Oklahoma INSURANCE Department
State of Oklahoma

BULLETIN NO. PC 2010-01

TO: **ALL PROPERTY & CASUALTY INSURERS LICENSED IN THE STATE OF OKLAHOMA**
ALL RATING AND ADVISORY ORGANIZATIONS
ALL JOINT UNDERWRITING ASSOCIATIONS
Attention: State Filing Division

RE: **MEDICAL MALPRACTICE – 2010 CLOSED CLAIM REPORTING**
Title 36 O.S. 6810 - 6820

FROM: **OKLAHOMA INSURANCE DEPARTMENT**

DATE: **MARCH 26, 2010 (Revised May 18, 2010)**

In 2009, the Oklahoma Legislature amended the Oklahoma Medical Professional Liability Insurance Closed Claim Reports Act, 36 O.S. § 6810 – 6816. The amendments to these statutes expanded the entities required to make closed claim reports and broadened the amount of information entities are required to report. The purpose of these amendments was to allow the Oklahoma Insurance Department to gather a greater amount and more accurate statistical information to provide a more comprehensive picture of costs associated with medical professional liability claims.

To implement these amendments, the Department has prepared the Medical Malpractice 2010 Report Instructions and Reporting Form – both of which are attached. These instructions will provide guidance in preparing and filling out the form.

Further, please be advised that any entity that has access to SERFF (System for Electronic Rate and Form Filing) will be required to submit their closed claim reports through SERFF in an Excel spreadsheet format. The Excel spreadsheet included in the SERFF filing must be titled with the identifying number of the claim being reported. When submitting reports by SERFF, select TOI **11.0**, Filing Type – **Report,** and place attachments under **Supporting Documents** tab. (Attachments to be submitted in Excel format only. *Do not convert the spreadsheet to .pdf format.)*

5 Corporate Plaza, 3625 NW 56th Street. Suite 100, Oklahoma City, OK 73112
P.O. BOX 53408 • OKLAHOMA CITY, OK 73152-3408 •
(405) 521-3681 • IN STATE 1-800-522-0071 • FAX (405) 522-3761

If any entity does not have access to SERFF, the report must be submitted to the Department in an Excel spreadsheet format by e-mail to oidreports@oid.ok.gov. The Excel spreadsheet must be titled with the identifying number of the claim being reported. (*Do not convert the spreadsheet to .pdf format.)*

The Department is also in the process of promulgating rules to further implement these amendments. Any rules will be submitted for public comment and be adopted through a formal process. Thus, changes to the Instruction and Reporting Form may be made next year. If changes are made, the Department will issue a Bulletin notifying entities of the changes.

Effective November 1, 2010, all medical malpractice closed claim reports must be reported by April 1 of the year in which the claim was closed; however, if the claim is closed after April 1, it must be reported the following April 1. Because the new law does not become effective until November 1, 2010, any claim closed after that date is not required to be reported until April 1, 2011. Please complete the 2010 calendar year reporting by submitting the 4th quarter 2010 separately from the 1st quarter 2011 closed claim experience.

Questions or comments applicable to this bulletin should be directed to:

Greg Lawson, Manager of Statistical Analysis
Greg.Lawson@oid.ok.gov
Oklahoma Insurance Department
Rate and Form Filing Division
Five Corporate Plaza, 3625 NW 56th
Suite 100
Oklahoma City, OK 73112

The Oklahoma Insurance Department encourages readers of this notice to periodically check the Department's web site http://www.oid.ok.gov/ for news and updates to Bulletins and other relevant material.

Medical Malpractice 2010 Report Instructions

This report shall be filed pursuant to 36 O.S.6811. Several terms in the report are defined in 36 O.S. 6810. Thus, the preparer should review both of these sections. Reports shall be sent to the Insurance Department between the 1st and the 10th day of each month following the calendar quarter. Include claims closed without payment. Complete all requested information on each report. If information is unknown, enter **UK**; if not applicable, enter **NA**. When an item calls for a dollar amount and no amount is involved, enter **0** in the space. Each entry marked (**CODE**) requires a specific code, which is described within this document. Record all amounts in **whole dollars** only and all dates as **MM/DD/YY**.

Further, please be advised that any entity that has access to SERFF (System for Electronic Rate and Form Filing) will be required to submit their closed claim reports through SERFF in an Excel spreadsheet format. The Excel spreadsheet included in the SERFF filing must be titled with the identifying number of the claim being reported. When submitting reports by SERFF, select TOI **11.0**, Filing Type – **Report,** and place attachments under **Supporting Documents** tab. (Attachments to be submitted in Excel format only. *Do not convert the spreadsheet to .pdf format.)*

If any entity does not have access to SERFF, the report must be submitted to the Department in an Excel spreadsheet format by e-mail to oidreports@oid.ok.gov. The Excel spreadsheet must be titled with the identifying number of the claim being reported. (*Do not convert the spreadsheet to .pdf format.)*

If defense and cost containment expenses or any other amounts are later changed and you are reporting by email, send an amended report after the end of the year between January 1st and January 10th. Please use the same reporting form as used for the original report. Complete the report with an asterisk at the end of the claim identifier to make known to us that the claim was previously reported (i.e. CL4589725*). The period of time (#G) should be the same as previously reported. For revisions to reports previously submitted in SERFF, ask OID to reopen filing and replace original submission with the revised report.

Lines A through F: Self-explanatory.

G. Period of time: Enter quarter and year, i.e. 3Q-03, 4Q-03.

H. Any closed claims: Enter **NO** if no claims closed and return form. If yes, enter **YES** and complete balance of questions. Complete a separate form for each closed claim, and title the form using the number of the claim being reported.

1. a: 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 named 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.

1. b: **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.

2. a: 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.

2. b: 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.

2. c: 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.

2. d: 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.

3. a: 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

NPDB Occupation/Field of Licensure Codes	
Code	**Description**
210	Nutritionist
	Emergency Med Tech (EMT)
250	EMT, Basic
260	EMT, Cardiac, critical care
270	EMT, Intermediate
280	EMT, Paramedic
	Eye and Vision Service Provider
630	Ocularist
633	Optician
636	Optometrist
	Nurse
100	Registered
110	Nurse anesthetist
120	Nurse midwife
130	Nurse practitioner
140	Licensed practical
141	Clinical nurse specialist
	Nurse aides, Home health aide, and other aide
148	Certified nurse aide/assistant
150	Nurses aide
160	Home health aide
165	Health care aide/direct care worker
175	Certified or qualified medication aide
	Pharmacy Service Provider
050	Pharmacist
055	Pharmacy intern
060	Pharmacist, nuclear
070	Pharmacy assistant
075	Pharmacy technician
	Physician
010	Physician (MD)
015	Physician inter/resident (MD)
020	Osteopathic Physician (DO)
025	Osteopathic Physician Intern/Resident (DO)
	Physician Assistant
642	Physician assistant, allopathic
645	Physician assistant, osteopathic
	Podiatric Service Provider
350	Podiatrist
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

NPDB Occupation/Field of Licensure Codes	
Code	**Description**
405	Massage therapist
410	Occupation therapist
420	Occupational therapy assistant
430	Physical therapist
440	Physical therapy assistant
450	Rehabilitation therapist
663	Respiratory therapist
666	Respiratory therapy technician
Social Worker	
300	Social worker
Speech, Language, and Hearing Service Provider	
400	Audiologist
460	Speech/language pathologist
470	Hearing aid/hearing instrument specialist
Technologist	
500	Medical technologist
505	Cytotechnologist
510	Nuclear medicine technologist
520	Radiation therapy technologist
530	Radiologist technologist
Other Health Care Practitioner	
600	Acupuncturist
601	Athletic trainer
615	Homeopath
618	Medical assistant
624	Midwife, Lay (non-nurse)
627	Naturopath
639	Orthotics/ Prosthetics Fitter
170	Psychiatric Technician
699	Other health care practitioner-not classified
Health Care Facility Administrator	
752	Adult care facility administrator
755	Hospital administrator
758	Long-term care administrator
999	Not an individual defendant.

3.b: 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

NPDB Specialty Codes	
Code	**Description**
10	Cardiovascular diseases
13	Child Psychiatry
20	Dermatology
23	Diagnostic Radiology
25	Emergency medicine
29	Forensic pathology
30	Gastroenterology
33	General / Family Practice
35	General preventive medicine
37	Hospitalist
39	Internal medicine
40	Neurology
43	Neurology, clinical neurophysiology
45	Nuclear medicine
50	Obstetrics & Gynecology
53	Occupational medicine
55	Ophthalmology
59	Otolaryngology
60	Pediatrics
63	Psychiatry
65	Public health
67	Clinical pharmacology
69	Physical medicine & rehabilitation
70	Pulmonary diseases
73	Anatomic/clinical pathology
75	Radiology
76	Radiation oncology
80	Colon and rectal surgery
81	General surgery
82	Neurological surgery
83	Orthopedic surgery
84	Plastic surgery
85	Thoracic surgery
86	Urological surgery
98	Other specialty-not classified
99	Unspecified
	Dental specialties
D1	General dentistry (no specialty)
D2	Dental: Public Health
D3	Endodontics
D4	Oral and maxillofacial surgery
D5	Oral and maxillofacial pathology
D6	Orthodontics and dentofacial Orthopedics
D7	Pediatric Dentistry
D8	Periodontics
D9	Prosthodontics

NPDB Specialty Codes	
Code	**Description**
DA	Oral and maxillofacial radiology
DB	Unknown

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**

5. 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

6.a: 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 5. If the injury did not occur in a city, enter **NA**.

6.b: **County where injury occurred**

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 5. See list below. Enter number for appropriate county.

OKLAHOMA COUNTIES:
1) ADAIR, 2) ALFALFA, 3) ATOKA, 4) BEAVER, 5) BECKHAM, 6) BLAINE, 7) BRYAN, 8) CADDO, 9) CANADIAN, 10) CARTER, 11) CHEROKEE, 12) CHOCTAW, 13) CIMMARON, 14) CLEVELAND, 15) COAL, 16) COMANCHE, 17) COTTON, 18) CRAIG, 19) CREEK, 20) CUSTER, 21) DELAWARE, 22) DEWEY, 23) ELLIS, 24) GARFIELD, 25) GARVIN, 26) GRADY, 27) GRANT, 28) GREER, 29) HARMON, 30) HARPER, 31) HASKELL, 32) HUGHES, 33) JACKSON, 34) JEFFERSON, 35) JOHNSTON, 36) KAY, 37) KINGFISHER, 38) KIOWA, 39) LATIMER, 40) LEFLORE, 41) LINCOLN, 42) LOGAN, 43) LOVE, 44) MCCLAIN, 45) MCCURTAIN, 46) MCINTOSH, 47) MAJOR, 48) MARSHALL, 49) MAYES, 50) MURRAY, 51) MUSKOGEE, 52) NOBLE, 53) NOWATA, 54) OKFUSKEE, 55) OKLAHOMA, 56) OKMULGEE, 57) OSAGE, 58) OTTAWA, 59) PAWNEE, 60) PAYNE, 61) PITTSBURG, 62) PONTOTOC, 63) POTTAWATOMIE, 64) PUSHMATAHA, 65) ROGER MILLS, 66) ROGERS, 67) SEMINOLE, 68) SEQUOYAH, 69) STEPHENS, 70) TEXAS, 71) TILLMAN, 72) TULSA, 73) WAGONER, 74) WASHINGTON, 75) WASHITA, 76) WOODS, 77) WOODWARD

7.a: **Gender** of injured person. Use M or F.

7.b: **Age of injured person** at the date of injury.

8. **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	

9.a: **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 5.

9.b: **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.

9.c: Date of lawsuit

The date a lawsuit was filed for this claim.

9.d: Date of final indemnity payment

The date last payment for indemnity was made.

9.e: 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).

10.a: **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

10.b: **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

Section 11: For claims disposed of by a court that results in a verdict or judgment complete 11.a (1)-(8) and complete 11.b (1)-(7) with **NA**. For claims that do not result in a verdict or judgment complete 11.b.(1)-(7) and complete 11.a (1)-(8) with **NA**.

11.a.(1) and 11.b.(1): **Indemnity or settlement paid by reporting entity**

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

Note on item (2) and (3) Economic and noneconomic portions of total indemnity paid by all parties.

Amounts entered into items (2) and (3) 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.**

11.a.(2) and 11.b.(2): 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.

11.a.(3) and 11.b.(3): 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.

11.a.(4): Verdict for Punitive Damages

The amount of the verdict consisting of punitive damages.

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

11.a.(5) and 11.b.(4): Defense and Cost Containment Expense for Legal Counsel

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

11.a.(6) and 11.b.(5): Defense and Cost Containment Expense for Experts

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

11.a.(7) and 11.b.(6): Defense and Cost Containment Expense Other than Legal Counsel of Experts

The remaining portion of defense and cost containment expenses.

11.a.(8) and 11.b.(7): Total Defense and Cost Containment Expense

The sum of last three above items.

12.a: 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

12.b: **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
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

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