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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

December 21, 1977

1977-17

TO: ALL COMPANIES LICENSED TO WRITE LIABILITY (OTHER THAN AUTOMOBILE) INSURANCE IN VIRGINIA

RE: Medical Malpractice Liability Insurance Claims Report

By letters dated November 26, 1976 and May 12, 1977 I advised of the statutory requirement concerning the reporting of medical malpractice claim information and data to this office.

A copy of the Virginia Medical Professional Liability Insurance Uniform Claims Report was forwarded to each company with my letter of November 26, 1976, for use in reporting such claims.

As you are aware, the National Association of Insurance Commissioners has resumed data collection in continuation of its Medical Malpractice Closed Claim Study, and has developed a new NAIC Medical Professional Liability Insurance Uniform Claims Report.

The new NAIC Claims Report varies in some areas from the current Virginia Claims Report; however, it appears that the information to be indicated on the new NAIC form will meet the Virginia reporting requirement.

In order that companies not be required to complete two different Claims Report forms, and in order that Virginia data be compatible and comparable with NAIC data, a completed report on the new NAIC form (in lieu of the current Virginia form) for each medical malpracti claim, including claims closed without payment, must be filed with thi office within sixty days following final dispotion of each such claim.

A copy of the NAIC Medical Professional Liability Insurance Uniform Claims Report, which may be reproduced for future use, is enclosed herewith for use in reporting each such claim reaching final disposition on or after January 1, 1978.

COPY ALSO TO HEALTH CARE PROVIDER ASSOCIATIONS, ETC.

As heretofore advised, the insurer of health care providers, rather than the provider, should file the report since all necessary information is readily available in the insurer's claim file.

If you have any questions concerning this matter, please communicate same to this office. Thank you for your assistance.

Very truly yours,

John G. Day
Commissioner of Insurance

JGD:mra

Enclosure

Report each claim closed on or after July 1, 1976. Submit a report for each defendant insured by filing insurer, including claims closed without payment. Complete all blocks on the form. If information is unknown, enter "UNK," if not applicable, enter "NA." When an item calls for a dollar amount and no amount is involved, enter 0 in the space after the $ sign. When you prepare a report on a reopened case on which a previous report has been made, mark "Previously Reported" at the top of the report. Record all amounts in whole dollars only, all dates as MM YY and all ages (on date of occurrence) as YY.

1a.	Name of insurer			1b.	Claim file identification		
2a.	Date of injury		2b.	Date reported to insurer		2c.	Date reopened
3a.	Insured's name	3b. Age	3c.	City	3d. State	3e.	Zip
4a.	Profession or business (CODE)		4b.	Specialty (CODE)	4c.	Type of practice (CODE)	
5a.	Board certification (CODE)		5b.	Foreign medical graduate?	5c.	Country	
6a.	Place where injury occurred (CODE)		6b.	City	6c. State	6d.	Zip
7a.	Name of institution (if injury occurred in institution)		7b.	Location in institution (CODE)	7c.	Hospital identification (Leave Blank)	
8a.	Injured person's name				8b. Age	8c.	Sex
9a.	Total defendants involved in claim			9b.	Derivative claim (CODE)		
10.	Amount of reserve for indemnity if still outstanding $			11.	Amount of reserve for expense if still outstanding $		
12a.	Plaintiff attorney's name		12b.	City	12c. State	12d.	Zip

13.	Describe action which caused claim to be made	(Leave Blank) 14a.
		14b.
14a.	Final diagnosis for which treatment was sought or rendered (patient's actual condition)	15.
14b	Describe misdiagnosis made, if any, of patient's actual condition	15.
15.	Operation, diagnostic or treatment procedure causing the injury	16a.
16a.	Describe principal injury giving rise to the claim	16a.

16b.	Severity of injury (CODE)				
17a.	Misadventures in procedures (CODE)		17b.	Misadventures in diagnosis (CODE)	
18a.	Others contributing to injury (CODE)	18b.	Associated issues (CODE)	18c.	Coverage (CODE)
19	Companion claim file identification	1.	2.	3.	4.
20a.	Date of this payment or closure	20b.	Claim disposition (CODE)	20c.	Settlement (CODE)
21a.	Court (CODE)	21b.	Binding arbitration (CODE)	21c.	Review panel (CODE)
22.	Indemnity paid by you on behalf of this defendant			$	
23.	Other indemnity paid by or on behalf of this defendant			$	D ☐ E ☐
24	Indemnity paid by all parties (for all defendants)			$	
25.	Loss adjustment expense paid to defense counsel			$	
26	All other allocated loss adjustment expense paid by you			$	
27.	Injured person's incurred medical expense			$	
28.	Injured person's anticipated future medical expense			$	
29.	Injured person's incurred wage loss			$	
30.	Injured person's anticipated wage loss			$	
31.	Injured person's other expense			$	
32.	Total amount allocated for future periodic payments (for all defendants)			$	

Contact Person and Telephone Number

Address

Person Responsible for Report

8/77

4a. Profession or Business Code: 1) physicians and surgeons, 2) hospitals, 3) other medical professionals, 4) other health care facilities. (When 3 is entered, specify type of professional in addition.)

4b. Specialty Code: (five digits) from ISO Common Statistical Base classifications.

4c. Type of Practice Code: 1) institutional (academic), 2) group or partnership, 3) self-employed, 4) employed physician, 5) employed nurse, 6) all other employees.

5a. Enter appropriate code if insured physician is Board Certified in 1) specialty coded in 4b, 2) a different specialty, 3) both specialty coded in 4b and another specialty 4) insured is not a board-certified physician. If 2 or 3 is entered, also enter the additional specialty code (5 digits) in this line.

5b. Indicate yes or no if insured physician is a Foreign Medical Graduate.

5c. Enter Country in which primary medical education was received if other than U.S.

6a. Enter the appropriate code of the Place Where the principal Injury Occurred: 1) hospital inpatient facility, 2) emergency room, 3) hospital outpatient facility, 4) nursing home, 5) physician's office, 6) patient's home, 7) other outpatient facility, 8) other. Use only one code. If code 8, other, is used enter description of the place.

7b. Enter appropriate code if Location of Institutional Injury was: 1) patient's room, 2) labor and delivery room, 3) operating suite, 4) recovery room, 5) critical care unit, 6) special procedure room, 7) nursery, 8) radiology, 9) physical therapy department.

9a. Enter the Total Number of Defendants (persons and institutions other than John Does) Involved in Claim.

9b. Enter the appropriate code(s) if a Derivative Claim (on behalf of someone other than the medically injured) was made by: 1) spouse, 2) children, 3) parent, 4) personal representative.

14a. Use nomenclature and/or descriptions to enter the Final Diagnosis for which Treatment was Sought or Rendered (actual abnormal condition), and also 14b. the Misdiagnosis, if any, of the Patient's Actual Condition.

15. Use nomenclature and/or descriptions of the procedure used. Include method of anesthesia, or name of drug used for treatment, with detail of administration.

16a. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable.

16b. Enter one digit code for Severity of Injury from scale provided below. Enter the code for the most serious injury if several are involved.

	Severity of Injury Scale	Examples
	1) Emotional only	Fright, no physical damage.
Temporary	2) Insignificant	Lacerations, contusions, minor scars, rash. No delay.
	3) Minor	Infections, misset fracture, fall in hospital. Recovery delayed.
	4) Major	Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
Permanent	5) Minor	Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
	6) Significant	Deafness, loss of limb, loss of eye, loss of one kidney or lung.
	7) Major	Paraplegia, blindness, loss of two limbs, brain damage.
	8) Grave	Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
	9) Death	

17a. Enter the appropriate Misadventure Code(s) if the Procedure was: 1) not adequately indicated, 2) contraindicated, 3) there was a more appropriate alternative, 4) delayed, 5) improperly performed, 6) not performed, 7) occasioned by misdiagnosis, 8) inadequate assessment, 9) mis-identification of the patient, 10) delay in notifying physician, 11) failure to notice an improper order, 12) failure to obtain a proper order, 13) failure to instruct patient.

17b. Enter the appropriate code if the following Misadventures in Diagnosis caused or aggravated the injury: 1) delay in diagnosis, 2) misdiagnosis of the abnormal condition, 3) misdiagnosis in the absence of an abnormal condition.

18a. Enter the appropriate code(s) if any Other person(s) caused or Contributed to the Injury: 1) attending physician, 2) house staff, 3) consultant, 4) nurse R.N., 5) nurse L.P.N. or L.V.N., 6) aide, 7) orderly, 8) pharmacist, 9) radiologist, 10) radiology technician, 11) anesthesiologist, 12) anesthetist, 13) pathologist, 14) laboratory technician, 15) physician's assistant, 16) O.R. technician, 17) physical therapist, 18) inhalation therapist, 19) other therapists, 20) other technicians, 21) dietitian, 22) maintenance personnel, 23) engineer, 24) administrator, 25) other personnel, 26) patient, 27) another patient.

18b. Enter the appropriate code(s) if one or more of the following factors were Associated Issues in the claim: 1) abandonment, 2) premature discharge from institution, 3) false imprisonment, 4) lack or delay of consultation, 5) lack of supervision, 6) breach of confidentiality, 7) failure to prevent an abnormal condition, 8) failure to accomplish intended result, 9) failure to conform with regulation or statutory rule, 10) lack of adequate facilities or equipment, 11) laboratory error, 12) pharmacy error, 13) products liability, 14) failure to timely disclose, 15) failure to provide warning instructions, 16) lack of consent from proper person, 17) inadequate information for informed consent, 18) procedure exceeded consensual understanding, 19) breach of contract, 20) warranty, 21) assault and battery, 22) res ipsa loquitur, 23) emergency equipment, 24) cooling devices, 25) heating devices, 26) cautery equipment, 27) x-ray equipment, 28) radiation therapy equipment, 29) traction equipment, 30) anesthesia equipment, 31) operative equipment, 32) surgical instruments and materials, 33) food preparation equipment, 34) laboratory equipment, 35) laboratory mislabeling, 36) laboratory computation error, 37) inadequate laboratory specimen, 38) lost laboratory specimen, 39) laboratory interpretation, 40) laboratory reporting error, 41) laboratory delay in reporting, 42) sterilization of equipment, 43) skin preparation, 44) aseptic technique, 45) isolation for infection control, 46) records, 47) billing and collection, 48) inter-professional relations, 49) vicarious liability, 50) statute of limitations, 51) punitive damages.

18c. Enter the appropriate Coverage Code for the type of policy covering the claim: 1) policy covers all claims made during the term of the policy, 2) policy covers all claims made during the policy term for events which occurred during a designated previous policy term, 3) policy covers all claims whenever presented for events which occur during the policy term.

20b. Enter final method of Claim Disposition: 1) settled by parties, 2) disposed of by a court, 3) disposed of by binding arbitration.

20c. If settled by agreement of parties, enter appropriate Settlement Code: 1) before filing suit or demanding hearing, 2) before trial or hearing, 3) during trial or hearing, 4) after trial or hearing, but before judgment or decision (award), 5) after judgment or decision, but before appeal, 6) during appeal, 7) after appeal, 8) claim or suit abandoned, 9) during review panel or non-binding arbitration.

21a. Enter the appropriate Court Code: 0) no court proceedings, 1) directed verdict for plaintiff, 2) directed verdict for defendant, 3) judgment notwithstanding the verdict for the plaintiff, 4) judgment notwithstanding the verdict for the defendant, 5) judgment for the plaintiff, 6) judgment for the defendant, 7) for plaintiff after appeal, 8) for defendant after appeal, 9) all other.

21b. Enter appropriate Binding Arbitration Code: 0) claim not subject to arbitration, 1) claim subject to arbitration, but previously coded disposition reached in lieu of award, 2) award for plaintiff, 3) award for defendant.

21c. If a review panel or non-binding arbitration was used in disposition, enter appropriate code: 1) finding for plaintiff, 2) finding for defendant.

27. Mark appropriate box if this amount was a deductible paid by the insured or indemnity paid under an excess limits policy by another insurer. Enter fees paid to your defense counsel for this defendant.

28. Enter filing fees, telephone charges, photocopy fees, expenses of defense counsel, etc.

30. Enter best estimate of future medical expense if it appears the claimant will incur expenses in the future.

32. Enter best estimate of future wage loss if it appears the claimant will incur wage loss in the future.

32. If a reserve, annuity, trust fund or similar mechanism was established to provide future periodic payments, enter total amount thereof.