RCW 48.140.030 Closed claim reports—Information requirements. Reports required under RCW 48.140.020 must contain the following information in a form and coding protocol prescribed by the commissioner that, to the extent possible and still fulfill the purposes of this chapter, are consistent with the format for data reported to the national practitioner data bank:

(1) Claim and incident identifiers, including:

(a) A claim identifier assigned to the claim by the insuring entity, self-insurer, facility, or provider; and

(b) An incident identifier if companion claims have been made by a claimant. For the purposes of this section, "companion claims" are separate claims involving the same incident of medical malpractice made against other providers or facilities;

(2) The medical specialty of the provider who was primarily responsible for the incident of medical malpractice that led to the claim;

(3) The type of health care facility where the medical malpractice incident occurred;

(4) The primary location within a facility where the medical malpractice incident occurred;

(5) The geographic location, by city and county, where the medical malpractice incident occurred;

(6) The injured person's sex and age on the incident date;

(7) The severity of malpractice injury using the national practitioner data bank severity scale;

(8) The dates of:

(a) The incident that was the proximate cause of the claim;

(b) Notice to the insuring entity, self-insurer, facility, or provider;

(c) Suit, if filed;

(d) Final indemnity payment, if any; and

(e) Final action by the insuring entity, self-insurer, facility, or provider to close the claim;

(9) Settlement information that identifies the timing and final method of claim disposition, including:

(a) Claims settled by the parties;

(b) Claims disposed of by a court, including the date disposed; or

(c) Claims disposed of by alternative dispute resolution, such as arbitration, mediation, private trial, and other common dispute resolution methods; and

(d) Whether the settlement occurred before or after trial, if a trial occurred;

(10) Specific information about the indemnity payments and defense expenses, as follows:

(a) For claims disposed of by a court that result in a verdict or judgment that itemizes damages:

(i) The total verdict or judgment;

(ii) If there is more than one defendant, the total indemnity paid by or on behalf of this facility or provider;

(iii) Economic damages;

(iv) Noneconomic damages; and

(v) Allocated loss adjustment expense, including but not limited to court costs, attorneys' fees, and costs of expert witnesses; and

(b) For claims that do not result in a verdict or judgment that itemizes damages:

(i) The total amount of the settlement;

(ii) If there is more than one defendant, the total indemnity paid by or on behalf of this facility or provider;

(iii) Paid and estimated economic damages; and

(iv) Allocated loss adjustment expense, including but not limited to court costs, attorneys' fees, and costs of expert witnesses;

(11) The reason for the medical malpractice claim. The reporting entity must use the same allegation group and act or omission codes used for mandatory reporting to the national practitioner data bank; and

(12) Any other claim-related data the commissioner determines to be necessary to monitor the medical malpractice marketplace, if such data are reported:

(a) To the national practitioner data bank; or

(b) Voluntarily by members of the physician insurers association of America as part of the association's data-sharing project. [2006 c 8 s 203.]