Federal /State Statutes Relative to Reporting of Malpractice Claims and Adverse Events

National Practitioner Data Bank

SUBCHAPTER II - REPORTING OF INFORMATION

-CITE-
42 USC Sec. 11131 01/03/2012 (112-90)

-EXPCITE-
TITLE 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 117 - ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES
SUBCHAPTER II - REPORTING OF INFORMATION

-HEAD-
Sec. 11131. Requiring reports on medical malpractice payments

-STATUTE-
(a) In general

Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with section 11134 of this title, information respecting the payment and circumstances thereof.

(b) Information to be reported

The information to be reported under subsection (a) of this section includes -

(1) the name of any physician or licensed health care practitioner for whose benefit the payment is made,

(2) the amount of the payment,

(3) the name (if known) of any hospital with which the physician or practitioner is affiliated or associated,

(4) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based, and

(5) such other information as the Secretary determines is required for appropriate interpretation of information reported under this section.

(c) Sanctions for failure to report

Any entity that fails to report information on a payment required to be reported under this section shall be subject to a civil money penalty of not more than $10,000 for each such payment involved.

Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a-7a of this title are imposed and collected under that section.

(d) Report on treatment of small payments

The Secretary shall study and report to Congress, not later than two years after November 14, 1986, on whether information respecting small payments should continue to be required to be reported under subsection (a) of this section and whether information respecting all claims made concerning a medical malpractice action should be required to be reported under such subsection.

-SOURCE-

(Pub. L. 99-660, title IV, Sec. 421, Nov. 14, 1986, 100 Stat. 3788.)

-End-

-CITE-

42 USC Sec. 11134 01/03/2012 (112-90)

-EXPCITE-

TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 117 - ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

SUBCHAPTER II - REPORTING OF INFORMATION

-HEAD-

Sec. 11134. Form of reporting

-STATUTE-

(a) Timing and form

The information required to be reported under sections 11131, 11132(a), and 11133 of this title shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date (not later than one year after November 14, 1986) specified by the Secretary.

(b) To whom reported

The information required to be reported under sections 11131, 11132(a), and 11133(b) of this title shall be reported to the Secretary, or, in the Secretary's discretion, to an appropriate private or public agency which has made suitable arrangements with

the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of the information under this subchapter.

(c) Reporting to State licensing boards

(1) Malpractice payments

Information required to be reported under section 11131 of this title shall also be reported to the appropriate State licensing board (or boards) in the State in which the medical malpractice claim arose.

(2) Reporting to other licensing boards

Information required to be reported under section 11133(b) of this title shall also be reported to the appropriate State licensing board in the State in which the health care entity is located if it is not otherwise reported to such board under subsection (b) of this section.

-SOURCE-

(Pub. L. 99-660, title IV, Sec. 424, Nov. 14, 1986, 100 Stat. 3790.)

-End-

-CITE-

42 USC Sec. 11151 01/03/2012 (112-90)

-EXPCITE-

TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 117 - ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

SUBCHAPTER III - DEFINITIONS AND REPORTS

-HEAD-

Sec. 11151. Definitions

-STATUTE-

In this chapter:

(1) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.

(2) The term "Board of Medical Examiners" includes a body comparable to such a Board (as determined by the State) with responsibility for the licensing of physicians and also includes a subdivision of such a Board or body.

(3) The term "clinical privileges" includes privileges, membership on the medical staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted

to furnish such care by a health care entity.
(4)(A) The term "health care entity" means -
(i) a hospital that is licensed to provide health care services by the State in which it is located,
(ii) an entity (including a health maintenance organization or group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary), and
(iii) subject to subparagraph (B), a professional society (or committee thereof) of physicians or other licensed health care practitioners that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary).

(B) The term "health care entity" does not include a professional society (or committee thereof) if, within the previous 5 years, the society has been found by the Federal Trade Commission or any court to have engaged in any anti-competitive practice which had the effect of restricting the practice of licensed health care practitioners.
(5) The term "hospital" means an entity described in paragraphs (1) and (7) of section 1395x(e) of this title.
(6) The terms "licensed health care practitioner" and "practitioner" mean, with respect to a State, an individual (other than a physician) who is licensed or otherwise authorized by the State to provide health care services.
(7) The term "medical malpractice action or claim" means a written claim or demand for payment based on a health care provider's furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages.
(8) The term "physician" means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized).

Mass. Department of Public Health

Chapter 111: Section 51H. Reporting about healthcare-associated infections, serious reportable events, and serious adverse drug events; charges or reimbursement for resulting services prohibited

[Subsections (a) to (c) as amended by 2008, 451, Sec. 65 effective October 1, 2012. See 2008, 451, Sec. 192. For text effective until October 1, 2012, see above.]

Section 51H. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Facility", a hospital, institution for the care of unwed mothers or clinic providing ambulatory surgery as defined by section 25B.

"Healthcare-associated infection", a localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that: (i) occurs in a patient in a facility, (ii) was not present or incubating at the time of the admission during which the reaction occurs, and (iii) if occurring in a hospital, meets the criteria for a specific infection site as defined by the federal Centers for Disease Control and Prevention and its national health care safety network.

"Serious adverse drug event", any preventable event that causes inappropriate medication use in a hospital or ambulatory surgical center that leads to harm to a patient, as further defined in regulations of the department.

"Serious reportable event", an event that results in a serious adverse patient outcome that is clearly identifiable and measurable, reasonably preventable, and that meets any other criteria established by the department in regulations.

(b) A facility shall report data and information about healthcare-associated infections, serious reportable events, and serious adverse drug events. A serious reportable event

shall be reported by a facility no later than 15 working days after its discovery. Reports shall be made in the manner and form established by the department in its regulations. The department may require facilities to register in and report to nationally recognized quality and safety organizations.

(c) The department, through interagency service agreements, shall transmit data collected under this section to the Betsy Lehman center for patient safety and medical error reduction and to the health care quality and cost council for publication on its consumer health information website. Any facility failing to comply with this section may: (i) be fined up to $1,000 per day per violation; (ii) have its license revoked or suspended by the department; or (iii) be fined up to $1,000 per day per violation and have its license revoked or suspended by the department.

[Subsection (d) as amended by 2008, 451, Sec. 65 does not take effect. See 2008, 451, Sec. 192 and 2012, 118, Secs. 18 and 69.]

(d) The department shall promulgate regulations prohibiting a health care facility from charging or seeking reimbursement for services provided as a result of the occurrence of a serious reportable event. A health care facility shall not charge or seek reimbursement for **a serious reportable event** that the facility has determined, through a documented review process, and under regulations promulgated by the department, **was (i) preventable; (ii) within its control; and (iii) unambiguously the result of a system failure based on the health care provider's policies and procedures.**

[Subsection (d) as amended by 2012, 118, Sec. 18 effective October 1, 2012. See 2012, 118, Sec. 69. For text effective until October 1, 2012, see above.]

Mass. Board of Registration in Medicine

Chapter 112 Section 5C. Every insurer or risk management organization which provides professional liability insurance to a registered physician shall report to the board any claim or action for damages for personal injuries alleged to have been caused by error, omission, or negligence in the performance of such physician's professional services where such claim resulted in:

(a) A final judgment in any amount,

(b) A settlement in any amount, or

(c) A final disposition not resulting in payment on behalf of the insured.

Reports shall be filed with the board no later than thirty days following the occurrence of any event listed in paragraph (a), (b), or (c).

Such reports shall be in writing on a form prescribed by the board and shall contain the following information:

(a) the name, address, specialty coverage, and policy number of the physician against whom the claim is made; and

(b) name, address and age of the claimant or plaintiff; and

(c) nature and substance of the claim; and

(d) date when and place at which the claim arose; and

(e) the amounts paid, if any, and the date and manner of disposition, judgment, settlement, or otherwise; and

(f) the date and reason for final disposition, if no judgment or settlement; and

(g) such additional information as the board shall require. No insurer or its agents or employees shall be liable in any cause of action arising from reporting to the board as required in this section.

Chapter 112 Section 5E. Any registered physician who does not possess professional liability insurance shall report to the board every settlement or arbitration award of a claim or action for damages for death or personal injury caused by negligence, error or omission in practice, or the unauthorized rendering of professional services by such physician. Such report shall be made within thirty days after any such settlement agreement has been reduced to writing thereto or thirty days after service of such arbitration award on the parties and signed by all the parties. Failure of the physician to comply with the provisions of this section is an offense punishable by a fine of not more than five hundred dollars. Knowing and intentional failure to comply with the provisions of this section, or conspiracy or collusion not to comply with the provisions of this section, or to hinder or impede any other person in such compliance is an offense

punishable by a fine of not less than five thousand dollars nor more than fifty thousand dollars.

Section 91 of Chapter 38 of the Acts of 2013 reads as follows:

Clause (f) of the sixth paragraph of section 5 of chapter 112 of the General Laws, as appearing in section 115 of chapter 139 of the acts of 2012, is hereby amended by inserting after the words “that are pending” the following words:- ; provided, however, that payments made as part of a disclosure, apology and early offer program, shall not be construed to be reportable to or by the board against the physician, absent a determination of substandard care rendered on the part of said physician.

It was signed into law.