

CASE ABSTRACT FOR MALPRACTICE CLAIMS		1. DATE OF REPORT (YYYYMMDD)	2. CLAIMANT LAST NAME
3. TYPE OF REPORT (X one) <input type="checkbox"/> a. INITIAL <input type="checkbox"/> c. REVISION TO ACTION <input type="checkbox"/> b. CORRECTION OR ADDITION <input type="checkbox"/> d. VOID PREVIOUS REPORT		4. DATES OF ACT(S) OR OMISSION(S) (YYYYMMDD) a. BEGINNING DATE b. ENDING DATE	
5. DATE CLAIM FILED (YYYYMMDD)	6. DATE OF JUDGMENT OR SETTLEMENT (YYYYMMDD)	7. MEDICAL TREATMENT FACILITY a. NAME b. DMIS CODE	
8. PRACTITIONER INFORMATION			
a. NAME (Last, First, Middle Initial)		b. SSN	c. DATE OF BIRTH (YYYYMMDD)
d. NAME OF PROFESSIONAL SCHOOL ATTENDED		e. DATE GRADUATED (YYYYMMDD)	f. SPECIALTY CODE
g. STATUS (X one) <input type="checkbox"/> (1) Army <input type="checkbox"/> (2) Navy <input type="checkbox"/> (3) Air Force <input type="checkbox"/> (4) PHS <input type="checkbox"/> (5) Civilian GS <input type="checkbox"/> (6) Partnership Internal <input type="checkbox"/> (7) Partnership External <input type="checkbox"/> (8) Personal Services Contract <input type="checkbox"/> (9) Non-Personal Services Contract			
h. SOURCE OF ACCESSION (X all that apply)			
(1) Military <input type="checkbox"/> (a) Volunteer <input type="checkbox"/> (b) Armed Forces Health Professional Scholarship Program <input type="checkbox"/> (c) Uniformed Services University of Health Sciences <input type="checkbox"/> (d) National Guard <input type="checkbox"/> (e) Reserve <input type="checkbox"/> (f) Other (Specify)		(2) Civilian <input type="checkbox"/> (a) Civil Service <input type="checkbox"/> (b) Contracted <input type="checkbox"/> (c) Consultant <input type="checkbox"/> (d) Foreign National (Local Hire) <input type="checkbox"/> (e) Other (Specify)	
i. LICENSING INFORMATION			
(1) State of License		(2) License Number	(1) State of License
			(2) License Number
9. TYPE OF PRACTITIONER AND SPECIALTY (FIELD OF LICENSURE) (X all that apply)			
a. PHYSICIAN DEGREE <input type="checkbox"/> M.D. (010) <input type="checkbox"/> D.O. (020)			
(1) Highest Level of Specialization <input type="checkbox"/> (a) Board Certified <input type="checkbox"/> (b) Residency Completed <input type="checkbox"/> (c) In Residency (015/025) <input type="checkbox"/> (d) No Residency			
(2) Primary Specialty <input type="checkbox"/> (a) In Training <input type="checkbox"/> (b) General Practice (GMO) <input type="checkbox"/> (c) Anesthesiology <input type="checkbox"/> (d) Aviation Medicine <input type="checkbox"/> (e) Dermatology <input type="checkbox"/> (f) Emergency Medicine <input type="checkbox"/> (g) Family Practice <input type="checkbox"/> (h) Internal Medicine <input type="checkbox"/> (h.a) Gastroenterology <input type="checkbox"/> (h.b) Hematology - Oncology <input type="checkbox"/> (h.c) Infectious Disease <input type="checkbox"/> (h.d) Nephrology <input type="checkbox"/> (h.e) Pulmonary <input type="checkbox"/> (h.f) Rheumatology <input type="checkbox"/> (h.g) Tropical Medicine <input type="checkbox"/> (h.h) Allergy/Immunology <input type="checkbox"/> (h.i) Cardiology <input type="checkbox"/> (h.j) Endocrinology <input type="checkbox"/> (i) Neurology <input type="checkbox"/> (j) Obstetrics/Gynecology <input type="checkbox"/> (k) Ophthalmology <input type="checkbox"/> (l) Otorhinolaryngology <input type="checkbox"/> (m) Orthopedics <input type="checkbox"/> (n) Pathology <input type="checkbox"/> (o) Pediatrics <input type="checkbox"/> (p) Physical Medicine <input type="checkbox"/> (q) Preventive Medicine <input type="checkbox"/> (r) Psychiatry <input type="checkbox"/> (s) Radiology <input type="checkbox"/> (t) Surgery, General <input type="checkbox"/> (t.a) Cardio-Thoracic <input type="checkbox"/> (t.b) Colon-Rectal <input type="checkbox"/> (t.c) Neurosurgery <input type="checkbox"/> (t) Surgery, General (Cont.) <input type="checkbox"/> (t.d) Oncology <input type="checkbox"/> (t.e) Pediatric <input type="checkbox"/> (t.f) Peripheral Vascular <input type="checkbox"/> (t.g) Plastic <input type="checkbox"/> (u) Underseas Medicine <input type="checkbox"/> (v) Urology <input type="checkbox"/> (w) Intensivist <input type="checkbox"/> (x) Neonatologist <input type="checkbox"/> (y) Other (Specify)			
(3) Board Certification(s)			
b. DENTIST <input type="checkbox"/> DENTIST (030)			
(1) Highest Level of Specialization <input type="checkbox"/> (a) Board Certified <input type="checkbox"/> (b) Residency Completed <input type="checkbox"/> (c) In Residency (035) <input type="checkbox"/> (d) No Residency		(2) Primary Specialty <input type="checkbox"/> (a) General Dental Officer <input type="checkbox"/> (b) Oral Surgeon <input type="checkbox"/> (c) Other (Specify)	
(3) Board Certification(s)			
c. OTHER PRACTITIONERS <input type="checkbox"/> OTHER PRACTITIONERS			
<input type="checkbox"/> Audiologist (400) <input type="checkbox"/> Clinical Dietician (200) <input type="checkbox"/> Clinical Pharmacist (050) <input type="checkbox"/> Clinical Psychologist (370) <input type="checkbox"/> Clinical Social Worker (300)	<input type="checkbox"/> Nurse Anesthetist (110) <input type="checkbox"/> Nurse Midwife (120) <input type="checkbox"/> Nurse Practitioner (130) <input type="checkbox"/> Occupational Therapist (410)	<input type="checkbox"/> Optometrist (636) <input type="checkbox"/> Physical Therapist (430) <input type="checkbox"/> Physician Assistant (642) <input type="checkbox"/> Podiatrist (350) <input type="checkbox"/> Speech Pathologist (450)	<input type="checkbox"/> Registered Nurse (100) <input type="checkbox"/> Emergency Medical Technician <input type="checkbox"/> Other (Specify)

**10. PATIENT DEMOGRAPHICS**

a. NAME (Last, First, Middle Initial)	b. SEX (X one) <input type="checkbox"/> (1) Male <input type="checkbox"/> (2) Female <input type="checkbox"/> (3) Unknown	c. AGE
d. STATUS (X and complete as applicable) <input type="checkbox"/> (1) Dependent of Active Duty <input type="checkbox"/> (3) Retired Member <input type="checkbox"/> (5) Active Duty <input type="checkbox"/> (2) Dependent of Retired Member <input type="checkbox"/> (4) Civilian Emergency <input type="checkbox"/> (6) Other (Specify)		e. SSN OF SPONSOR

<b>11. DIAGNOSES</b>	<b>ICD9-CM CODE</b>	<b>12. PROCEDURES</b>	<b>ICD9-CM CODE</b>
a. (Primary)		a. (Primary)	
b.		b.	
c.		c.	

**13. PATIENT ALLEGATION(S) OF NEGLIGENT CARE**

a. DESCRIPTION OF THE ACTS OR OMISSIONS AND INJURIES UPON WHICH THE ACTION OR CLAIM WAS BASED (Limit to 300 characters.)

b. ACT OR OMISSION CODE(S) (Refer to table on Page 4)			c. CLINICAL SERVICE CODE	
<input type="checkbox"/> (1) Primary Act or Omission Code	<input type="checkbox"/> (2) Additional Act or Omission Code	<input type="checkbox"/> (1) Primary		
<input type="checkbox"/> (3) Additional Act or Omission Code	<input type="checkbox"/> (4) Additional Act or Omission Code	<input type="checkbox"/> (2) Secondary		
<input type="checkbox"/> (5) Additional Act or Omission Code	<input type="checkbox"/> (6) Additional Act or Omission Code	<input type="checkbox"/> (3) Tertiary		

d. DESCRIPTION OF FINDINGS ON WHICH THE ACTION OR CLAIM WAS PAID

**14. MALPRACTICE CLAIM MANAGEMENT**

a. AMOUNT CLAIMED	b. ADJUDICATIVE BODY CASE NUMBER	c. ADJUDICATIVE BODY NAME	d. DATE OF PAYMENT (YYYYMMDD)
e. OUTCOME (X one) <input type="checkbox"/> (1) Administratively Settled (Service) <input type="checkbox"/> (2) Denied: Dismissed by Plaintiff or by Agreement		<input type="checkbox"/> (3) Denied: Statute of Limitations <input type="checkbox"/> (4) Denied: FERES <input type="checkbox"/> (5) Denied: Not a Legitimate Claim, Non-Meritorious <input type="checkbox"/> (6) Litigated: Decision for Plaintiff <input type="checkbox"/> (7) Litigated: Decision for U.S. <input type="checkbox"/> (8) Litigated: Out of Court Settlement (DOJ) <input type="checkbox"/> (9) Other (Specify)	
f. AMOUNT PAID	g. NUMBER OF CLAIMS FOR THIS INCIDENT	h. NUMBER OF PRACTITIONERS ON WHOSE BEHALF PAYMENT WAS MADE	

**CUI (when filled in)**

**15. PROFESSIONAL REVIEW ASSESSMENT BY MEDICAL TREATMENT FACILITY**

<b>a. ATTRIBUTION OF CAUSE</b> <i>(X all that apply)</i> <input type="checkbox"/> (1) Facility or Equipment <input type="checkbox"/> (2) Physician <input type="checkbox"/> (3) Personnel other than Physician <input type="checkbox"/> (4) Management <input type="checkbox"/> (5) System			<b>b. EVALUATION OF CARE</b> <i>(X one)</i> <input type="checkbox"/> (1) Met <input type="checkbox"/> (2) Not Met <input type="checkbox"/> (3) Indeterminate	
<b>c. IDENTIFY LOCATION OF CARE</b> <i>(X one)</i> <input type="checkbox"/> (1) Ambulatory Clinic <input type="checkbox"/> (2) Inpatient Clinic <input type="checkbox"/> (3) Dental Service <input type="checkbox"/> (4) Emergency <input type="checkbox"/> (5) Other <i>(Specify)</i>				
<b>d. INJURY SEVERITY</b> <i>(X one)</i> <input type="checkbox"/> (1) None <input type="checkbox"/> (2) Some <input type="checkbox"/> (3) Death			<b>e. INJURY DURATION</b> <i>(X one)</i> <input type="checkbox"/> (1) Temporary <input type="checkbox"/> (2) Permanent <input type="checkbox"/> (3) Cannot Predict/Undetermined	

**16. ASSESSMENT**

<b>a. AFIP REQUIRED?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(Evaluation of Care. X one)</i> <input type="checkbox"/> (1) Met <input type="checkbox"/> (2) Not Met <input type="checkbox"/> (3) Indeterminate				
<b>b. OTHER ASSESSMENTS</b>				
(1) UCA or Name			<input type="checkbox"/> (1) Met <input type="checkbox"/> (2) Not Met <input type="checkbox"/> (3) Indeterminate	
(1) UCA or Name			<input type="checkbox"/> (1) Met <input type="checkbox"/> (2) Not Met <input type="checkbox"/> (3) Indeterminate	
(1) UCA or Name			<input type="checkbox"/> (1) Met <input type="checkbox"/> (2) Not Met <input type="checkbox"/> (3) Indeterminate	
(1) UCA or Name			<input type="checkbox"/> (1) Met <input type="checkbox"/> (2) Not Met <input type="checkbox"/> (3) Indeterminate	

<b>c. FINAL OTSG DETERMINATION ACT OR OMISSION CODE(S)</b> <i>(Refer to table on Page 4)</i>				<b>d. CLINICAL SERVICE CODE</b>	
	(1) Primary Act or Omission Code		(2) Additional Act or Omission Code		(1) Primary
	(3) Additional Act or Omission Code		(4) Additional Act or Omission Code		(2) Secondary
	(5) Additional Act or Omission Code		(6) Additional Act or Omission Code		(3) Tertiary
<b>17. STANDARD OF CARE (OTSG DETERMINATION)</b> <i>(X one)</i> <input type="checkbox"/> MET <input type="checkbox"/> NOT MET				<b>18. NPDB REPORTED</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	

**19. REMARKS**

## 20. ACT OR OMISSION CODES

\*NOC = Not Otherwise Classified

DIAGNOSIS RELATED

- 010 Failure to diagnose (i.e., concluding that patient has no disease or condition)
- 020 Wrong diagnosis (misdiagnosis, i.e., original diagnosis is incorrect)
- 030 Improper performance of test
- 040 Unnecessary diagnostic test
- 050 Delay in diagnosis
- 060 Failure to obtain consent/lack of informed consent
- 090 Diagnosis related (NOC)\*

ANESTHESIA RELATED

- 110 Failure to complete patient assessment
- 120 Failure to monitor
- 130 Failure to test equipment
- 140 Improper choice of anesthesia agent or equipment
- 150 Improper technique/induction
- 160 Improper equipment use
- 170 Improper intubation
- 180 Improper positioning
- 185 Failure to obtain consent/lack of informed consent
- 190 Anesthesia related (NOC)\*

SURGERY RELATED

- 210 Failure to perform surgery
- 220 Improper positioning
- 230 Retained foreign body
- 240 Wrong body part
- 250 Improper performance of surgery
- 260 Unnecessary surgery
- 270 Delay in surgery
- 280 Improper management of surgical patient
- 285 Failure to obtain consent for surgery/lack of informed consent
- 290 Surgery related (NOC)\*

MEDICATION RELATED

- 305 Failure to order appropriate medication
- 310 Wrong medication ordered
- 315 Wrong dosage ordered of correct medication
- 320 Failure to instruct on medication
- 325 Improper management of medication program
- 330 Failure to obtain consent for medication/lack of informed consent
- 340 Medication error (NOC)\*
- 350 Failure to medicate
- 355 Wrong medication administered
- 360 Wrong dosage administered
- 365 Wrong patient
- 370 Wrong route
- 380 Improper technique
- 390 Medication administration related (NOC)\*

INTRAVENOUS AND BLOOD PRODUCTS RELATED

- 410 Failure to monitor
- 420 Wrong solution
- 430 Improper performance
- 440 IV related (NOC)\*
- 450 Failure to insure contamination free
- 460 Wrong type
- 470 Improper administration
- 480 Failure to obtain consent/lack of informed consent
- 490 Blood product related (NOC)\*

OBSTETRICS RELATED

- 505 Failure to manage pregnancy
- 510 Improper choice of delivery method
- 520 Improperly performed vaginal delivery
- 525 Improperly performed C-section
- 530 Delay in delivery (induction or surgery)
- 540 Failure to obtain consent/lack of informed consent
- 550 Improperly managed labor (NOC)\*
- 555 Failure to identify/treat fetal distress
- 560 Delay in treatment of fetal distress (i.e., identified but treated in untimely manner)
- 570 Retained foreign body/vaginal/uterine
- 580 Abandonment
- 590 Wrongful life/birth
- 590 Obstetrics related (NOC)\*

TREATMENT RELATED

- 610 Failure to treat
- 620 Wrong treatment/procedure performed (also improper choice)
- 630 Failure to instruct patient on self care
- 640 Improper performance of a treatment/procedure
- 650 Improper management of course of treatment
- 660 Unnecessary treatment
- 665 Delay in treatment
- 670 Premature end of treatment (also abandonment)
- 675 Failure to supervise treatment/procedure
- 680 Failure to obtain consent for treatment/lack of informed consent
- 685 Failure to refer/seek consultation
- 690 Treatment related (NOC)\*

MONITORING

- 710 Failure to monitor
- 720 Failure to respond to patient
- 730 Failure to report on patient condition
- 790 Monitoring related (NOC)

BIOMEDICAL EQUIPMENT/PRODUCT RELATED

- 810 Failure to inspect/monitor
- 820 Improper maintenance
- 830 Improper use
- 840 Failure to respond to warning
- 850 Failure to instruct patient on use of equipment/product
- 860 Malfunction/failure
- 890 Biomedical equipment/product related (NOC)\*

MISCELLANEOUS

- 910 Inappropriate behavior of clinician (i.e., sexual misconduct allegation, assault)
- 920 Failure to protect third parties (i.e., failure to warn/protect from violent patient behavior)
- 930 Breach of confidentiality/privacy
- 940 Failure to maintain appropriate infection control
- 950 Failure to follow institutional policy or procedure
- 960 Other (Provide detailed written description)
- 990 Failure to review provider performance