retained to represent a practitioner of the healing arts, or that lawyer's agent, and that practitioner's employers, partners, agents, servants, employees, co-employees or others for whom, at law, the practitioner is or may be liable or who, at law, are or may be liable for the practitioner's acts or omissions;

2. Information about a patient provided to a lawyer or his agent by a practitioner of the healing arts employed by that lawyer to examine or evaluate the patient in accordance with Rule 4:10 of the Rules of ~~the~~ Supreme Court; or

3. Contact between a lawyer or his agent and a nonphysician employee or agent of a practitioner of healing arts for any of the following purposes: (i) scheduling appearances, (ii) requesting a written recitation by the practitioner of handwritten records obtained by the lawyer or his agent from the practitioner, provided the request is made in writing and, if litigation is pending, a copy of the request and the practitioner's response is provided simultaneously to the patient or his attorney, (iii) obtaining information necessary to obtain service upon the practitioner in pending litigation, (iv) determining when

records summoned will be provided by the practitioner or his agent, (v) determining what patient records the practitioner possesses in order to summons records in pending litigation, (vi) explaining any summons that the lawyer or his agent caused to be issued and served on the practitioner, (vii) verifying dates the practitioner treated the patient, provided that if litigation is pending the information obtained by the lawyer or his agent is promptly given, in writing, to the patient or his attorney, (viii) determining charges by the practitioner for appearance at a deposition or to testify before any tribunal or administrative body, or (ix) providing to or obtaining from the practitioner directions to a place to which he is or will be summoned to give testimony.

E. A clinical psychologist duly licensed under the provisions of Chapter 36 (§ 54.1-3600 et seq.) of Title 54.1 shall be considered a practitioner of a branch of the healing arts within the meaning of this section.

F. Nothing herein shall prevent a duly licensed practitioner of the healing arts, or his agents, from disclosing any information that he may have acquired in attending, examining or treating a patient in a professional capacity where such disclosure is necessary in connection with the care of the patient, the protection or enforcement of ~~the~~ *a* practitioner's legal rights including such rights with respect to medical malpractice actions, or the operations of a health care facility or health maintenance organization or in order to comply with state or federal law.

§ 8.01-581.1. Definitions.

As used in this chapter:

"Health care" means any act, or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical diagnosis, care, treatment or confinement.

"Health care provider" means (i) a person, corporation, facility or institution licensed by this Commonwealth to provide health care or professional services as a physician or hospital, dentist, pharmacist, registered nurse or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist, physical therapy assistant, clinical psychologist, clinical social worker, professional counselor, licensed dental hygienist, health maintenance organization, or emergency medical care attendant or technician who provides services on a fee basis~~,~~*;* (ii) a professional corporation, all of whose shareholders or members are so licensed~~,~~*;* (iii) a partnership, all of whose partners are so licensed~~,~~*;* (iv) a nursing home as defined in § 54.1-3100 except those nursing institutions conducted by and for those who rely upon treatment by spiritual means alone through prayer in accordance with a recognized church or religious denomination~~,~~*;* (v) a professional limited liability company comprised of members as described in subdivision A 2 of § 13.1-1102~~,~~*;* (vi) a corporation, partnership, limited liability company or any other entity, except a state-operated facility, which employs or engages a licensed health care provider and which primarily renders health care services~~,~~*;* or (vii) a director, officer, employee, independent contractor, or agent of the persons or entities referenced herein, acting within the course and scope of his employment or engagement as related to health care or professional services.

"Health maintenance organization" means any person licensed pursuant to Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2 who undertakes to provide or arrange for one or more health care plans.

"Hospital" means a public or private institution licensed pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or Chapter 8 (§ 37.1-179 et seq.) of Title 37.1.

"Impartial attorney" means an attorney who has not represented (i) the claimant, his family, his partners, co-proprietors or his other business interests; or (ii) the health care provider, his family, his partners, co-proprietors or his other business interests.

"Impartial health care provider" means a health care provider who (i) has not examined, treated or been consulted regarding the claimant or his family; (ii) does not anticipate examining, treating, or being consulted regarding the claimant or his family; or (iii) has not been an employee, partner or co-proprietor of the health care provider against whom the claim is asserted.

"Malpractice" means any tort *action or breach of contract action for personal injuries or wrongful death,* based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient.

"Patient" means any natural person who receives or should have received health care from a licensed health care provider except those persons who are given health care in an emergency situation which exempts the health care provider from liability for his emergency services in accordance with § 8.01-225.

"Physician" means a person licensed to practice medicine or osteopathy in this Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

§ 8.01-581.20:1. Admissibility of expressions of sympathy.

In any civil action brought by an alleged victim of an unanticipated outcome of health care, or in any arbitration or medical malpractice review panel proceeding related to such civil action, the portion of statements, writings, affirmations, benevolent conduct, or benevolent gestures expressing sympathy, or general sense of benevolence, which are made by a health care provider or an agent of a health care provider to the patient, a relative of the patient, or a representative of the patient shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest. A statement of

fault that is part of or in addition to any of the above shall not be made inadmissible by this section.

For purposes of this section, unless the context otherwise requires:

"Health care" has the same definition as provided in § 8.01-581.1.

"Health care provider" has the same definition as provided in § 8.01-581.1.

"Relative" means a patient's spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half-brother, half-sister, or spouse's parents. In addition, "relative" includes any person who has a family-type relationship with the patient.

"Representative" means a legal guardian, attorney, person designated to make decisions on behalf of a patient under a medical power of attorney, or any person recognized in law or custom as a patient's agent.

"Unanticipated outcome" means the outcome of the delivery of health care that differs from an expected result.

§ 16.1-83.1. Certification of expert witness opinion at time of service of process.

Every warrant in debt, counter claim, or third party claim in a medical malpractice action, at the time the plaintiff requests service of process upon a defendant, shall be deemed a certification that the plaintiff has obtained from an expert whom the plaintiff reasonably believes would qualify as an expert witness pursuant to subsection A of § 8.01-581.20 a written opinion signed by the expert witness that, based upon a reasonable understanding of the facts, the defendant for whom service of process has been requested deviated from the applicable standard of care and the deviation was a proximate cause of the injuries claimed. This certification is not necessary if the plaintiff, in good faith, alleges a medical malpractice action that asserts a theory of liability where expert testimony is unnecessary because the alleged act of negligence clearly lies within the range of the jury's common knowledge and experience.

The certifying expert shall not be required to be an expert witness expected to testify at trial nor shall any defendant be entitled to discover the identity of the certifying expert or the nature of the certifying expert opinions. Should the certifying expert be identified as an expert expected to testify at trial, the opinions and bases therefor shall be discoverable pursuant to Rule 4:1 of the Rules of Supreme Court of Virginia with the exception of the expert's status as a certifying expert.

Upon written request of any defendant, the plaintiff shall, within 10 business days after receipt of such request, provide the defendant with a certification form which affirms that the plaintiff had obtained the necessary certifying expert opinion at the time service was requested or affirms that the plaintiff did not need to obtain a certifying expert opinion. If the plaintiff did not obtain a necessary certifying expert opinion at the time the plaintiff requested service of process on a defendant, the court shall impose sanctions according to the provisions of § 8.01-271.1 and may dismiss the case with prejudice.

§ 38.2-2228.2. Certain medical malpractice claims to be reported to the Commission.

All medical malpractice claims settled or adjudicated to final judgment against a person, corporation, firm, or entity providing health care, and any such claim closed without payment during each calendar year shall be reported annually to the Commission by the insurer of the health care provider. The reports shall not identify the parties. The report shall state the following data, to the extent applicable, in a format prescribed by the Commission:

1. The nature of the claim and damages asserted;

2. The principal medical and legal issues;

3. Attorneys' fees and expenses paid in connection with the claim or defense, to the extent these amounts are known;

4. Attorneys' fees and expenses reserved in connection with the claim or defense;

5. The amount of the settlement or judgment awarded to the claimant to the extent this amount is known;

6. The specialty of each health care provider;

7. The date the claim was reported to the company;

8. The date the loss occurred;

9. The date the claim was closed;

10. The date and amount of the initial reserve;

11. The amount of loss paid by the insurer if different from the amount of settlement or judgment awarded to the claimant; and

12. Any other pertinent information the Commission may require as is consistent with the provisions of this section.

The report shall include a statistical summary of the information collected in addition to an individual report on each claim. The report shall be submitted in an electronic format. Statistical summaries and individual closed claim reports shall be a matter of public record, except that data reported under item 10 shall, at the request of the reporting insurer, not be disclosed in the public record.

The report shall be filed electronically by July 1 of the year following the applicable calendar year; however, a report with data for calendar years 2002, 2003, and 2004 shall be filed by September 1, 2005.

§ 54.1-2912.3. Competency assessments of certain practitioners.

The Board shall require an assessment of the competency of any person licensed under this chapter on whose behalf three medical malpractice claims are paid in a 10-year period. The assessment shall be accomplished in 12 months or less by a program acceptable to the Board. The licensee shall bear all costs of the assessment. The results of the assessment shall be reviewed by the Board and the Board shall determine a plan of corrective action or appropriate resolution pursuant to the assessment. The assessment, related documents and the processes shall be governed by the confidentiality provisions of § 54.1-2400.2 and shall not be admissible into evidence in any medical malpractice action involving the licensee. The Board shall report annually to the General Assembly the number of competency assessments undertaken.

Summary Report for Years 2002, 2003, and 2004

Report Year	Total Number of Records	Number of Claims Closed **with** a Payment	Number of Claims Closed **without** a Payment	Total Dollar Amount of Paid Losses (excluding LAE)	Total Dollar Amount of LAE for Paid Losses	Total Dollar Amount of LAE for Claims Closed without Payment
2002						
2003						
2004						

Pursuant to § 38.2-2228.2, statistical summaries and individual closed claim reports shall be a matter of public record, except that data reported under item 10 shall, at the request of the reporting insurer, not be disclosed in the public record. In consideration of this option, do you wish the following three fields to be **excluded** from the public records? _______ (Yes/No)

1. resrvdte
2. amtresrv
3. laeresrv

Summary Report for Year 20XX

Report Year	Total Number of Records	Number of Claims Closed **with** a Payment	Number of Claims Closed **without** a Payment	Total Dollar Amount of Paid Losses (excluding LAE)	Total Dollar Amount of LAE for Paid Losses	Total Dollar Amount of LAE for Claims Closed without Payment
20XX						

Pursuant to § 38.2-2228.2, statistical summaries and individual closed claim reports shall be a matter of public record, except that data reported under item 10 shall, at the request of the reporting insurer, not be disclosed in the public record. In consideration of this option, do you wish the following three fields to be **excluded** from the public records? _______ (Yes/No)

1. resrvdte
2. amtresrv
3. laeresrv

File Format

Field Name	Starting Position	Field Length	Format	Description
rptyear	1	4	YYYY	Reporting Year
insurer	6	50	Alpha-Numeric	The name of the insurance company reporting the closed claims
naicnu	57	5	Numeric	The NAIC number of the reporting insurance company
claimnu	63	20	Alpha-Numeric	The claim file identification number used by the insurance company for the reported closed claim
insrdzip	84	5	Numeric	The zip code of the insured's primary office/facility
poltype	90	1	Coded**	The description of the policy form on which the claim was reported**
vamsc	92	3	Coded**	The Virginia specific medical specialty code used to categorize the nature of the insured's practice**
clmtype	96	1	Coded**	The description code used to identify how the claim was presented to the insurer**
alllegat	98	3	Coded**	The description code used to categorize the nature of the claimant's allegation**
outcome	102	2	Coded**	The description coded identifying the severity of alleged malpractice injury**
lossdte	105	8	MMDDYYYY	The date the loss occurred
rptdte	114	8	MMDDYYYY	The date the loss was reported to the insurer
resrvdte***	123	8	MMDDYYYY	The date that the insurer set the initial claim reserve***
amtresrv***	132	10	Numeric*	The dollar value assigned to the initial claim reserve***
laeresrv***	143	10	Numeric*	The dollar value assigned to the initial loss adjustment expense reserve***
closedte	154	8	MMDDYYYY	The date that the claim was closed
closersn	163	1	Coded**	The description code used to identify why the claim was closed**
pmtq	165	1	Coded**	The description code specifying whether the claim was closed with a payment**
pmt1	167	10	Numeric*	The dollar value of the final settlement or judgment
pmt2	178	10	Numeric*	The dollar amount paid to the claimant if different than final settlement or judgment
finlae	189	10	Numeric*	The final dollar value of the claim's loss adjustment expense

Total Record Length: 199 characters

* All dollar amounts should be rounded to the nearest whole number
** Please review the work sheet with the corresponding field name to determine proper coding requirements
*** The insurer may choose not to have these fields disclosed in the public record. To exercise this option, be sure to respond to the corresponding question on the Statistical Summary Sheet.

Policy Form

Code	Description
1	Standard Policy
2	Extended Reporting Endorsement

Virginia Medical Specialty Codes

Code	Description
001	Aerospace Medicine
002	Allergist
003	Anesthesiologist
004	Broncho-Esophagologist
005	Cardiologist
006	Cardiovascular Surgeon
007	Chiropractor
008	Clinic
009	Colon and Rectal Surgeon
010	Dental Student
011	Dentist
012	Dermatologist
013	Diabetes Specialist
014	Emergency Room Physician
015	Endocrinologist
016	Family or General Practitioner
017	Family Practitioner (claim involves OB/GYN care)
018	Forensic Medicine
019	Gastroenterologist
020	General Surgeon
021	Geriatrician
022	Group Practice
023	Gynecologist/Obstetrician
024	Hematologist
025	Hospital
026	Immunologist
027	Infectious Disease Specialist
028	Internist
029	Laryngologist
030	Legal Medicine
031	Medical Facility (not otherwise specified)
032	Medical Technician/Laboratory
033	Neoplastic Disease Specialist
034	Nephrologist
035	Neurological Surgeon
036	Neurologist
037	Nuclear Medicine
038	Nurse
039	Nurse Anesthetist

040	Nurse Midwife
041	Nurse Practitioner
042	Nursing Home
043	Nursing Student
044	Nutritionist
045	OB/GYN Surgeon
046	Occupational Medicine
047	Oncologist
048	Ophthalmologist
049	Optician
050	Optometrist
051	Oral Surgeon
052	Orthodontist
053	Orthopedic Surgeon
054	Orthopedist
055	Otheopathic Medicine
056	Otologist
057	Otorhinolaryngologist
058	Pathologist
059	Pediatrician
060	Periodontist
061	Pharmacist
062	Pharmacologist
063	Phlebotonist
064	Physical Medicine and Rehabilitation Specialist
065	Physical Therapist
066	Plastic Surgeon
067	Podiatrist
068	Preventive Medicine
069	Psychiatric Institution
070	Psychiatrist
071	Psychologist
072	Public Health
073	Pulmonary Disease Specialist
074	Radiologist
075	Resident, Intern, or Medical Student
076	Rheumatologist
077	Rhinologist
078	Surgeon (not otherwise specified)
079	Thoracic Surgeon
080	Urological Surgeon
081	Urologist
999	Other (not specified above)

How the Claim Was Presented

Code	Description
1	Unrepresented Demand
2	Represented Demand
3	Law Suit

Nature of Claimant's Allegation

Code	Description
100	Failure to Use Aseptic Technique
101	Failure to Diagnose
102	Failure to Delay a 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
200	Delay in Diagnosis
201	Delay in Performance
202	Delay in Treatment
203	Delay in Treatment of Identified Fetal Distress
300	Administration of Blood or Fluids Problem
301	Agent Use or Selection Error
302	Complementary 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	Laboratory Error
314	Pathology Error
315	Medication Administered via Wrong Route
316	Patient History, Exam, or Workup Problem
317	Problems With Patient Monitoring in Recovery
318	Patient Monitoring Problem
319	Patient Positioning Problem
320	Problem with Appliance, Prostheses, Orthotic, Device, etc.
321	Radiology or Imaging Error
322	Surgical or Other Foreign Body Retained
323	Wrong or Misdiagnosis (e.g. Original Diagnosis is Incorrect)
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
400	Contraindicated Procedure
401	Surgical or Procedural Clearance Contraindicated
402	Unnecessary Procedure
403	Unnecessary Test
404	Unnecessary Treatment
500	Communication Problem Between Practitioners
501	Failure to Instruct or Communicate with Patient or Family
502	Failure to Report on Patient Condition
503	Failure to Respond to Patient
504	Failure to Supervise
505	Improper Supervision
600	Failure/Delay in Admission to Hospital or Institution
601	Failure/Delay in Referral or Consultation
602	Premature Discharge from Institution
603	Altered, Misplaced or Prematurely Destroyed Records
700	Abandonment
701	Assault and Battery
702	Breach of Contract or Warranty
703	Breach of Patient Confidentiality
704	Equipment Malfunction
705	Failure to Conform with Regulation, Statute, or Rule
706	Failure to Ensure Patient Safety
707	Failure to Obtain Consent or Lack of Informed Consent
708	Failure to Protect a Third Party (Failure to Warn, etc.)
709	Failure to Test Equipment
710	False Imprisonment
711	Improper Conduct
712	Inadequate Utilization Review
713	Negligent Credentialing
714	Practitioner with Communicable Disease
715	Product Liability
716	Religious Issues
717	Sexual Misconduct
718	Third Party Claimant
719	Vicarious Liability
720	Wrongful Life/Birth
899	Cannot Be Determined from Available Records

Severity of Alleged Malpractice Injury Code

Code	Description
01	Emotional Injury Only
02	Insignificant Injury
03	Minor Temporary Injury
04	Major Temporary Injury
05	Minor Permanent Injury
06	Significant Permanent Injury
07	Major Permanent Injury
08	Quadriplegic, Brain Damage, Lifelong Care
09	Death
10	Cannot Be Determined from Available Records

Reason Claim Was Closed

Code	Description
1	Verdict
2	Arbitration/Mediation
3	Negotiated settlement

Closed With a Payment?

Code	Description
Y	Yes
N	No