NATIONAL PRACTITIONER DATA BANK (NPDB)

INTERFACE CONTROL DOCUMENT (ICD) FOR MEDICAL MALPRACTICE PAYMENT REPORT (MMPR) XML TRANSACTIONS

Version 1.07

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Health Resources and Services Administration
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The table below identifies changes that have been incorporated into each baseline of this document.

Date	Version #	Change Description
10/17/2005	1.01	Below is a summary of changes to the Interface Control Document (ICD) for Medical Malpractice Payment Report (MMPR) XML Transactions version 1.01. Effective October 17, 2005, this ICD version 1.01 replaces version 1.0. The changes in this version are indicated below: Rules of Behavior • Added an appendix that describes the Rules of Behavior. See Appendix B. Occupation/Field of Licensure Codes • Modified the Heading Nurses Aide/Home Health Aide to Nurse Aide, Home Health Aide and Other Aide. See Section 4.4, List C. • Added the New Codes 148, 165, 175 under the Heading Nurse Aide, Home Health Aide and Other Aide. See Section 4.4, List C. • Added the New Code 470 under the Heading Speech, Language, and Hearing Service Provider. See Section 4.4, List C. Error Codes • Modified error code descriptions and added new error codes. See Section 4.4, List G.
5/8/2006	1.02	Below is a summary of changes to the Interface Control Document (ICD) for Medical Malpractice Payment Report (MMPR) XML Transactions version 1.02. Effective May 8, 2006, this ICD version 1.02 replaces version 1.01. The changes in this version are indicated below: • The Data Banks' Web site is now located at www.npdb-hipdb.hrsa.gov. The Data Banks are using a .gov domain name to help prevent fraud by showing Data Banks' users that the NPDB-HIPDB Web site is under the Government-run domain. Please update your Internet bookmarks to reference the .gov address for the Data Banks' Web site. NPDB-HIPDB Web site references in this document now refer to the new Web site address. • Due to the NPDB-HIPDB Web site address change, all ITP and QRXS client programs must be upgraded to a new version. Updated client programs are now available on the NPDB-HIPDB Web site. While the current versions of the ITP and Querying and Reporting XML Service (QRXS) client programs will continue to function for a limited time, all ITP and QRXS users must upgrade their client program to the new version no later than September 18, 2006.

Date	Version #	Change Description
7/31/2006	1.03	Below is a summary of changes to the Interface Control Document (ICD) for Medical Malpractice Payment Report (MMPR) XML Transactions version 1.03. Effective July 31, 2006, this ICD version 1.03 replaces version 1.02. The changes in this version are indicated below: • Updated descriptions for Specific Allegation Codes 101, 323, 706, and 708. See Section 4-4, List E. • Updated description for Outcome Code 08. See Section 4-4, List F. • Removed unused error codes and added error code AF. See Section 4.4, List G.
	1.04	Not Publicly Released
3/31/2008	1.05	Below is a summary of changes to the Interface Control Document (ICD) for Medical Malpractice Payment Report (MMPR) XML Transactions version 1.05. Effective March 31, 2008, this ICD version 1.05 replaces version 1.03. The changes in this version are indicated below: Password Change Transaction Specifications • Created ability for users to change passwords using the QRXS. See the Interface Control Document (ICD) for Password Change XML Transactions, and Section 1. Data Bank Correspondence • Created ability for the Data Banks to send text-based messages to individual users with an entity. See Sections 1.2.4, 2.2.4, 3.39, and 3.40 and Table 4-1. Report Change Notifications • Created ability for the reporting entity to receive QRXS-based report change notifications. Report change notifications will also be available through the IQRS. The entity will continue to receive paper notifications through the mail. The IQRS allows the entity administrator to opt-out of receiving paper versions of report change notifications. See Sections 1.2.3, 2.2.3, 3.37, and 3.38, Table 4-1, and Lists H and I. Reporting Compliance Notice • Added a Data Bank Reporting Compliance Notice to Initial Report responses indicating whether the submitted report was filed with the Data Banks within the timeframe required by law. See Sections 3.21 and 3.23, and Table 4-1. Reporting Entity's Current Contact Information • Created the ability to return the reporting entity's current contact information related to a report. See Sections 3.25 and 3-27, Table 4-1 and List J.

Date	Version #	Change Description
		Support for International Telephone Numbers • Added support for international telephone numbers. See Section 3.6 and Table 4-1. Expanded Narrative Description Elements • Expanded narrative description elements from 2,000 to 4,000 characters. See Table 4-1. Error Codes • Expanded the error message element from 2,000 to 4,000 characters. See Table 4-1.
6/16/2008	1.06	Below is a summary of changes to the Interface Control Document (ICD) for Medical Malpractice Payment Report (MMPR) XML Transactions version 1.06. Effective June 16, 2008, this ICD version 1.06 replaces version 1.05. The changes in this version are indicated below: • Report Change Notifications Added Legacy MMPR format. See Section 3.32, 3.33, and section 4.4, List K. Individual, Section 3.7, Figure 12 • Changed the maximum number of other Occupation and Licensures from 9 to 19.
6/16/2008	1.06.01	Below is a summary of changes to the Interface Control Document (ICD) for Medical Malpractice Payment Report (MMPR) XML Transactions version 1.06.01. Effective June 16, 2008, this ICD version 1.06.01 replaces version 1.06. The changes in this version are indicated below: Individual, Section 3.7, Figure 12 • Changed the maximum number of other Occupation and Licensures from 19 to 59.
9/2/2008	1.07	Below is a summary of changes to the Interface Control Document (ICD) for Medical Malpractice Payment Report (MMPR) XML Transactions version 1.07. Effective September 2, 2008, this ICD version 1.07 replaces version 1.06.01. The changes in this version are indicated below: Error Codes. See Section 4.4, List G. • Modified description for error code 20.

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1. Overview

1.1 Introduction

This Interface Control Document (ICD) provides information concerning the format, structure, and content of electronic files for submitting Medical Malpractice Payment Reports (MMPRs) via the Querying and Reporting XML Service (QRXS) client program to the National Practitioner Data Bank (NPDB).

There are three methods for submitting reports to the NPDB-HIPDB:

- Interactively via the Internet using the Integrated Querying and Reporting Service (IQRS).
- Through an XML transaction file submission, the QRXS with data provided in the format specified in this ICD.
- Through an electronic transaction file submission, the ICD Transfer Program (ITP), with the data provided in the format specified in *Interface Control Document (ICD) for Medical Malpractice Payment Report (MMPR) Transactions*, available at *www.npdb-hipdb.hrsa.gov/itp.html*. For new users that wish to submit MMPRs electronically, the QRXS is the recommended method.

The IQRS is the primary method of report submission. The IQRS allows reporters to submit single reports through a Web-based interface using a browser. In addition, users can create draft versions of reports prior to submission. The IQRS also provides data validation capabilities and allows maintenance of a subject database for subsequent query or report submissions. Submission by QRXS is an alternative for those reporters who generate reports from custom (third-party) software or other special purpose software.

To report to the NPDB, an entity must be authorized under Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended and 45 CFR Part 60, and must be registered with the NPDB. Certain entities also must report to the Healthcare Integrity and Protection Data Bank (HIPDB). To report to the HIPDB, an entity must be authorized under Section 1128E of the *Social Security Act* and 45 CFR Part 61, and must be registered with the HIPDB. Attempts to access the Data Banks by unauthorized entities or persons are punishable by fine and/or imprisonment under Federal statute. Do not attempt to access the Integrated Querying and Reporting Service (IQRS) or use this document until you are properly registered with the NPDB-HIPDB.

This document should be used only for submitting (i.e., reporting) MMPRs to the NPDB. Health care-related criminal convictions and civil judgments that are reportable to the HIPDB must be submitted using the Judgment or Conviction Reports (JOCR) Transaction Specifications. Adverse Action Reports (AAR) must be submitted to the NPDB using the AAR Transaction Specifications. Password change transactions must be submitted to the Data Banks using the Password Change Transaction Specifications. To query the NPDB, the HIPDB, or both Data Banks, you may use the IQRS, or use the ICD for Query Transactions with the ITP Interface, available at *www.npdb-hipdb.hrsa.gov/itp.html*. Only authorized and registered users are permitted to query the Data Bank(s).

Use of the procedures outlined in this ICD signifies acceptance of the Disclaimer in Appendix A and the Rules of Behavior in Appendix B. Should you have questions concerning your responsibilities, please contact the Customer Service Center immediately as specified in Section 1.5, Contact Information.

1.2 Types of Transactions

There are four types of transaction related to reports:

1. Report submission transactions
2. Report change notification transactions
3. Password change transactions
4. Data Bank correspondence transactions

1.2.1 Report Submission and Response Transactions

All report submissions sent to the Data Bank(s) must specify the type of report. The report type will determine the format and structure of the report submission, and how the report submission is processed. Initial and Correction report submissions must include one of the codes defined for the transaction data element of the report record in Section 4.1, Data Dictionary – Elements. Void report submissions are identified using the void record.

The types of reports are defined as follows:

> **Initial**: The first record of a medical malpractice payment submitted to and processed by the NPDB. An Initial report is the current version of the report until a Correction or Void is submitted.
>
> **Correction**: A report that corrects an error or omission in an existing report. The Correction will supersede the contents of a current version of a report in the NPDB. It should be submitted as soon as possible after a reporting error or omission is discovered. Corrections may be submitted as often as necessary.
>
> **Void**: The retraction of a report in its entirety from the NPDB. The report is removed from the subject's disclosable record.

1.2.2 Report Change Notification Transactions

Once a report has been accepted by the Data Banks, it may be corrected or voided by the submitting entity. The subject of the report may also choose to dispute the report, add a statement, or request that the Secretary of Health and Human Services (HHS) review the disputed report. This transaction provides the latest version of the report to the reporting entity.

While the QRXS does not accept legacy MMPR submissions, the entity administrator can use the IQRS to elect to receive legacy MMPR report change notifications via the QRXS. This ICD also documents the legacy MMPR format.

The entity administrator can also use the IQRS to elect to stop receiving paper copies of changed reports.

1.2.3 Password Change Transactions

This transaction enables a user and an administrator to change their passwords and enables an administrator to reset a user's password. This type of transaction is documented the Password Change Transaction Specification, which includes an ICD, XML Schema, and sample files, and is available at *www.npdb-hipdb.hrsa.gov/qrxs.html*.

1.2.4 Data Bank Correspondence Transactions

This transaction enables the Data Banks to communicate important messages to an entity's users. This type of transaction is documented in this ICD.

1.3 Submission of Reports to the NPDB-HIPDB

This ICD specifies the data elements (variables), data types, acceptable values and codes, organization, and format for submitting MMPRs to the NPDB by the QRXS and for interpreting (i.e., parsing) electronic transaction responses received from the QRXS. QRXS files submitted to the NPDB system will be validated against the specifications in this document, which may be amended periodically. All mandatory fields must be completed, and only values specified in this ICD may be used in coded fields. The party submitting a transaction file to the NPDB is solely responsible for ensuring that the file adheres to the format specified in this ICD. The Data Banks recommend that submitters use an XML Schema validator to validate the structure and format of submission files. Any file that deviates from these specifications will be rejected.

1.3.1 The QRXS Client Program

XML files are transferred electronically to and from the NPDB-HIPDB system via the QRXS client program. The QRXS client and user guide are available on the NPDB-HIPDB Web site at *www.npdb-hipdb.hrsa.gov/qrxs.html*. For security, all communication with the QRXS is transmitted over a secure socket layer (SSL) connection.

1.4 User Account Security

1.4.1 User Accounts

Each entity has two types of accounts to access the Data Banks, the administrator account and user accounts. The administrator account is used to create and manage the user accounts. User accounts are used to submit transactions and retrieve responses from the Data Banks. The Data Banks have established security policies in order to reduce the risk of unauthorized access to user accounts and protect the confidentiality of practitioner reports.

1.4.2 New Entity Registration Passwords

New entities that register with the Data Banks will receive registration information via U.S. mail that includes a Data Bank Identification Number (DBID), the administrator account User ID, and a temporary administrator account password. A newly registered entity is required to log in to the IQRS or QRXS and change the administrator account password within 30 calendar days of the registration verification mailing date. If an entity does not log in to the IQRS or QRXS within 30 calendar days of the registration verification mailing date, the registration password will expire, the account is automatically locked, and the administrator must contact the Data Banks to reset the password.

1.4.3 User Account Password Policies

A user must provide their organization's DBID, their user ID, and user account password each time they access the IQRS, ITP, or QRXS. If a valid password is not provided after five consecutive attempts, the user account is locked and the user must contact the entity administrator to submit a user account password reset request. For more information, see the Password Change Transaction Specifications.

Users are required to change their account password **every 90 calendar days.** An IQRS or QRXS password change request can be submitted at any time to change an account's password. QRXS password change transactions must be submitted to the Data Banks using the Password Change Transaction Specifications. Once a password expires, a **30 calendar day** grace login period is available to allow the account password to be changed. Once a password has expired, the NPDB-HIPDB will not accept submissions and access will not be permitted to response files from that account until the account

password is successfully changed. Once the grace login period is expired, the account is automatically locked and the user must use the IQRS to change the password or contact the entity administrator to reset the user's password.

NOTE: In order to use the IQRS to change a password once the grace login period has expired, a user must have an e-mail address stored in their user account in the IQRS. An e-mail will be sent to the user to enable the expired password to be changed.

To ensure the security and privacy of user account passwords when using QRXS, the response to a password change request transaction can only be downloaded by the same user account that submitted the transaction.

1.4.4 Resetting Password

When a user forgets his or her password, or is locked out of the IQRS, ITP, or QRXS, the entity administrator is responsible for providing a new Data Banks-generated temporary password to the user. A Data Banks-generated temporary password is valid for three calendar days and must be changed by the user before the user can submit transactions or retrieve response files. Only the administrator can submit and download transactions to reset user passwords using QRXS. The administrator cannot reset his or her own password. A password change transaction should be submitted instead of a password reset transaction.

To ensure that the current administrator is correctly identified in the Data Banks, he or she must log in to the IQRS and update the administrator's user account with the administrator's name, title, telephone number, and e-mail address.

If the entity's administrator forgets his or her password, or is locked out of the IQRS or QRXS, the administrator must call the NPDB-HIPDB Customer Service Center to receive a Data Banks-generated temporary password. If the administrator's name is not maintained in the administrator's IQRS user account, the company's certifying official will be required to submit a signed, faxed request for the change on company letterhead. The Customer Service Center will respond by immediately changing the old administrator password and contacting the new administrator with a Data Banks-generated temporary password and instructions for updating the administrator's user account. These temporary passwords (user and administrator) will only be valid for three calendar days. The user/administrator should change his or her password immediately; and no grace login period will be permitted.

1.4.5 Submission of Password Change/Reset Transactions to the Data Banks

The password change transactions can be submitted to the Data Banks using the Password Change Transaction Specifications, which include an ICD, XML Schema, and sample files, and is available at *www.npdb-hipdb.hrsa.gov/qrxs.html*.

1.5 Contact Information

Periodic updates are made to the ICD for MMPR XML Transactions by the Data Banks. To receive advance notice of QRXS news and system changes, users should join the QRXS Mailing List at *www.npdb-hipdb.hrsa.gov/MailingListReg.html*.

The Data Banks make an effort to notify users at least one month in advance of an update to code lists. Users should expect code lists to be updated quarterly. Additional updates to the XML Schema files are required periodically. Users will be notified six months in advance of updates to the XML Schema files. If you are already registered for the QRXS Mailing List and would like to be removed, contact the Customer Service Center.

For specific questions concerning registration or NPDB-HIPDB reporting requirements, contact the NPDB-HIPDB Customer Service Center by e-mail at *npdb-hipdb@sra.com* or by phone at

1-800-767-6732 (TDD 703-802-9395). Only authorized and registered users may report to or query the Data Bank(s). The *Entity Registration* form, information regarding NPDB-HIPDB policies and procedures, and the specifications are available at *www.npdb-hipdb.hrsa.gov*.

1.6 On-line Resources

The QRXS resources are available for download at *www.npdb-hipdb.hrsa.gov/qrxs.html*. The Web site contains:

- This ICD, in PDF format.
- The QRXS distribution package containing the stand-alone client program that transmits files containing report data to, and receives response files from the Data Banks, as well as supporting documentation for the client program Application Programming Interface (API).
- The QRXS Client Program User Guide, in PDF format.
- The XML Schema files for this ICD.
- Sample report submission and response files for each transaction type.
- The ICD for Password Change Transactions, in PDF format..
- The XML Schema files for the ICD for Password Change Transactions.
- Sample Password Change Transactions submission and response files.

1.7 Document Organization

This document is organized into four sections and two appendices.

Section 1, Overview, contains a brief description of the ICD and information concerning user account security.

Section 2, Transaction File Formats, contains the general submission and response file formats and explains how to read the schema diagrams.

Section 3, Transaction File Data Records, contains the format for and the contents of the submission and response files.

Section 4, Reports and Data Definitions, contains the element definitions and common MMPR codes found within the schema, and it contains the list of error codes.

Appendix A, Disclaimer, specifies the terms and conditions for using this ICD. This appendix defines the limit of responsibility for the information contained in and the use of this ICD.

Appendix B, Rules of Behavior, specifies the conditions that must be followed to gain access and obtain information from and report to the NPDB-HIPDB system.

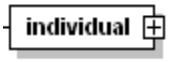
2. Transaction File Formats

Reports sent to the NPDB system are referred to as submission files. Responses sent by the NPDB to each reporter who submitted a report (via electronic transaction file) are referred to as response files. A submission file may contain multiple transactions. Responses are limited to one per file.

Submissions and responses are XML documents that conform to the MMPR schema written in the W3C XML Schema Language (version 1.0). The specifications (the schema and this ICD) for submission and response files are available at *www.npdb-hipdb.hrsa.gov/qrxs.html*. Submission files should be checked for schema compliance using an XML Schema validator prior to submission.

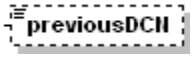
Section 3, Transaction File Data Records, defines the format and content of data records within a transaction file. Section 4, Reports and Data Definitions, defines each of the data elements in the file formats. The data fields required for a file depend on the type of transaction submitted. For example, the transaction file format for submitting an initial MMPR contains a different set of data records than the transaction file format for voiding a previously submitted MMPR. Data that are always required are indicated in the record formats in Section 3, Transfer File Data Records. Rules for data that may be optional or conditionally required are indicated in the data dictionary.

Below is a guide to the format diagrams:

A box with a solid line 

surrounds required elements.

The little box on the right side of the element displaying a "+" or "–" indicates that the element is a complex type. The "+"means that the simple elements in the complex type are not displayed in the same figure where as the "–" indicates that the simple elements are displayed.

A box with a dashed line surrounds 

elements that may be optional (depending on the type of transaction).

The cardinality of an element is indicated with a range 

if more than one instance may be allowed.

The symbol  denotes a schema sequence; elements in the sequence must appear in the order shown.

The symbol  denotes a schema choice; only one of the elements shown may appear in the record.

2.1 Submission File Format

An MMPR Submission File consists of a Submitter Record and one or more submissions. Record formats are described in Section 3, Transaction File Data Records.

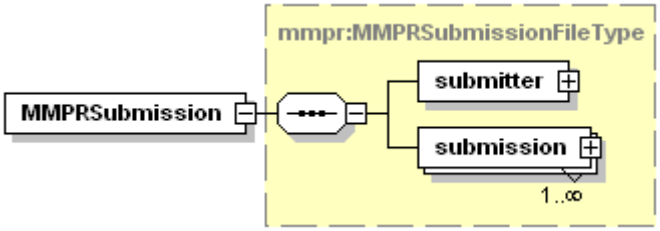


Figure 1: MMPR Submission File

2.2 Response File Formats

A valid submission will generate a response for each transaction in the Submission File. Accepted transactions result in a Report Response File. Rejected transactions result in a Report Rejection File. Report Change Notifications and Data Bank Correspondence transactions are not specifically based upon a previous report submission. Report Change Notification transactions result in a Report Change Notification Response File. Data Bank Correspondence transactions result in a Correspondence Response File.

2.2.1 Report Response

A Report Response File contains one submitter record and one response record. Record formats are described in Section 3, Transaction File Data Records.

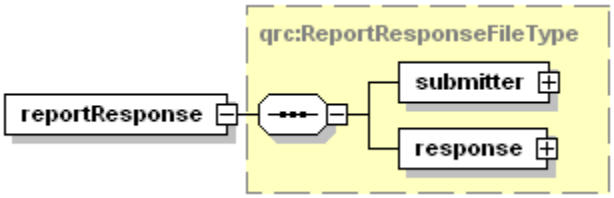


Figure 2: MMPR Report Response File

2.2.2 Report Rejection

A Report Rejection File contains one submitter record and one rejection record. Record formats are described in Section 3, Transaction File Data Records.

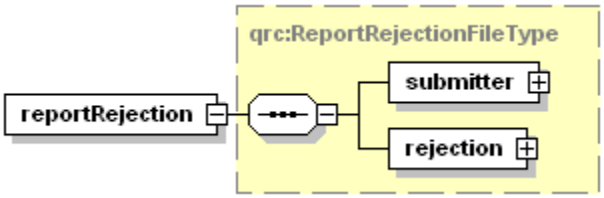


Figure 3: MMPR Report Rejection File

2.2.3 Report Change Notification

A Report Change Notification File contains one record providing general transaction information, and two records describing the reason for the notification and why the report changed, followed by one report or void record. Record formats are described in Section 3, Transaction File Data Records.

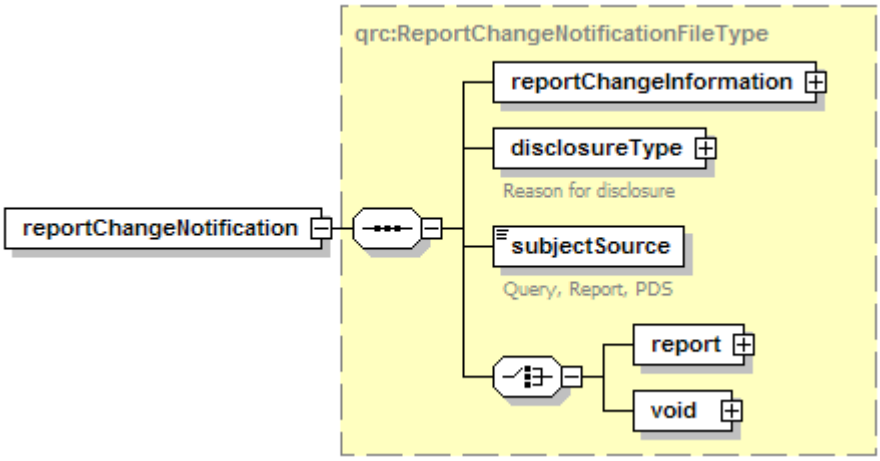


Figure 4: Report Change Notification File

2.2.4 Correspondence

A Correspondence File contains one recipient record identifying who the message is for and one response record. Record formats are described in Section 3, Transaction File Data Records.

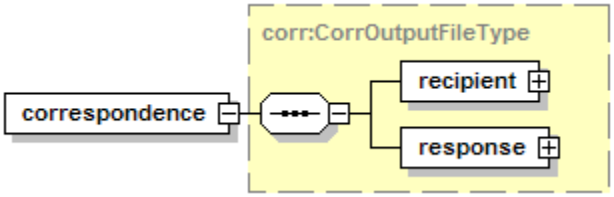


Figure 5: Correspondence File

3. Transaction File Data Records

The format and content of data records within a transaction file are defined in the W3C XML Schema Language. The specifications (the schema and this ICD) for the data records can be found on-line at *www.npdb-hipdb.hrsa.gov/qrxs.html*. A single data record type may be used in multiple transaction file formats.

All elements in a data record are either mandatory, or mandatory if known. Refer to Section 4, Reports and Data Definitions to determine the specific requirements for the information being reported. Mandatory fields must be completed or the report **will be rejected**. If an element is 'mandatory if known' and the reporting entity does not have the information, the field **must be omitted entirely** rather than contain a default or empty value.

The record elements are defined in Section 4.1, Data Dictionary – Elements. The description, format, and length are given for each element. An element may appear in multiple records.

Unless otherwise noted, the specified width represents the maximum number of characters allowed for the element. **All fields larger than the specified field width will be truncated**. Data values that are shorter than the specified field width should not be padded with additional characters. **Reports submitted using an incorrect record format or invalid codes will be rejected**.

The schema specifies that the UTF-8 character set must be used. Submitted reports must not contain American Standard Code for Information Interchange (ASCII) characters outside the range of 32 to 126 or the report will be rejected.

Record types are organized into logical groups using XML Schema types and namespaces. Simple and complex types (e.g., Individual Name, Address, Occupation and Licensure) that are common to the XML MMPR format specification are defined in lower-level schemas so that they can be used to define higher-level records. Some elements are described as being optional in order to provide a flexible schema that can be used to submit all action types reportable to the Data Banks. Refer to Section 4.2, Data Dictionary – Subject Data and Section 4.3, Data Dictionary – Medical Malpractice Payment Data to determine which elements are required for reporting a medical malpractice payment.

3.1 Submitter

The Submitter Record is required for every Submission File and included in every response. The agent DBID is used by an agent submitting a report on behalf of an entity.

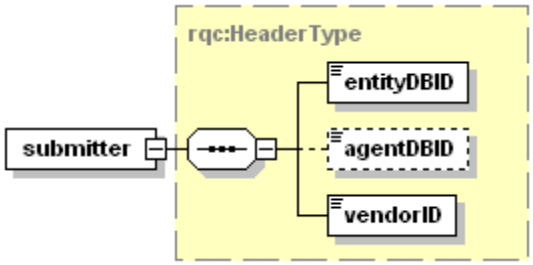


Figure 6: Submitter Record

3.2 Submission

The Submission Record contains the information for a single transaction. The record is repeated for each report submitted in the Submission File.

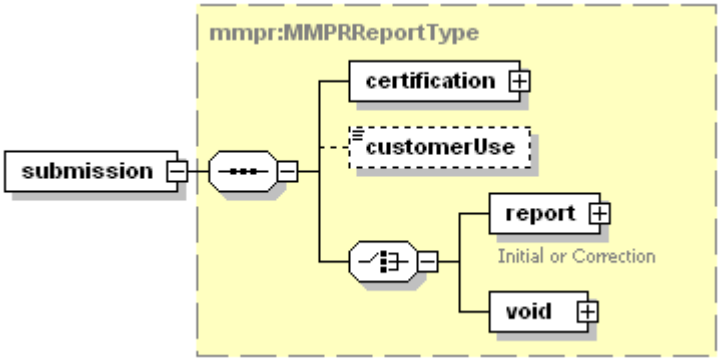


Figure 7: Submission Record

3.3 Certification

The Certification Record contains the information for the authorized submitter of the transaction or the person to contact regarding the report.

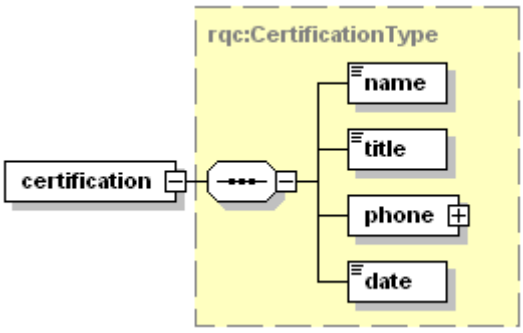


Figure 8: Certification Record

3.4 Report

The Report Record contains the subject and report data for Initial and Correction transactions.

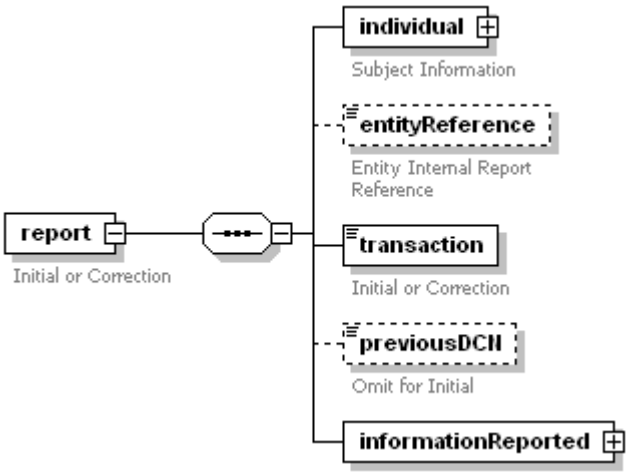


Figure 9: Report Record

3.5 Void

The Void Record contains the report number of the report that is to be voided.

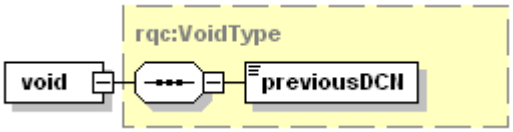


Figure 10: Void Record

3.6 Phone

The Phone Record contains phone number information. The phone number is required (no formatting allowed) and an optional extension may be specified.

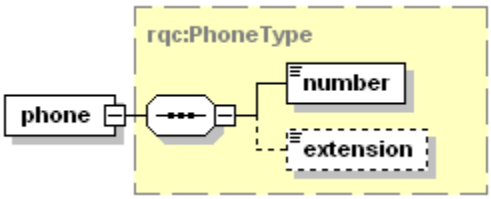


Figure 11: Phone Record

3.7 Individual

The Individual Record contains the subject information for a reported individual. Refer to Section 4.2, Data Dictionary – Subject Data, for specific individual subject requirements.

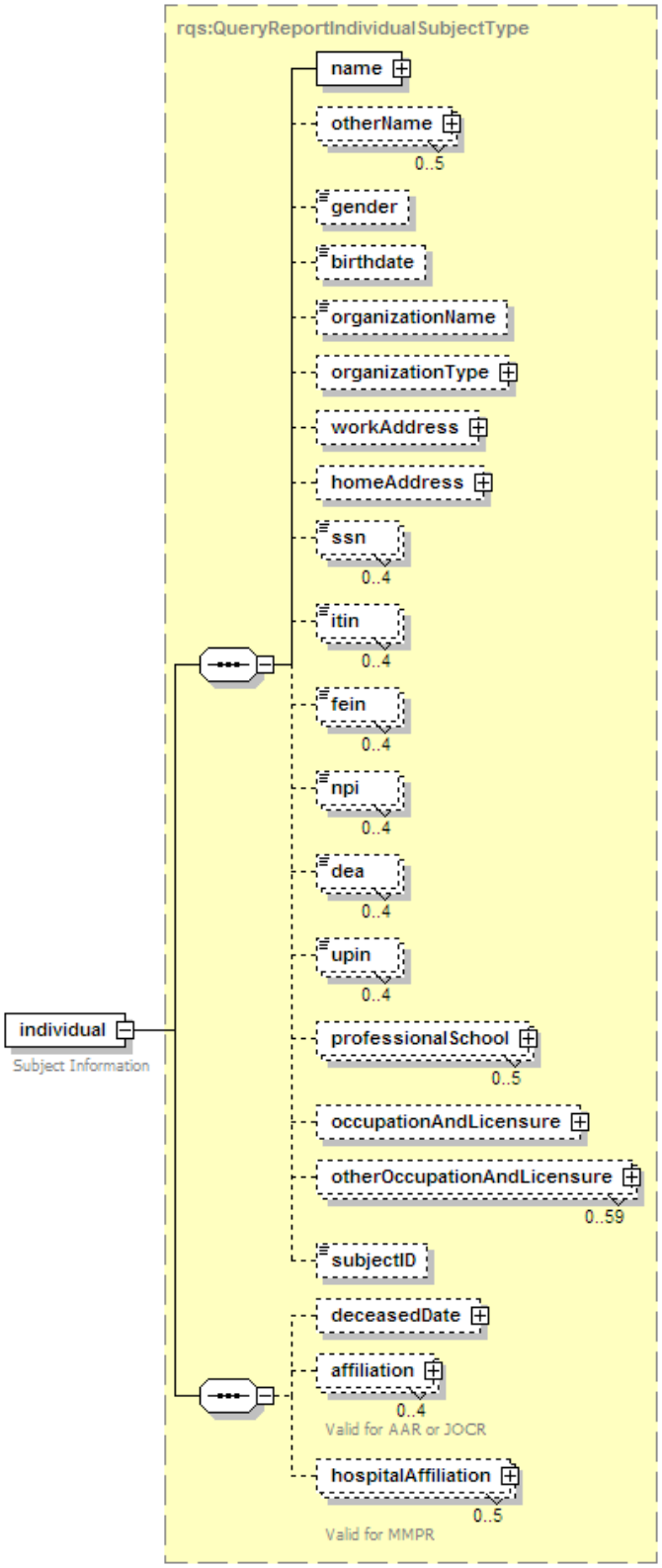


Figure 12: Individual Record

3.8 Name, Other Name

The Name Record contains the name data for an individual subject. First and last are always required for any name specified.

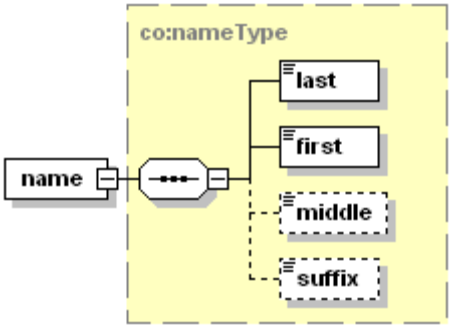


Figure 13: Name Record

3.9 Organization Type

The Organization Type Record is not reportable for MMPRs. Do not submit this information.

3.10 Work Address, Home Address, Address

The Address Type Record contains the information for a subject's address and an affiliate's address. For U.S. addresses, address, city, state, zip are required and country must be omitted. For non-U.S. addresses, address, city and country are required. See Section 4.4, List A: State Abbreviations and U.S. Territories for all rules regarding non-U.S. or military addresses.

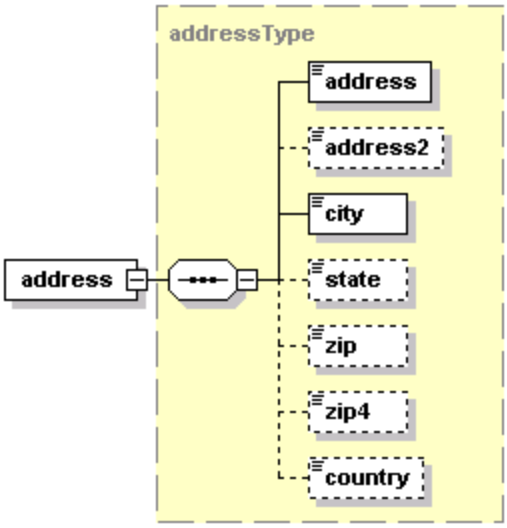


Figure 14: Address Record

3.11 Professional School

The Professional School Record contains the school and graduation year of an individual subject. All fields are required when a school is specified.

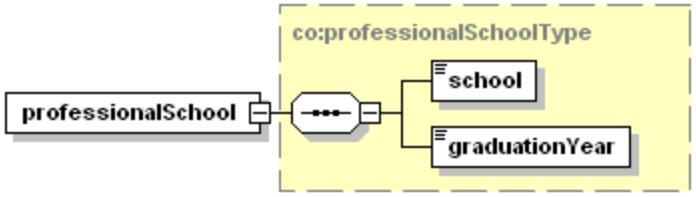


Figure 15: Professional School Record

3.12 Occupation and Licensure, Other Occupation and Licensure

The Occupation and Licensure Record contains the professional occupation and licensure information for an individual subject. Either number or noLicense is required. Specialty is not allowed for MMPRs.

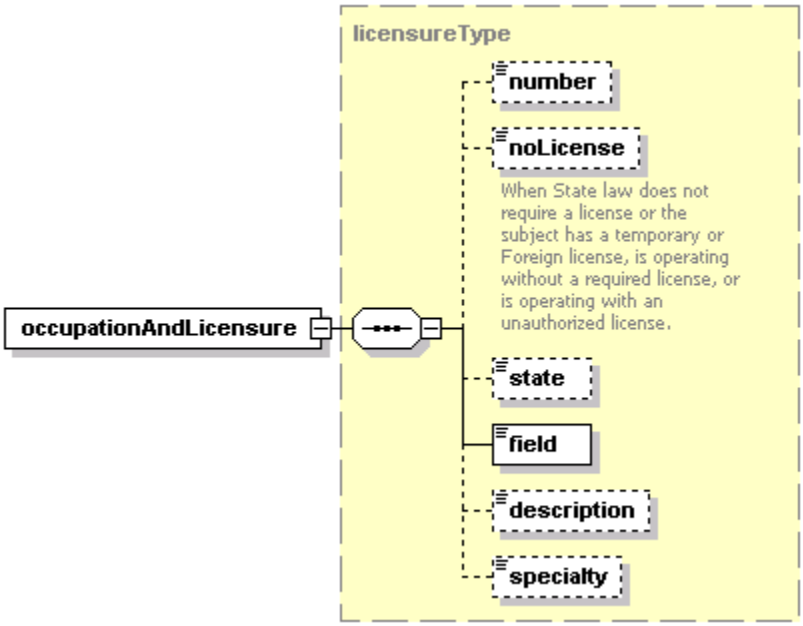


Figure 16: Occupation and Licensure Record

3.13 Deceased Date

The Deceased Date Record contains the deceased status of an individual subject.

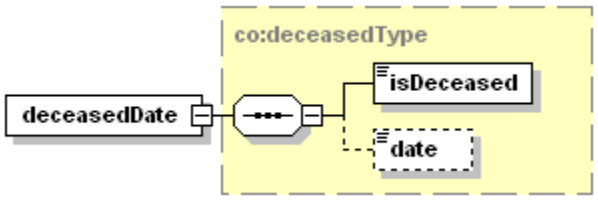


Figure 17: Deceased Date Record

3.14 Affiliation

The Affiliation Record is not reportable for MMPRs; use the Hospital Affiliation Record instead.

3.15 Hospital Affiliation

The Hospital Affiliation Record contains a subject's hospital affiliation(s).

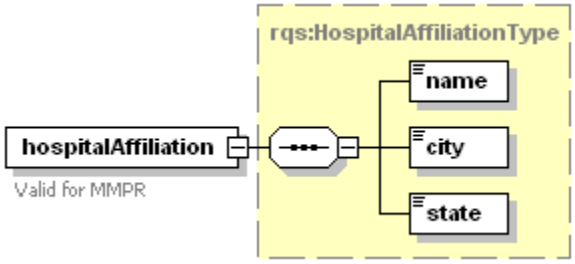


Figure 18: Hospital Affiliation Record

3.16 Information Reported (MMPR)

The MMPR Information Reported Record contains the report data for an MMPR. Refer to Section 4.3, Data Dictionary – Medical Malpractice Payment for detailed requirements.

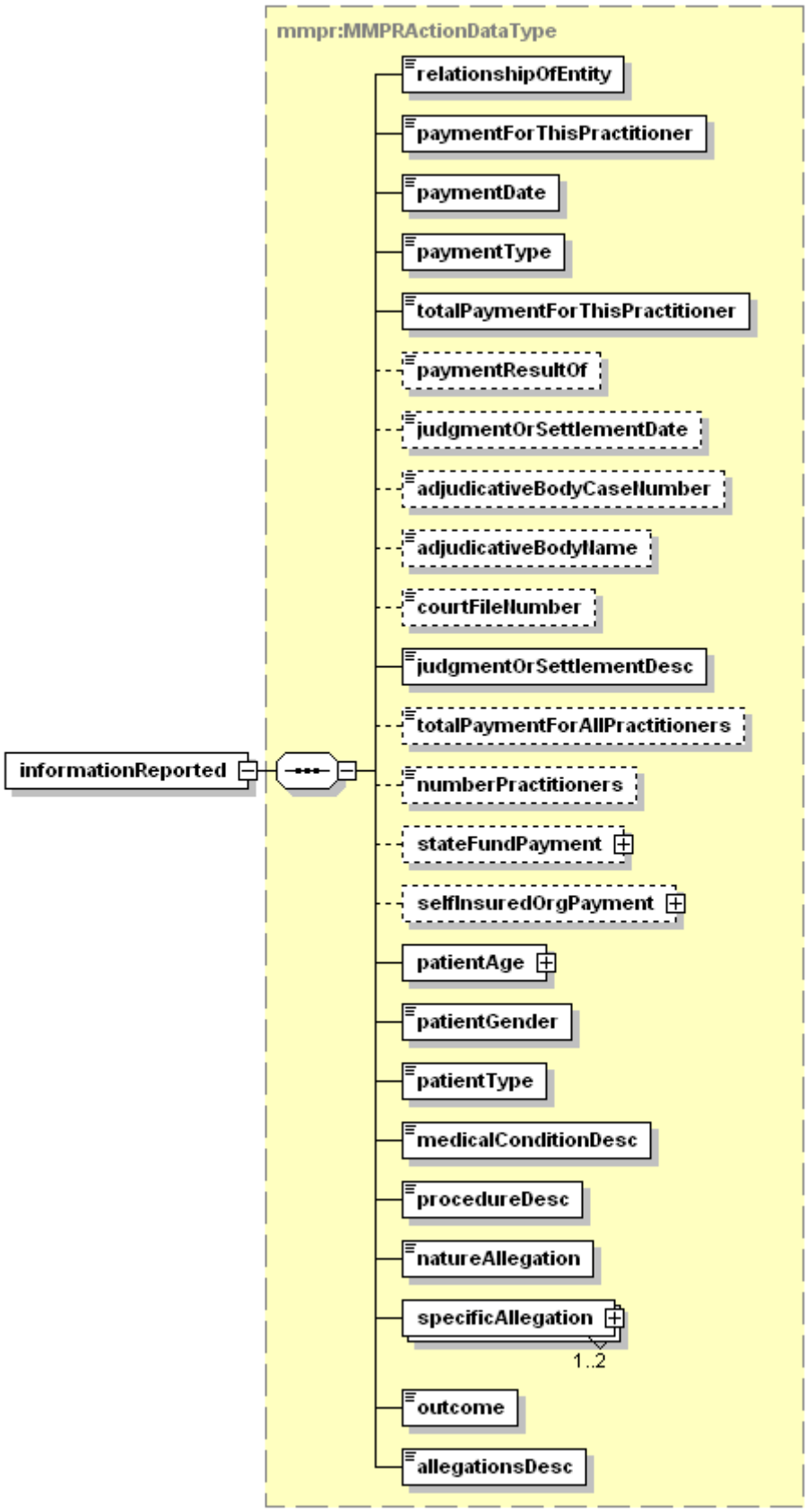


Figure 19: MMPR Information Reported Record

3.17 State Fund Payment

The State Fund Payment Record contains payment information made by a state guaranty fund or state excess judgment fund. This payment is made by a state guaranty fund or state excess judgment fund in addition to the payment made by the reporting entity. Only include this information if your entity is an insurance company or self-insured organization.

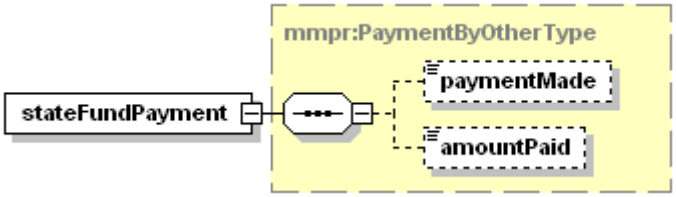


Figure 20: State Fund Payment Record

3.18 Self-Insured Organization Payment

The Self-Insured Organization Payment Record contains payment information made by a self-insured organization and/or other insurance company/companies. This payment is made by a self-insured organization and/or other insurance company/companies in addition to the payment made by the reporting entity. Only include this information if your entity is an insurance company, an insurance guaranty fund or a state medical malpractice payment fund.

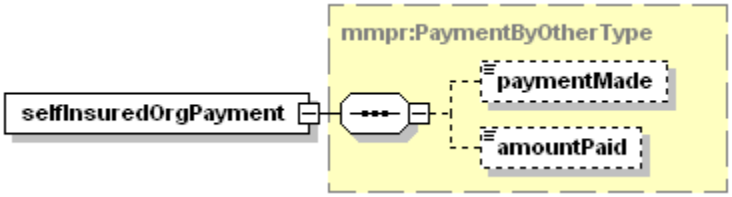


Figure 21: Self-Insured Organization Payment Record

3.19 Patient Age

The Patient Age Record contains the age of the patient at the time of the initial event. Enter the age in days if the patient is less than one month old or a fetus, in months if the patient is less than one year old and in years if the patient is one or older. Enter an age of zero days if the patient is a fetus.

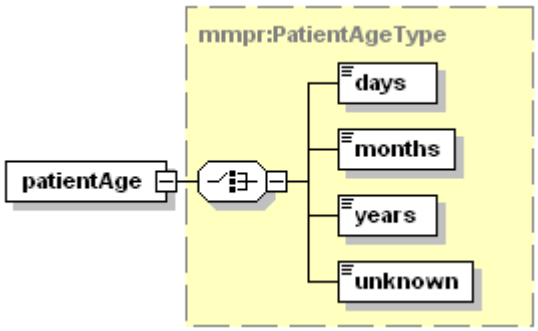


Figure 22: Patient Age Record

3.20 Specific Allegation

The Specific Allegation Record contains the subject's alleged acts or omissions.

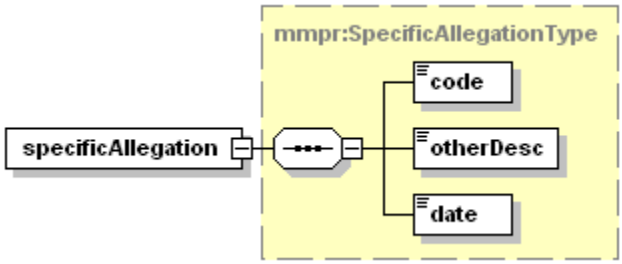


Figure 23: Specific Allegation Record

3.21 Response

The Response Record contains the response information for a report that was accepted and successfully processed. MMPR Response information will only contain Initial or Correction reports on Individual subjects.

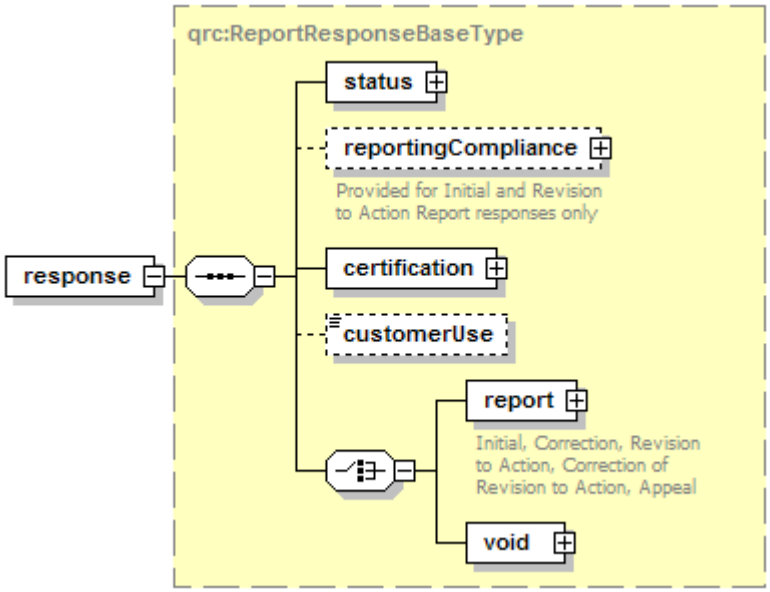


Figure 24: Response Record

3.22 Status

The Status Record contains the information associated with the receipt of the report.

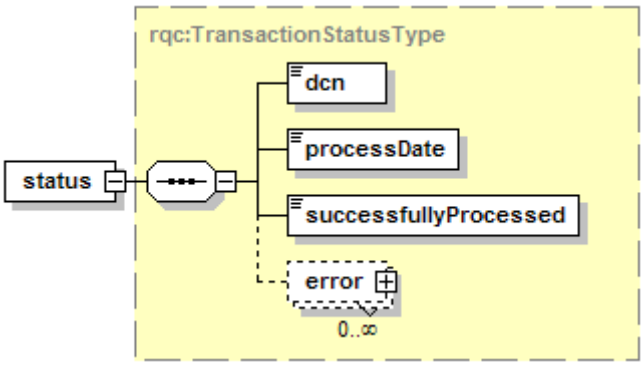


Figure 25: Status Record

3.23 Reporting Compliance

The Reporting Compliance Record contains the information indicating whether the submitted report was filed with the Data Banks within the timeframe required by law. This record is provided only in report responses for Initial Report submissions.

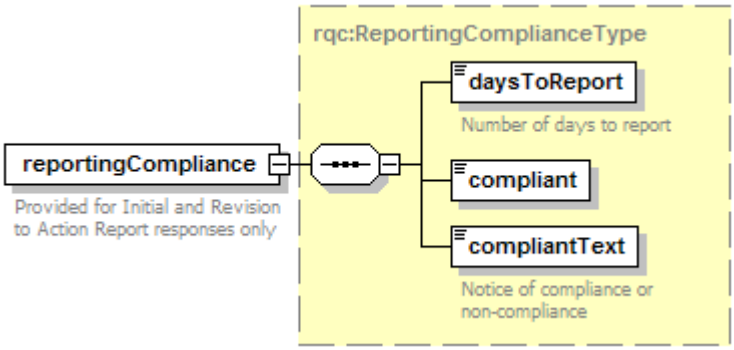


Figure 26: Reporting Compliance Record

3.24 Error

The Error Record contains the information for any errors that occurred during the processing of the report.

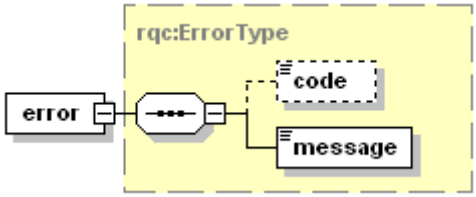


Figure 27: Error Record

3.25 Report (Response)

The Report (Response) Record contains the report information returned in a response. MMPR Report (Response) information will only contain Initial or Correction reports on Individual subjects.

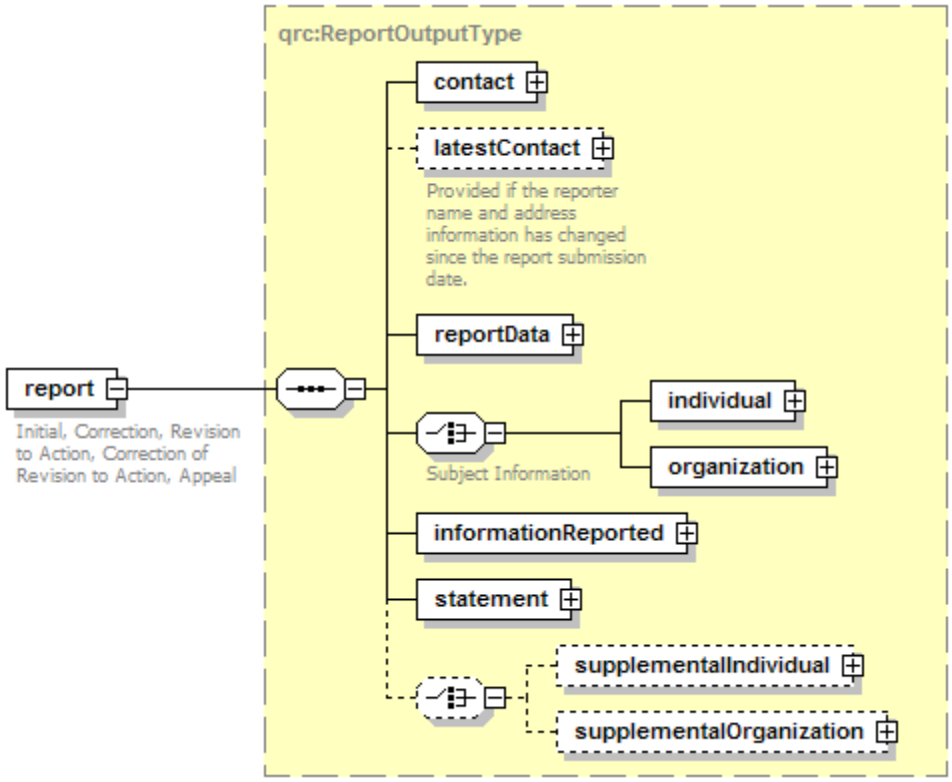


Figure 28: Report (Response) Record

3.26 Contact

The Contact Record contains the contact information for the reporting entity.

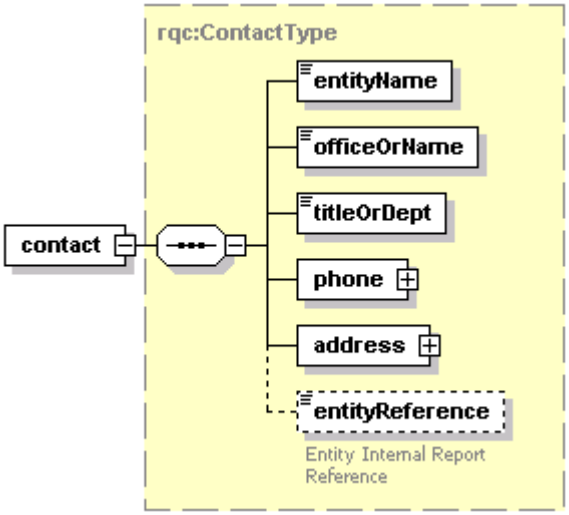


Figure 29: Contact Record

3.27 Latest Contact

The Latest Contact Record contains the most recent contact information on file with the Data Banks for the reporting entity. This record is provided if the reporter name and address information has changed since the report submission date. Point of contact information (officeOrName, titleOrDept, and phone) is only provided when the entity has a successor and the successor has provided that information to the Data Banks.

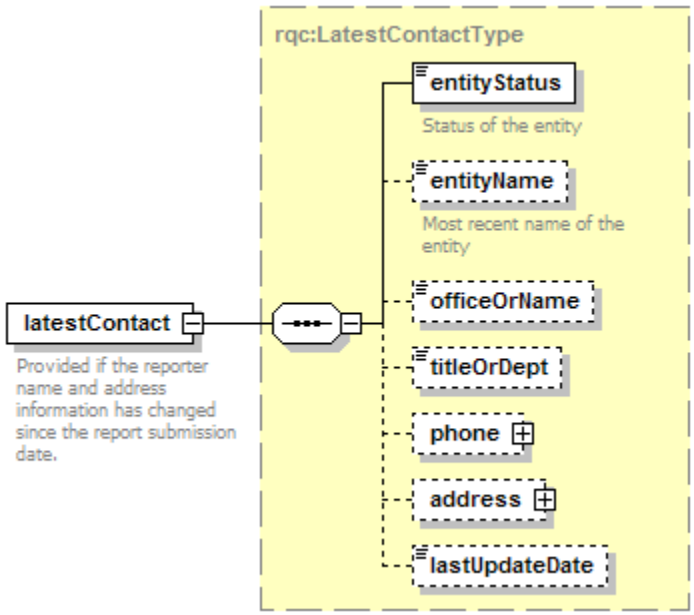


Figure 30: Latest Contact Record

3.28 Report Data

The Report Data Record contains the information for the report submission transaction type, dates, and statutory authority for maintaining the report in the Data Bank(s). The previousTransaction, latestRelatedDCN, latestRelatedTransaction, latestRelatedNote fields are not applicable for MMPRs and will not be provided for any responses.

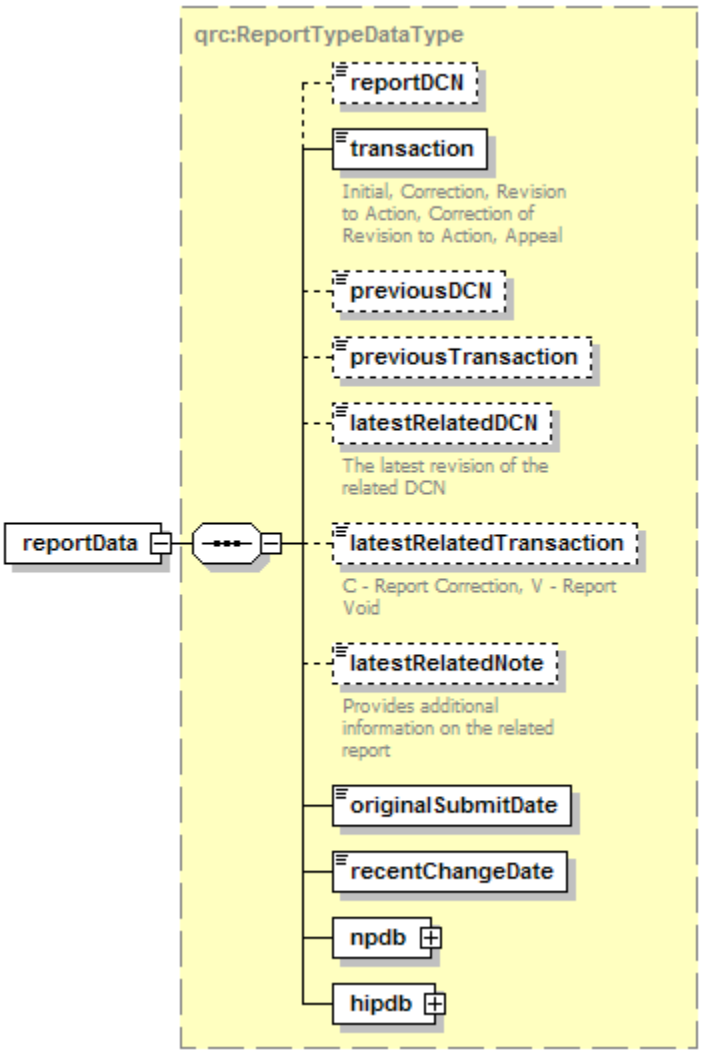


Figure 31: Report Data Record

3.29 NPDB

The NPDB Authority Record contains the statutory authority information for maintaining and disclosing the report.

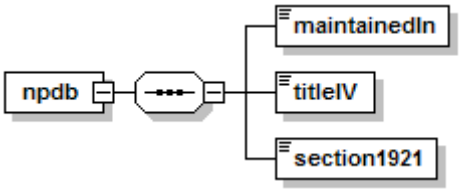


Figure 32: NPDB Authority Record

3.30 HIPDB

The HIPDB Authority Record contains the statutory authority information for maintaining and disclosing the report. Medical Malpractice Payments are not maintained in the HIPDB, so maintainedIn will always be false.

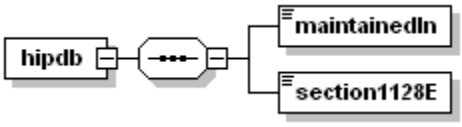


Figure 33: HIPDB Authority Record

3.31 Information Reported (Response, Rejection, Report Change)

The Information Reported Record contains the same information as the Information Reported Record from the report submission. It will be an Information Reported (MMPR) Record for an MMPR submission. It will be an Information Reported (MMPR) Record, or Legacy MMPR Record, for an MMPR report change notice.

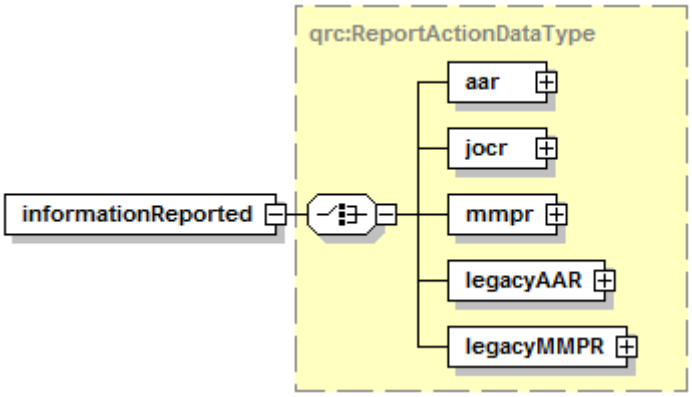


Figure 34: Information Reported Record (Response, Rejection, Report Change)

3.32 Legacy MMPR

The Legacy MMPR Record contains the information reported for a Legacy MMPR report.

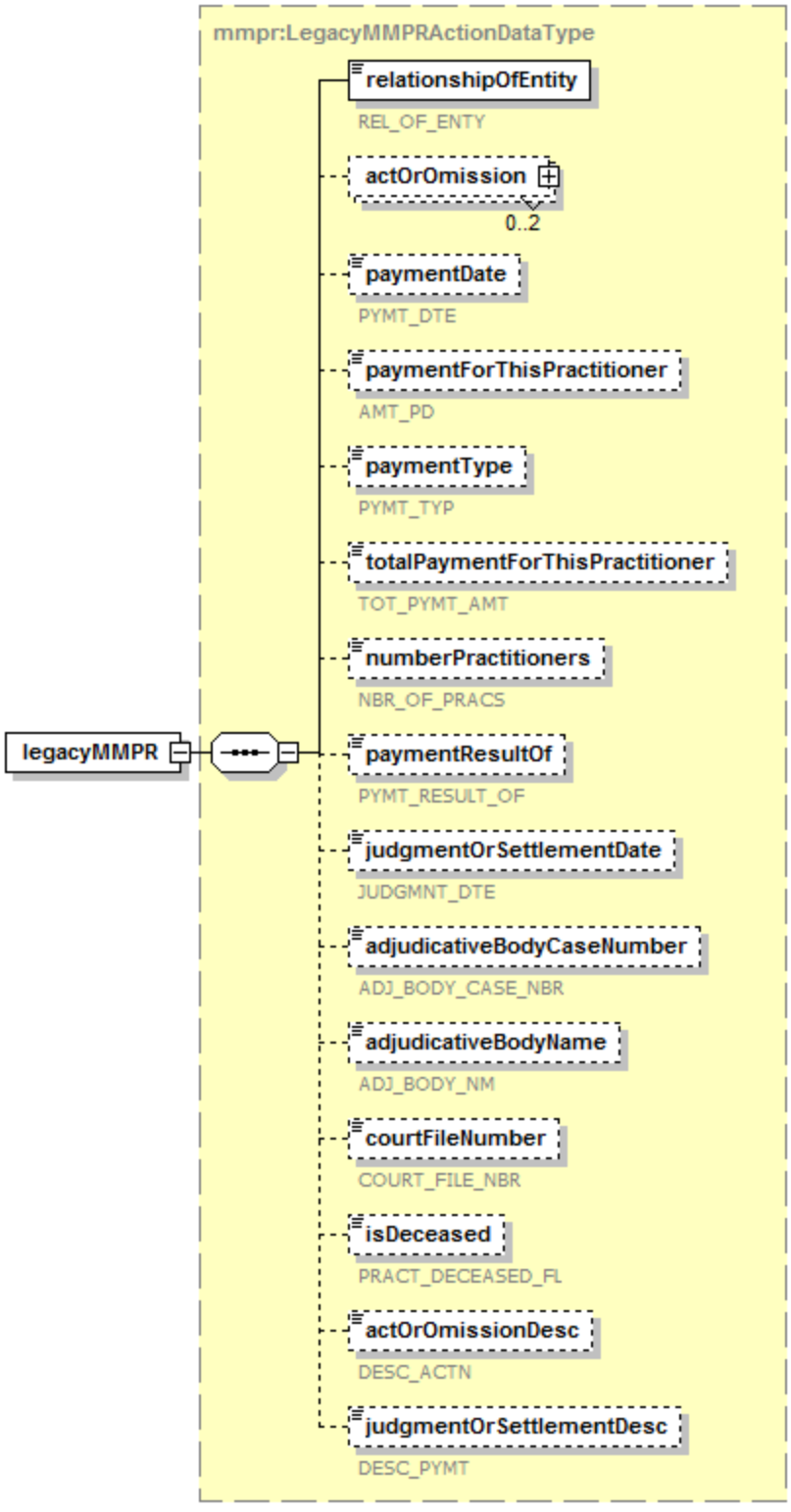


Figure 35: Legacy MMPR Record

3.33 Act or Omission

The Act or Omission Record contains the act or omission reported for a Legacy MMPR report.

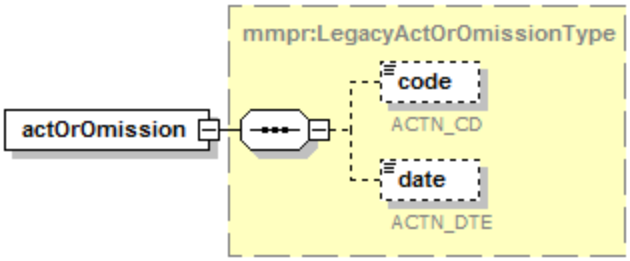


Figure 36: Act or Omission Record

3.34 Statement

The Statement Record contains the statements associated with the report and the dispute status.

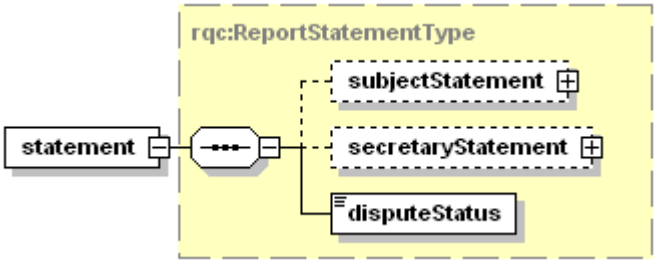


Figure 37: Statement Record

3.35 Subject Statement, Secretary Statement

The Subject Statement Record contains the statement information for the report's subject. The Secretary Statement contains the statement information from the Secretary of the U.S. Department of Health and Human Services.

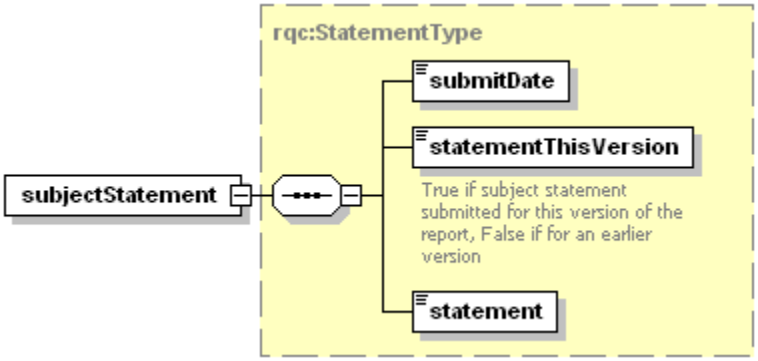


Figure 38: Subject Statement Record

3.36 Supplemental Individual

The Supplemental Individual Record contains the supplemental information associated with an individual subject. Information in this data record was not provided by the reporting entity. This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report. This disclaimer should be clearly identified on generated reports.

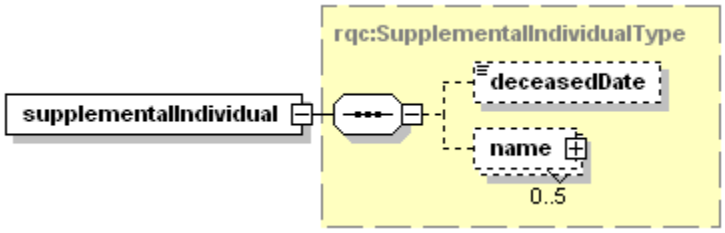


Figure 39: Supplemental Individual Record

3.37 Rejection

The Rejection Record contains the response information for a report that was not accepted or was not successfully processed. MMPR Rejection information will contain responses only for Initial, Correction or Void reports.

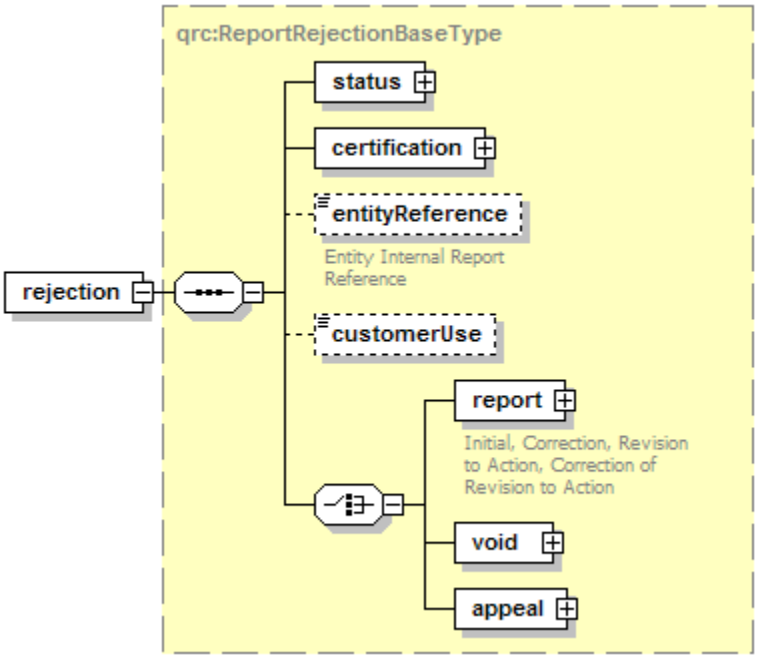


Figure 40: Rejection Record

3.38 Report (Rejection)

The Rejection Report Record contains the report information returned in a rejection.

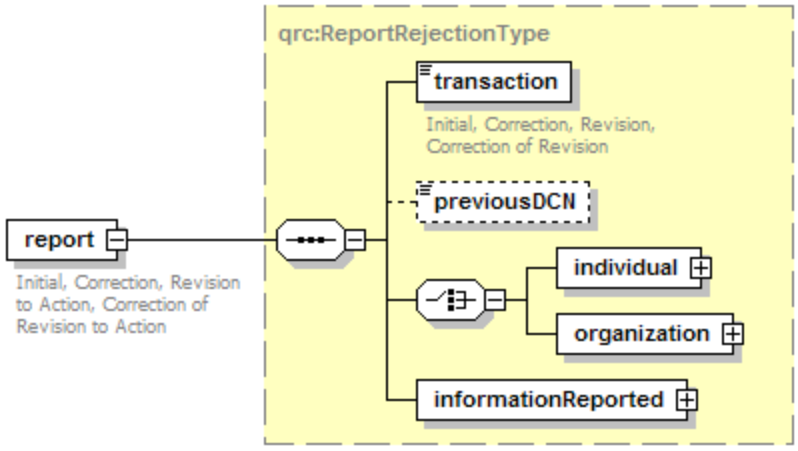


Figure 41: Rejection Report Record

3.39 Report Change Information

The Report Change Information Record contains general report change information.

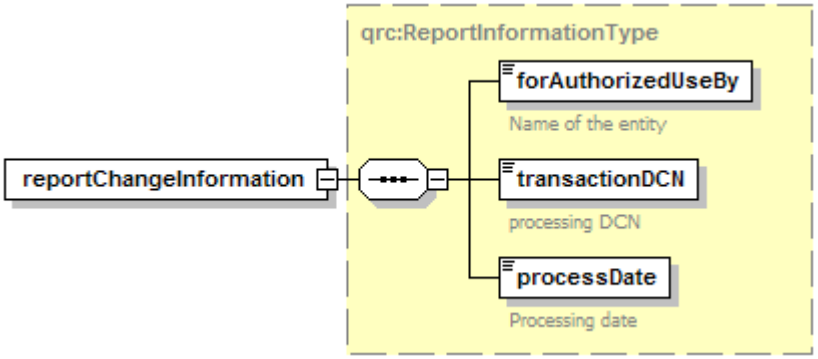


Figure 42: Report Change Information Record

3.40 Disclosure Type

The Disclosure Type Record contains the description of the change to the report.

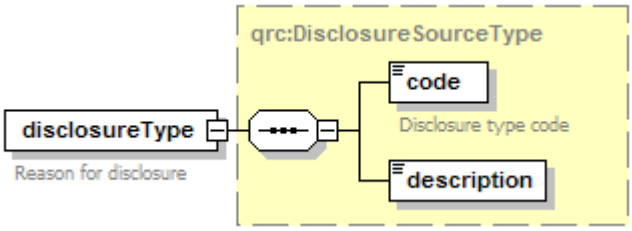


Figure 43: Report Disclosure Record

3.41 Recipient

The Recipient Record is included in every Data Bank Correspondence response and identifies for whom the message is intended.

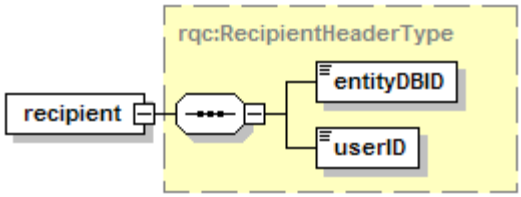


Figure 44: Recipient Record

3.42 Response (Correspondence)

The Correspondence Response Record contains the message information.

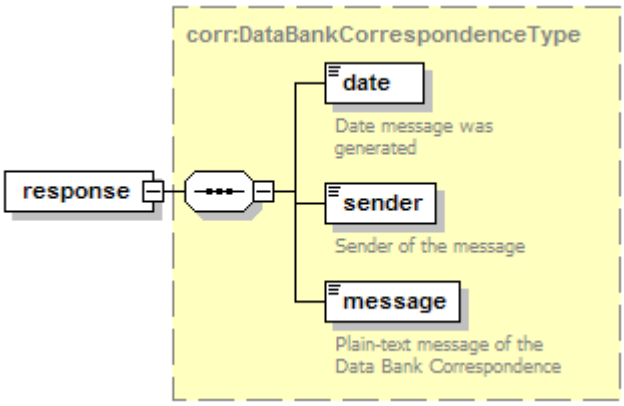


Figure 45: Response (Correspondence) Record

4. Reports and Data Definitions

4.1 Data Dictionary – Elements

The data dictionary defines each element that appears in the MMPR schemas (Submission, Response, and Rejection, and Correspondence). Data must follow the specified type according to the following codes:

A = Alphanumeric.
C = Code (refer to the appropriate code list in Section 4.4 or the data description).
D = Date (YYYY-MM-DD). Dates are specified using the XML Schema date type unless noted otherwise.
N = Numeric.
B = Boolean (true, false, 1, 0). Boolean values are specified using the XML Schema Boolean type unless noted otherwise.
M = Monetary (NNNN.NN). Specify dollars and cents (do not include dollar sign; include decimal point; max value 999999999.99; must be greater than 0.00 if a required field).

Unless otherwise noted, the specified field width represents the maximum number of characters allowed for the field. **All fields larger than the specified field width will be truncated.** Data values that are shorter than the specified field width should **not** be padded with additional characters. **Reports submitted using an incorrect format or code(s) will be rejected.**

Table 4-1: Data Dictionary Elements

Data Element	Description	Field Type	Field Width
entityDBID	Data Bank Identification Number (DBID) of Reporting Entity assigned by the Data Bank(s).	N	15
agentDBID	Agent DBID (if registered agent is submitting report). Complete only if a registered agent is reporting on behalf of the entity identified (entityDBID) above. If an agent is not submitting the report, omit this field.	N	15
vendorID	Self-defined value identifying the vendor of the software that was used to generate the submission file.	A	40
certification/name	Name of individual certifying transaction. (The individual certifying a transaction must be authorized to submit information to the Data Bank(s) on behalf of the eligible entity. This individual certifies that all transaction information is true and correct to the best of his or her knowledge.)	A	40
certification/title	Title of individual certifying transaction.	A	40
certification/phone/number	Telephone number of individual certifying transaction. Area code must be included. For international phone numbers, include country code. Do not use delimiters. Format: NNNNNNNNNNNNNN.	N	15
certification/phone/extension	Telephone extension.	N	5
certification/date	Certification date.	D	10
customerUse	Identification record for use by the submitting entity. This data field does not appear on report output and will be returned without modification in the response file. This field may be used by the submitter to identify this transaction.	A	20
name/last	Last name of subject.	A	25
name/first	First name of subject.	A	15
name/middle	Middle name of subject.	A	15
name/suffix	Suffix (e.g., JR, SR, III).	A	4
gender	“M” = Male, “F” = Female, “U” = Unknown	C	1
birthdate	Subject’s birth date.	D	10
organizationName	Name of organization where subject works.	A	50

Data Element	Description	Field Type	Field Width
address/address	First line of street address.	A	40
address/address2	Second line of address.	A	40
address/city	City. Refer to Section 4.4, List A if Military.	A	28
address/state	If State or territory is inside U.S. Refer to Section 4.4, List A for State codes.	C	2
address/zip	ZIP code. Refer to Section 4.4, List B for APO/FPO Codes.	A	5
address/zip4	4-digit ZIP code extension.	A	4
address/country	Required if country is not U.S. Omit if country is U.S.	A	20
ssn	Social Security Number (SSN) of subject. Cannot be all zeros. Must be all numbers or include optional hyphens (NNN-NN-NNNN).	N	9 or 11
dea	Drug Enforcement Administration Number of subject.	A	12
professionalSchool/school	Name of professional school attended by a subject. Enter name of professional school or certificate program. NOTE: You may only provide up to 40 characters. Submission data beyond 40 characters will be truncated. When reporting on practitioners whose occupation does not require professional schooling or a certification program, enter "None" for the school attended and, in the year of graduation field, enter the year the State authorized them to practice.	A	4000
professionalSchool/ graduationYear	Year of graduation in YYYY format. Enter year of graduation from professional school or year of completion of certificate program. The graduation year must be at least 15 years beyond the date of birth, and between 1900 and the current year (inclusive).	N	4
licensure/number	State license number. If State law does not require a license, or if the subject has a temporary or foreign license, is operating without a required license, or is operating with an unauthorized license, this will be omitted. Must contain at least one digit.	A	16
licensure/noLicense	State law does not require a license or the subject has a temporary or foreign license, is operating without a required license, or is operating with an unauthorized license. Omit when a number is provided for this license.	B	N/A
licensure/state	State of license. Refer to Section 4.4, List A for State codes.	C	2
licensure/field	Occupation/Field of Licensure. Refer to Section 4.4, List C for codes. Provide the Occupation/Field of Licensure code most closely associated with the medical malpractice payment being reported.	C	3
licensure/description	Other Occupation/Field of Licensure. Complete only if Occupation/Field of Licensure code of "699" is selected. Describe the Occupation/Field of Licensure. Otherwise, omit this field.	A	60
subjectID	Not applicable.	A	20
deceasedDate/isDeceased	Is the subject deceased? "Y" = Yes, "N" = No, "U" = Unknown; If "Y" then deceasedDate/date must be specified if known.	C	1
deceasedDate/date	Deceased Date.	D	10
hospitalAffiliation/name	Name of hospital with which practitioner is affiliated (Inclusion does not imply complicity in the reported action).	A	40
hospitalAffiliation/city	City where affiliated hospital is located.	A	28
hospitalAffiliation/state	State where affiliated hospital is located. Refer to Section 4.4, List A for State codes.	C	2

Data Element	Description	Field Type	Field Width
MMPRReportType			
entityReference	Entity Internal Report Reference. This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the Data Banks, but it will be provided on copies of the report sent to querier(s).	A	20
transaction	"I" = Initial, "C" = Correction.	C	1
previousDCN	Data Bank Control Number of Corrected, or Voided report.	N	16
MMPRActionDataType			
relationshipOfEntity	Relationship of entity to this practitioner "P" = Insurance Company – Primary Insurer, "E" = Insurance Company – Excess Insurer, "S" = Self-Insured Organization, "G" = Insurance Guaranty Fund, "M" = State Medical Malpractice Payment Fund as the Primary Payer for This Practitioner, "O" = State Medical Malpractice Payment Fund as a Secondary Payer for This Practitioner.	C	1
paymentForThisPractitioner	Amount of this payment for this practitioner. If this payment represents a preliminary payment prior to a final settlement, use "M" for the paymentType field and explain the circumstances in the judgmentOrSettlementDesc field. Once the settlement is reached, file a correction report and provide a revised total amount in the totalAmountForThisPractitioner field.	M	12
paymentDate	Date of this payment. Date must not be in the future.	D	10
paymentType	This payment represents: "S" = Single Final Payment, "M" = One of Multiple Payments.	C	1
totalPaymentForThisPractitioner	Total dollar amount paid or to be paid by this payer for this practitioner in this case. If this payment is a preliminary payment before a final settlement, file a correction report once the settlement is reached and the total amount is known.	M	12
paymentResultOf	Action from which payment resulted. "J" = Judgment, "S" = Settlement, "B" = Payment Prior to Settlement.	C	1
judgmentOrSettlementDate	Date of the judgment or settlement. Date must not be in the future.	D	10
adjudicativeBodyCaseNumber	Case or docket number of adjudicative body with which the claim was filed. If none, leave blank.	A	20
adjudicativeBodyName	Name of the adjudicative body with which the claim was filed. If none, leave blank.	A	60
courtFileNumber	File number assigned by the court with which the claim was filed. If none, leave blank.	A	10
judgmentOrSettlementDesc	Description of judgment or settlement and any conditions, including terms of payment. Do not reference any personal identification information about the patient or other practitioners.	A	4000
totalPaymentForAllPractitioners	Total amount paid or to be paid by this payer for all practitioners.	M	12
numberPractitioners	Number of practitioners for whom this payer has paid or will pay in this case.	N	3
stateFundPayment/ paymentMade	Has a State Guaranty Fund or State Excess Judgment Fund made a payment for this practitioner in this case, or is such a payment expected to be made. "Y" = Yes, "N" = No, "U" = Unknown.	C	1
stateFundPayment/amountPaid	Amount paid or expected to be paid by State Guaranty Fund or State Excess Judgment Fund.	M	12

Data Element	Description	Field Type	Field Width
selfInsuredOrgPayment/ paymentMade	Has a self-insured organization(s) and/or other insurance company/companies made payment for this practitioner in this case or is such payment expected to be made? "Y" = Yes, "N" = No, "U" = Unknown.	C	1
selfInsuredOrgPayment/ amountPaid	Amount paid or expected to be paid by self-insured organization(s) and/or other insurance company/companies.	M	12
patientAge/days	Patient's age at time of initial event in days. Specify age in days if the patient is a fetus (use 0 days), or the patient is less than one month old.	N	2
patientAge/months	Patient's age at time of initial event in months. Specify age in months if the patient is 1-11 months old.	N	2
patientAge/years	Patient's age at time of initial event in years. Specify age in years if the patient is 1 or older.	N	3
patientAge/unknown	If the age of the patient is unknown.	B	N/A
patientGender	Gender of the patient. "M" = Male, "F" = Female, "U" = Unknown.	C	1
patientType	Type of patient. "I" = Inpatient, "O" = Outpatient, "B" = Both, "U" = Unknown.	C	1
medicalConditionDesc	Description of the medical condition with which the patient presented for treatment (prior to the event that led to the malpractice allegation). Do not reference any personal identification information about the patient or other practitioners.	A	4000
procedureDesc	Description of the procedure performed or treatment rendered by the insured to the patient. Do not reference any personal identification information about the patient or other practitioners.	A	4000
natureAllegation	Nature of the allegation. Refer to Section 4.4, List D for codes.	C	3
specificAllegation/code	Specific allegation best describing the alleged acts or omissions. Refer to Section 4.4, List E for codes.	C	3
specificAllegation/otherDesc	Other allegation description. Complete only if Specific allegation "999" is used. Describe the other allegation.	A	60
specificAllegation/date	Date of the event associated with allegation or incident. Date must be before the payment date.	D	10
outcome	Select the severity of injury category that best describes the actual impact of the alleged acts or omissions on the patient. Refer to Section 4.4, List F for codes.	C	2
allegationsDesc	Description of the allegations and injuries or illnesses upon which the action or claim was based. Do not reference any personal identification information about the patient or other practitioners.	A	4000
Response, Rejection Report Elements			
successfullyProcessed	Status indicating if the file was successfully processed.	B	N/A
processDate	Date transaction was processed.	D	10
reportingCompliance/ daysToReport	Indicates the number of days between the date this action was taken and the date this report was filed. This field will only be provided in the response to an Initial Report. Federal Law as implemented by 45 CFR Part 60 requires reporting entities to file reports generally within 30 days of taking a reportable action.	N	5
reportingCompliance/compliant	"true": This report was filed in accordance with the timeframes required by Federal Law. "false": The reporting entity has failed to satisfy its reporting obligations under Federal law by filing this report late.	B	N/A
reportingCompliance/ compliantText	Text detailing the report compliance notice.	A	4000

Data Element	Description	Field Type	Field Width
dcn	Data Bank Control Number. Unique number assigned to this transaction.	N	16
reportChangeInformation/ transactionDCN	Data Bank Control Number. Unique number assigned to the transaction that generated the Report Change Notification response.	N	16
reportChangeInformation/ forAuthorizedUseBy	Name of the entity for which the Report Change Notification response is generated.	A	40
disclosureType/code	Indicates why the changed report is being disclosed. Refer to Section 4.4, List H.	C	2
disclosureType/description	Description corresponding to the disclosure type code.	A	4000
subjectSource	Indicates why the entity is receiving the report change notification. Refer to Section 4.4, List I.	C	1
reportData/reportDCN	Data Bank Control Number. Unique number assigned to the report contained in the Report Change Notification response.	N	16
entityName	The entity of the point of contact.	A	40
officeOrName	The current individual or office designated as the point of contact for this report.	A	40
titleOrDept	Title or department of point of contact.	A	40
latestContact/entityStatus	Most recent status of the entity. Refer to Section 4.4, List J for Entity Status Codes.	C	1
latestContact/entityName	Most recent name of the entity or its successor entity.	A	40
latestContact/lastUpdateDate	Date of most recent name or address change made by the original reporting entity. The date is only provided if the original reporting entity has no successor.	D	10
error/code	Indicates why the transaction was rejected and could not be processed. Refer to Section 4.4, List G for Error Codes. This field will be repeated for each error found. The field is only present when an error is present.	C	2
error/message	Error message description corresponding to the error code.	A	4000
subjectStatment/submitDate	Date statement was submitted by the subject.	D	10
subjectStatment/ statementThisVersion	"true": The subject entered the statement in response to this version of this report. "false": The subject entered the statement submitted in response to an earlier version of this report. The reporting entity changed the report after the subject prepared the statement. As of the date this report response was processed, the subject has not changed the statement in response to the changes in the report.	B	N/A
subjectStatement/statement	Subject statement.	A	4000
secretaryStatement/ submitDate	Date statement was submitted by the Secretary of the U.S. Department of Health and Human Services.	D	10
secretaryStatement/ statementThisVersion	"true": The Secretary of the U.S. Department of Health and Human Services reviewed this version of this report and entered this statement. "false": The Secretary of the U.S. Department of Health and Human Services reviewed an earlier version of this report and entered this statement. After the Secretarial Review decision and subject statement were entered, the reporting entity changed the report. The Secretary has not reviewed the current version of the report.	B	N/A
secretaryStatement/statement	Secretary of the U.S. Department of Health and Human Services statement.	A	4000
disputeStatus	Report dispute status. "N" = not in dispute, "Y" = in dispute, "S" = elevated to Secretarial Review, "R" = reviewed by Secretary.	C	1
maintainedIn	The report is maintained in the specified Data Bank.	B	N/A

Data Element	Description	Field Type	Field Width
npdb/titleIV	The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Title IV of Public Law 99-660, as amended; and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. Disclosure or use of confidential information for other purposes is a violation of Federal law.	B	N/A
npdb/section1921	The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Section 1921 of the Social Security Act, and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. Disclosure or use of confidential information for other purposes is a violation of Federal law.	B	N/A
hipdb/section1128E	The information contained in this report is maintained by the Healthcare Integrity and Protection Data Bank for restricted use under the provisions of Section 1128E of the Social Security Act, and 45 CFR Part 61. All information is confidential and may be used only for the purpose for which it was disclosed. Disclosure or use of confidential information for other purposes is a violation of Federal law.	B	N/A
previousTransaction	Not applicable to MMPRs.	C	1
latestRelatedDCN	Not applicable to MMPRs.	N	16
latestRelatedTransaction	Not applicable to MMPRs.	C	1
latestRelatedNote	Not applicable to MMPRs.	A	4000
originalSubmitDate	Date of original submission.	D	10
recentChangeDate	Date of most recent change.	D	10
supplementalIndividual/ deceasedDate	Deceased date of individual subject. This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report. This disclaimer should be clearly identified on generated reports.	D	10
supplementalIndividual/ name/last	Last name of subject. This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report. This disclaimer should be clearly identified on generated reports.	A	25
supplementalIndividual/ name/first	First name of subject. This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report. This disclaimer should be clearly identified on generated reports.	A	15
supplementalIndividual/ name/middle	Middle name of subject. This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report. This disclaimer should be clearly identified on generated reports.	A	15
supplementalIndividual/ name/suffix	Suffix (e.g., JR, SR, III). This information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report. This disclaimer should be clearly identified on generated reports.	A	4
supplementalOrganization/ name	Not applicable to MMPRs.	A	50
LegacyMMPRActionDataType			
relationshipOfEntity	Entity's relationship to practitioner. "I" = Insurance Company, "S" = Self-Insured Organization, "O" = Other - Guaranty Fund.	C	1
actOrOmission/code	Code for act or omission allegedly committed. (Refer to Section 4, List K, for Medical Malpractice Acts or Omissions codes.)	C	3
actOrOmission/date	Date act or omission occurred.	D	10
paymentDate	Date on which payment was made.	D	10

Data Element	Description	Field Type	Field Width
paymentForThisPractitioner	Dollar amount of this payment in dollars and cents.	M	12
paymentType	Type of payment. "S" = Single Payment, "M" = Multiple Payments.	C	1
totalPaymentForThisPractitioner	Total dollar amount of settlement.	M	12
numberPractitioners	Number of practitioners for whose benefit payment was made.	D	3
paymentResultOf	Action from which payment resulted. "J "= Judgment, "S" = Settlement, "B" = Payment Prior to Settlement, "U" = Unknown, "O" = Other.	C	1
judgmentOrSettlementDate	Date of the judgment or settlement.	D	10
adjudicativeBodyCaseNumber	Case or docket number of adjudicative body with which the claim was filed.	A	20
adjudicativeBodyName	Name of the adjudicative body with which the claim was filed.	A	60
courtFileNumber	File number assigned by the court.	A	10
isDeceased	Is practitioner is known to be deceased?	B	N/A
actOrOmissionDesc	Description of the alleged act(s) or omission(s) that led to the claim.	A	4000
judgmentOrSettlementDesc	Description of payment made and any terms or conditions.	A	4000
Other Response Elements			
correspondence/ recipient/entityDBID	Data Bank Identification Number (DBID) for whom the Data Bank Correspondence is intended.	N	15
correspondence/ recipient/userID	The user ID for whom the Data Bank Correspondence is intended.	A	14
correspondence/ response/date	The date the Data Bank Correspondence was generated.	D	10
correspondence/ response/sender	The sender of the Data Bank Correspondence.	A	40
correspondence/ response/message	The plain-text message of the Data Bank Correspondence.	A	4000

4.2 Data Dictionary – Subject Data

Table 4-2: Individual Subject Data Elements

Individual Element	Required	Valid Values / Limitations
name	Yes	
otherName	No	Up to 5.
gender	Yes	
birthdate	Yes	
organizationName	No	
workAddress	Conditional	Valid work or home address required.
homeAddress	Conditional	Valid work or home address required.
ssn	No	Up to 4.
dea	No	Up to 4.
professionalSchool	Yes	Up to 5; see Note(1).
occupationAndLicensure	Yes	
occupationAndLicensure/number	Conditional	See Note (2).
occupationAndLicensure/noLicense	Conditional	See Note (2).
occupationAndLicensure/state	Yes	
occupationAndLicensure/field	Yes	
occupationAndLicensure/description	Conditional	See Note (3).
otherOccupationAndLicensure	No	Up to 59; see Note (4).
subjectID	No	Reserved; do not specify.
deceasedDate	Yes	
hospitalAffiliation	No	Up to 5; See Note (5).

Note(s):

(1) When specifying professional school information, both professional school and year of graduation must be provided. If the report subject did not graduate (but completed a certificate program), provide the school name in the Professional School Attended field and the last year of attendance. If the subject did not attend a school, provide the name of the certificate program and the year that it was completed. In the event that the subject neither attended a school nor completed a certificate program, enter "None" in the Professional School Attended field and enter the year that the subject was authorized by the state to provide health care services in the Year of Graduation field.

(2) If State law does not require a license, or if the subject has a temporary or foreign license, is operating without a required license, or is operating with an unauthorized license, omit number and specify noLicense. If a number is specified, omit noLicense. Either number or noLicense must be provided.

(3) The description is required only if field "699" if specified; otherwise omit.

(4) Used if more than one set of occupation and licensure information is provided; refer to Notes (2) – (4) for otherOccupationAndLicensure fields.

(5) When specifying any hospital affiliate information, the name, city and state are required.

4.3 Data Dictionary – Medical Malpractice Payment Data

Table 4-3: Medical Malpractice Payment Data Elements

Element	Required	Valid Values / Limitations
relationshipOfEntity	Yes	"P" = Insurance company – Primary Insurer, "E" = Insurance company – Excess Insurer, "S" = Self-Insured Organization, "G" = Insurance Guaranty Fund, "M" = State Medical Malpractice Payment Fund as the Primary Payer for This Practitioner, "O" = State Medical Malpractice Payment Fund as a Secondary Payer for This Practitioner.

Element	Required	Valid Values / Limitations
paymentForThisPractitioner	Yes	Must be less than or equal to totalPaymentForThisPractitioner.
paymentDate	Yes	See Note (1).
paymentType	Yes	"S" = Single Final Payment, "M" = One of Multiple Payments.
totalPaymentForThisPractitioner	Yes	
paymentResultOf	No	"J" = Judgment, "S" = Settlement, "B" = Payment Prior to Settlement.
judgmentOrSettlementDate	No	Must not be a date in the future.
adjudicativeBodyCaseNumber	No	
adjudicativeBodyName	No	
courtFileNumber	No	
judgmentOrSettlementDesc	Yes	
totalPaymentForAllPractitioners	No	If provided, must be greater than totalPaymentForThisPractitioner.
numberPractitioners	No	
stateFundPayment/paymentMade	Conditional	See Note (2).
stateFundPayment/amountPaid	Conditional	See Note (2).
selfInsuredOrgPayment/paymentMade	Conditional	See Note (3).
selfInsuredOrgPayment/amountPaid	Conditional	See Note (3).
patientAge	Yes	If providing days, must be 0 to 31 inclusive If providing months, must be 1 to 11 inclusive. If providing years, must be 1 to 200 inclusive.
patientGender	Yes	"M" = Male, "F" = Female, "U" = Unknown.
patientType	Yes	"I" = Inpatient, "O" = Outpatient, "B" = Both, "U" = Unknown.
medicalConditionDesc	Yes	
procedureDesc	Yes	
natureAllegation	Yes	
specificAllegation	Yes	See Note(4).
specificAllegation/code	Yes	
specificAllegation/otherDesc	Conditional	Only provide if specificAllegation/code is "999".
specificAllegation/date	Yes	Date must be before the payment date. Must not be a date in the future.
outcome	Yes	
allegationsDesc	Yes	

Note(s):

(1) The NPDB will not accept reports with a Payment Date taken prior to September 1, 1990. The Payment Date must also be after the Specific Allegation Date(s).

(2) Do not provide stateFundPayment information if the relationshipOfEntity is "G", "M", or "O". If the paymentMade is "Y", then the amountPaid must be provided. If the amountPaid is provided, the paymentMade must be "Y".

(3) Do not provide selfInsuredOrgPayment information if the relationshipOfEntity is "S". If the paymentMade is "Y", then the amountPaid must be provided. If the amountPaid is provided, the paymentMade must be "Y".

(4) One specific allegation record must be provided. Both a code and date must be provided. A second specific allegation record may also be reported.

4.4 Data Dictionary – Common List of Values

List A. State Abbreviations and U.S. Territories

AL	Alabama	KY	Kentucky	ND	North Dakota
AK	Alaska	LA	Louisiana	OH	Ohio
AZ	Arizona	ME	Maine	OK	Oklahoma
AR	Arkansas	MD	Maryland	OR	Oregon
CA	California	MA	Massachusetts	PA	Pennsylvania
CO	Colorado	MI	Michigan	RI	Rhode Island
CT	Connecticut	MN	Minnesota	SC	South Carolina
DE	Delaware	MS	Mississippi	SD	South Dakota
DC	District of Columbia	MO	Missouri	TN	Tennessee
FL	Florida	MT	Montana	TX	Texas
GA	Georgia	NE	Nebraska	UT	Utah
HI	Hawaii	NV	Nevada	VT	Vermont
ID	Idaho	NH	New Hampshire	VA	Virginia
IL	Illinois	NJ	New Jersey	WA	Washington
IN	Indiana	NM	New Mexico	WV	West Virginia
IA	Iowa	NY	New York	WI	Wisconsin
KS	Kansas	NC	North Carolina	WY	Wyoming
AS	American Samoa	GU	Guam	PR	Puerto Rico
FM	Federated States of Micronesia	MP	Northern Marianas	VI	Virgin Islands
		PW	Palau		
AA	Central and South America (Armed Forces)	AE	Europe (Armed Forces)	AP	Pacific (Armed Forces)

Please adhere to the following guidelines when entering foreign or military addresses:

Addresses for United States Territories:

- Enter Territory abbreviation in State field.

Addresses outside the United States or its territories:

- Leave the State field blank.
- Enter the city and/or province in the city field.
- Enter the Country Code in the ZIP fields—maximum five characters in first field, maximum four characters in the second field.
- Enter the country in the country field.

Military Addresses:

- Enter APO in the city field.
- Enter AE, AA or AP in the State field.
- Enter the ZIP code in the ZIP field.

Following State Codes are not valid for State of Licensure:

- AA - Central and South America (Armed Forces).
- AE - Europe (Armed Forces).
- AP - Pacific (Armed Forces).

List B. APO/FPO Postal Codes

APO/FPO Code	First 3 Digits of ZIP Code	Geographic Area	APO/FPO Code	First 3 Digits of ZIP Code	Geographic Area
AE - Europe	090-092	Germany	**AA - Americas**	340	Central, South Americas
	094	United Kingdom			
	095	Atlantic Ocean/ Mediterranean Sea Ships	**AP - Pacific**	962	Korea
				963	Japan
	096	Italy, Spain		964	Philippines
	097	Other Europe		965	Other Pacific and Alaska
	098	Middle East, Africa		966	Pacific and Indian Ocean Ships

APO/FPO Codes (State Codes) are not valid for State of Licensure. Refer to List A.

List C. Occupation/Field of Licensure Codes

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 Dental Resident
606 Dental Assistant
609 Dental Hygienist
612 Denturist

Dietician/Nutritionist
200 Dietician
210 Nutritionist

Emergency Medical Technician (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/Advanced Practice Registered Nurse
100 Registered (Professional) Nurse
110 Nurse Anesthetist
120 Nurse Midwife
130 Nurse Practitioner
140 Licensed Practical or Vocational Nurse
141 Clinical Nurse Specialist

Nurses Aide, Home Health Aide and Other Aide
148 Certified Nurse Aide/Certified Nursing Assistant
150 Nurses Aide
160 Home Health Aide (Homemaker)
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 Intern/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 Assistant
371 Psychologist
372 School Psychologist
373 Psychological Assistant, Associate, Examiner

Rehabilitative, Respiratory, and Restorative Service Provider
402 Art/Recreation Therapist
405 Massage Therapist
410 Occupational Therapist
420 Occupational Therapy Assistant
430 Physical Therapist
440 Physical Therapy Assistant
450 Rehabilitation Therapist
663 Respiratory Therapist
666 Respiratory Therapy Technician

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 Radiologic 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
647 Perfusionist
170 Psychiatric Technician
699 Other Health Care Practitioner—Not Classified, Specify

List D. Nature of Allegation Codes

001 Diagnosis Related	060 Treatment Related
010 Anesthesia Related	070 Monitoring Related
020 Surgery Related	080 Equipment/Product Related
030 Medication Related	090 Other Miscellaneous
040 IV & Blood Products Related	100 Behavioral Health Related
050 Obstetrics Related	

List E. Specific Allegation Codes

Failure to Take Appropriate Action
- 100 Failure to Use Aseptic Technique
- 101 Failure to Diagnose
- 102 Failure to Delay a 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 Fluids Problem
- 301 Agent Use or Selection Error
- 302 Complementary 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 Laboratory Error
- 314 Pathology Error
- 315 Medication Administered via Wrong Route
- 316 Patient History, Exam, or Workup Problem
- 317 Problems With Patient Monitoring in Recovery
- 318 Patient Monitoring Problem
- 319 Patient Positioning Problem
- 320 Problem with Appliance, Prostheses, Orthotic, Restorative, Splint, Device, etc.
- 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
- 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 or Family
- 502 Failure to Report on Patient Condition
- 503 Failure to Respond to Patient
- 504 Failure to Supervise
- 505 Improper Supervision

Continuity of Care/Care Management
- 600 Failure/Delay in Admission to Hospital or Institution
- 601 Failure/Delay in Referral or Consultation
- 602 Premature Discharge from Institution
- 603 Altered, Misplaced or Prematurely Destroyed Records

Behavior/Legal
- 700 Abandonment
- 701 Assault and Battery
- 702 Breach of Contract or Warranty
- 703 Breach of Patient Confidentiality
- 704 Equipment Malfunction
- 705 Failure to Conform with Regulation, Statute, or Rule
- 706 Failure to Ensure Patient Safety
- 707 Failure to Obtain Consent or Lack of Informed Consent
- 708 Failure to Protect a Third Party
- 709 Failure to Test Equipment
- 710 False Imprisonment
- 711 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 Wrongful Life/Birth
- **899 Cannot Be Determined from Available Records**
- **999 Allegation – Not Otherwise Classified, Specify_____**

These codes were adapted from code lists developed by The Risk Management Foundation of the Harvard Medical Institutions and the Physician Insurers Association of America.

List F. Outcome Codes

Code	Description
01	Emotional injury only
02	Insignificant injury
03	Minor temporary injury
04	Major temporary injury
05	Minor permanent injury
06	Significant permanent injury
07	Major permanent injury
08	Grave Permanent Injury, such as quadriplegic or brain damage, requiring lifelong dependent care
09	Death
10	Cannot be determined from available records

List G. Error Codes

Error Code	Description
03	File is not compliant with the current format version.
06	Invalid transaction code entered.
07	Invalid Data Bank ID.
09	This entity does not have the privilege to perform this transaction.
13	This agent does not have the authority to act for entity.
20	All or part of a subject's name is missing or invalid. Subject First Name and Last Name are required.
25	All or part of school information is missing or illegible: professional school information must include both the name of the professional health care school attended and the year the subject graduated. If the subject did not graduate, provide the last year he or she attended the school-this will be presented on the response as the subject year of graduation.
26	Invalid Drug Enforcement Administration number.
27	Invalid Social Security Number.
28	Missing, invalid, or illegible date of birth. Date of birth must be at least 15 years before today's date and after 1900.
29	Invalid gender code.
35	Invalid Hospital data. A valid Name, City, and State is required for each hospital provided.
36	Missing or invalid relation of entity to subject.
37	Invalid payment type.
38	Invalid payment result.
69	Graduation year is inconsistent with year of birth: the subject's date of birth and year of graduation must be at least 15 years apart.
77	Invalid certification phone number.
78	Invalid certification phone extension.
79	Invalid subject deceased flag.
81	Invalid subject address.
AF	This agent user ID does not have authority to perform this action for this entity.
B1	Incomplete individual subject Occupation/Field of Licensure.
B2	Incomplete or invalid subject Occupation/Field of Licensure information. For each License provided, a valid, two-letter abbreviation for the U.S. State from where the license was issued and a valid, three-digit Occupation/Field of Licensure code must be provided. License Numbers must contain at least one digit. If the subject does not have a license, specify No License and do not provide a License Number. An Occupation/Field of Licensure Description is required if the Occupation/Field of Licensure code is "Other", and not allowed otherwise.
D0	Invalid deceased date.
D6	Report is not valid under any NPDB-HIPDB statutory authority.
F6	The previous DCN did not match a report in the Data Bank.
F8	The previous DCN is not applicable for this type of report.
I8	Invalid Entity Internal Report Reference.
I9	Invalid report type.
M0	Specific allegation or date of event is missing or invalid, or description for an unclassified specific allegation is missing.
M1	Missing or invalid Payment date. The date must be a valid date, must not be in the future, and must occur after the date(s) of event(s) associated with the allegation(s) or incident(s).
M2	Description of judgment or settlement is missing or invalid.
M3	Number of practitioners for whom this payer has paid or will pay in this case must be a value between 1 and 999 inclusive.
M4	State fund payment flag or amount is invalid.
M5	Self-insured payment flag or amount is invalid.
M6	Patient age, gender or type is missing or invalid.
M7	Description of the medical condition with which the patient presented for treatment is missing or invalid.
M8	Description of the procedure performed is missing or invalid.
M9	Nature of allegation code is missing or invalid.

Error Code	Description
MA	Outcome is missing or invalid.
MB	Description of allegations and injuries or illnesses is missing or invalid.
MC	Total amount paid or to be paid by this payer for this practitioner must be greater than or equal to the amount of this payment by this payer for this practitioner.
MD	Total amount paid or to be paid by this payer for all practitioners must be greater than or equal to total amount paid or to be paid by this payer for this practitioner.
ME	The NPDB no longer accepts initial Medical Malpractice Payment Reports in legacy format.
MF	State fund payment flag and/or amount is invalid. Your entity's relationship to this practitioner (as specified in this submission) does not allow the completion of the state fund payment fields.
MG	Self-insured payment flag or amount is invalid. Your entity's relationship to this practitioner (as specified in this submission) does not allow the completion of the self-insured organization and/or other insurance company payment fields.
MH	Judgment or Settlement Date is invalid.
MJ	Invalid Adjudicative Body Case Number.
MK	Invalid Adjudicative Body Name.
ML	Invalid Court File Number.
MM	Missing or invalid Amount of This Payment for This Practitioner.
MN	Missing or invalid Total Amount Paid or to Be Paid by This Payer for This Practitioner.
MO	Total amount paid or to be paid by this payer for this practitioner must be greater than or equal to the state fund payment amount.
MP	Missing or invalid Total Amount Paid or to Be Paid by This Payer for All Practitioners.
MQ	Total amount paid or to be paid by this payer for this practitioner must be greater than or equal to the self-insured payment amount.
MR	ITIN not allowed in medical malpractice payment reports.
MS	Licensure Specialty not allowed in medical malpractice payment reports.
MT	Organization Type not allowed in medical malpractice payment reports.
MU	NPI not allowed in medical malpractice payment reports.
MV	FEIN not allowed in medical malpractice payment reports.
MW	UPIN not allowed in medical malpractice payment reports.
MX	Only information regarding hospital affiliations may be reported for medical malpractice payment reports.
R1	All or part of certification information is missing.
R4	Invalid Organization Name.
R6	Invalid Customer Use data.
RE	The DBID for your organization must be renewed before you can access the Data Banks services. The NPDB-HIPDB requires all registered entities to periodically renew their registration information. Re-registration enables the NPDB-HIPDB to maintain accurate entity contact information and provides the entity with the opportunity to review the legal requirements and verify their compliance for participation with NPDB-HIPDB. The certifying official for your organization must review the NPDB-HIPDB regulations, available at http://www.npdb-hipdb.hrsa.gov/legislation.html, as part of the renewal process. Once the regulations have been reviewed, complete the on-line registration renewal form by logging in to the IQRS and selecting Renew Registration on the registration confirmation screen. The completed form must be signed and mailed to the NPDB-HIPDB for processing. If your organization has already mailed the registration renewal to the Data Banks, it will be processed within one business day of its receipt by the NPDB-HIPDB. Data Bank Correspondence will be sent once the Data Banks have successfully processed your registration renewal form. If necessary, you may complete a new form by selecting Renew Registration below. If you need further assistance, please contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732.
RF	The DBID for your organization must be renewed before you can access the Data Banks services. The NPDB-HIPDB requires all registered entities to periodically renew their registration information. Re-registration enables the NPDB-HIPDB to maintain accurate entity contact information and provides the entity with the opportunity to review the legal requirements and verify their compliance for participation with NPDB-HIPDB. The certifying official for your organization must review the NPDB-HIPDB regulations, available at http://www.npdb-hipdb.hrsa.gov/legislation.html, as part of the renewal process. Contact the administrator of your organization so they can renew the registration. If you need further assistance, please contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732.

Error Code	Description
RG	The DBID for the entity on whose behalf you are submitting the file must be renewed before the submission file can be processed by the Data Banks. The NPDB-HIPDB requires all registered entities to periodically renew their registration information. Re-registration enables the NPDB-HIPDB to maintain accurate entity contact information and provides the entity with the opportunity to review the legal requirements and verify their compliance for participation with NPDB-HIPDB. As part of the renewal process, the certifying official of the entity on whose behalf you are submitting the file must review the NPDB-HIPDB regulations, available at http://www.npdb-hipdb.hrsa.gov/legislation.html. Once the certifying official has reviewed these regulations, the entity administrator can complete the on-line registration renewal form by logging in to the IQRS and selecting Renew Registration on the registration confirmation screen. If you need further assistance, please contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732.
RI	The administrator account can not be used to submit report transactions. These transactions must be submitted using a user account.

List H. Disclosure Type Codes

Code	Description
IR	The reporting entity identified in this disclosure has submitted Initial Report {1}.
RR	The reporting entity identified in this disclosure has submitted Revision to Action Report {1}.
CR	The reporting entity identified in this disclosure has submitted correction(s) to report {1}.
CA	The reporting entity identified in this disclosure has submitted correction(s) to report {1}.
DA	The subject of report {1} has filed a dispute with the Data Bank(s) concerning information contained in the report. The reporting entity identified in this disclosure and the subject of the report are responsible for settling the dispute.
DW	The subject of report {1} has withdrawn the dispute originally associated with this report.
SA	The subject of report {1} has added a statement to the report to explain or comment on the action reported.
SW	The subject of report {1} has withdrawn the statement previously associated with this report.
NA	The reporting entity identified in this disclosure has indicated that the action described in report {1} is being appealed.
RE	The subject of report {1} has requested that this dispute be reviewed by the Secretary of the U.S. Department of Health and Human Services.
RW	The subject of report {1} has withdrawn the request for review of this dispute by the Secretary of the U.S. Department of Health and Human Services.
RD	The Secretary of the U.S. Department of Health and Human Services has reviewed the facts of the dispute and has made a determination regarding report {1}.
VR	Report {1} and all information in it have been expunged from the Data Bank(s) and should not be used. Please destroy all copies of this report.
OC	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) corrected report {1}. The following data fields have been modified: {2}.
OA	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) corrected report {1}. The following data fields have been modified: {2}.
RC	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) corrected report {1} as directed by the Secretary of the U.S. Department of Health and Human Services. For further information, see the Secretary's comments included in this disclosure.
RA	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) corrected report {1} as directed by the Secretary of the U.S. Department of Health and Human Services. For further information, see the Secretary's comments included in this disclosure.
OV	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) voided report {1} because it was determined to be a duplicate report. Please destroy all copies of report {1}. The original report remains in the Data Bank(s).

Code	Description
RV	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) voided report {1} as directed by the Secretary of the U.S. Department of Health and Human Services. The referenced report and all information in it have been expunged from the Data Bank(s) and should not be used. Please destroy all copies of this report.
BI	Correction Report {1} should have been submitted as a Revision to Action since it modifies a previously reported action. To correct this, the Data Bank(s), on behalf of the reporting entity identified in this disclosure, have re−submitted the original or previous Initial Report as {2}. Additionally, the Correction Report {1} has been voided and re−submitted as Revision to Action {3}. Please destroy all copies of report {1}.
BV	Correction Report {1} should have been submitted as a Revision to Action since it modifies a previously reported action. To correct this, the Data Bank(s), on behalf of the reporting entity identified in this disclosure, have re−submitted the original or previous Initial Report as {2}. Additionally, the Correction Report {1} has been voided and re−submitted as Revision to Action {3}. Please destroy all copies of report {1}.
BR	Correction Report {1} should have been submitted as a Revision to Action since it modifies a previously reported action. To correct this, the Data Bank(s), on behalf of the reporting entity identified in this disclosure, have re−submitted the original or previous Initial Report as {2}. Additionally, the Correction Report {1} has been voided and re−submitted as Revision to Action {3}. Please destroy all copies of report {1}.
AV	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) converted report {1} to Revision to Action Report {2}. This action should have been reported as a Revision to Action since it modifies the previously reported action {3}. Please destroy all copies of report {1}.
AR	On behalf of the reporting entity identified in this disclosure, the Data Bank(s) converted report {1} to Revision to Action Report {2}. This action should have been reported as a Revision to Action since it modifies the previously reported action {3}. Please destroy all copies of report {1}.
Note(s): The descriptions listed herein contain placeholder references ({1}, {2}, and{3}) and each will be replaced with an actual report DCN when a notification is generated by the Data Bank(s).	

List I. Subject Source Codes

Code	Description
Q	You received the previous version of this report via a query.
R	Your entity submitted the previous version of this report.
P	You received the previous version of this report via a PDS enrollment that has since been canceled.

List J. Entity Status Codes

Code	Type	Description
A	Original Reporting Entity is Active	The entity that filed the report may have changed its name or address on file with the Data Banks. The most recent entity contact information reported to the Data Banks and the date on which it was reported is provided.
S	Original Reporting Entity is Inactive but has a Successor	The entity that filed the report is no longer an active registrant with the Data Banks. The most recent information for the registered successor entity is provided.
D	Original Reporting Entity is Inactive with no Successor	The entity that filed the report is no longer an active registrant with the Data Banks. The most recent entity contact information reported to the Data Banks and the date on which it was reported is provided. The Data Banks have no additional information regarding this entity.
N	Original Reporting Entity is Inactive and its Successor is Inactive	The entity that filed the report is no longer an active registrant with the Data Banks. The most recent information for the registered successor entity is provided, but that entity is also no longer an active registrant with the Data Banks. The Data Banks have no additional information regarding this entity.

List K. Medical Malpractice Act or Omission Codes - Legacy MMPR

Diagnosis
010 Failure to Diagnose (i.e., Concluding That Patient Has No Disease or Condition Worthy of Follow-Up or Observation)
020 Wrong Diagnosis or 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—Not Otherwise Classified

Anesthesia
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—Not Otherwise Classified

Surgery
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/Lack of Informed Consent
290 Surgery Related—Not Otherwise Classified

Medication
305 Failure to Order Appropriate Medication
310 Wrong Medication Ordered
315 Wrong Dosage Ordered of Correct Medication

Medication (contd.)
320 Failure to Instruct on Medication
325 Improper Management of Medication Regimen
330 Failure to Obtain Consent/Lack of Informed Consent
340 Medication Error—Not Otherwise Classified
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—Not Otherwise Classified

Intravenous and Blood Products
410 Failure to Monitor
420 Wrong Solution
430 Improper Performance
440 IV Related—Not Otherwise Classified
450 Failure to Ensure Contamination Free
460 Wrong Type
470 Improper Administration
480 Failure to Obtain Consent/Lack of Informed Consent
490 Blood Product Related—Not Otherwise Classified

Obstetrics
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—Not Otherwise Classified
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
575 Abandonment
580 Wrongful Life/Birth
590 Obstetrics Related—Not Otherwise Classified

Treatment
610 Failure to Treat
620 Wrong Treatment/Procedure Performed
630 Failure to Instruct Patient on Self-Care
640 Improper Performance of 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/Lack of Informed Consent
685 Failure to Refer or Seek Consultation
690 Treatment Related—Not Otherwise Classified

Monitoring
710 Failure to Monitor
720 Failure to Respond to Patient
730 Failure to Report on Patient Condition
790 Monitoring Related—Not Otherwise Classified

Biomedical Equipment/Product
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—Not Otherwise Classified

Miscellaneous
910 Inappropriate Behavior of Clinician (e.g., Sexual Misconduct Allegation, Assault)
920 Failure to Protect Third Parties (e.g., 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 Description)
990 Failure to Review Provider Performance

* Codes other than those listed above may be returned to the user. These additional codes are no longer accepted by the Data Banks and should be interpreted as 'UNKNOWN'.

Appendix A: Disclaimer

Terms and Conditions: The National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) make this ICD available as a courtesy to assist authorized clients who have unique operating requirements.

No warranty or guarantee of any type is implied or intended for the use of ICDs by the QRXS user or its customers. Should there remain any latent faults in the ICD, or for any other reason, the QRXS user will not hold or attempt to hold the Data Bank(s) or individuals associated with them responsible for damages of any type resulting from its use.

The Data Bank(s) make no commitment, and none shall be inferred by the QRXS user or its customers, for providing any technical support or other assistance or consultation whatsoever regarding the modification, installation, use, maintenance, or operation of software produced by the QRXS user to produce transaction files as described in the ICD.

Any QRXS user is prohibited from identifying its product as sanctioned or authorized by the Data Bank(s). The QRXS user is required to inform its customers that the Data Bank(s) do not sanction or authorize any software, other than software produced by the NPDB or the HIPDB, that produces transaction files as described in the ICD.

The QRXS user agrees to indemnify and hold harmless the Data Bank(s) in the event that one of its customers obtains a judgment as a result of any use of the QRXS user's software.

Definitions:

Customer – Any NPDB or HIPDB entity to whom the QRXS user provides application software and support for electronic querying and/or reporting to the NPDB-HIPDB.

HIPDB entity – Any entity that is authorized to query or report to the HIPDB, pursuant to 42 U.S.C. §1301, et seq., as amended by Sections 201 and 205, the *Health Insurance Portability and Accountability Act of 1996*.

ICD – The Interface Control Document that provides information about the format, structure, and content of electronic transaction files for processing by the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank (NPDB-HIPDB).

NPDB entity – Any entity that is authorized to query or report to the NPDB, pursuant to 42 U.S.C. §11101, et seq., the *Health Care Quality Improvement Act of 1986*.

QRXS user – Any individual who or organization that implements software to produce transaction files as described in the ICD, either for his, her, or its own use or to provide to NPDB or HIPDB entities.

Appendix B: Rules of Behavior

All individuals that have access to obtain information from and report information to the NPDB-HIPDB system must comply with the following conditions:

B.1 Ownership

This system is the property of the U.S. Department of Health and Human Services, Health Resources and Services Administration and is for authorized users only. The system is for official NPDB-HIPDB business only. Unauthorized access or use of this system may subject violators to criminal, civil and/or administrative penalties.

B.2 Responsibilities

Individual users are provided with a unique user ID and initial password to access this system. You are responsible for maintaining the integrity of and are held accountable for everything done using your user ID and password. No other person, including those at the NPDB-HIPDB Customer Service Center has access to your password. Passwords shall not be shared with others. If password security is suspected to be compromised you agree to change the password immediately, and notify the NPDB-HIPDB Customer Service Center.

Information and activities associated with the NPDB-HIPDB system shall not be false, inaccurate or misleading; violate any law, statute, ordinance or regulation; and contain any viruses or any malicious code that may damage, detrimentally interfere with, surreptitiously intercept, or expropriate any system, data, or personal information. "Information" is defined as any information you provide to the NPDB-HIPDB System in the course of using this system. "Activities" is defined as any process of interacting with the NPDB-HIPDB system.

B.3 Confidentiality

The system contains personal information protected under the provisions of the Privacy Act of 1974, 5 USC Section 552a. Violations of the provisions of the Privacy Act may subject the offender to criminal penalties.

Information reported to the NPDB and the HIPDB is confidential and shall not be disclosed except as specified in the NPDB and HIPDB regulations. The HHS OIG has the authority to impose civil money penalties on those who violate the confidentiality provisions of NPDB and/or HIPDB information. Persons or entities that receive information either directly or indirectly are subject to the confidentiality provisions specified in the NPDB regulations at 45 CFR Part 60 and the imposition of a civil money penalty of up to $11,000 for each offense if they violate those provisions. When an authorized agent is designated to handle NPDB-HIPDB queries, both the entity and the agent are required to maintain confidentiality in accordance with the federal statutory requirements.

B.4 Intrusion Detection

The system is maintained for the U.S. Government. It is protected by various provisions of Title 18, U.S. Code. Violations of Title 18 are subject to criminal prosecution in federal court.

Individuals using this system are subject to monitoring of those activities. Anyone using this system expressly consents to such monitoring and is advised that if such monitoring reveals possible evidence of criminal activity, system personnel may provide the evidence obtained by such monitoring to law enforcement officials. Moreover, for system security purposes and to ensure that the system is used for legitimate purposes by authorized, registered users, we collect information concerning the use of this system e.g. data you view and alter. We employ software programs to monitor traffic, and to identify unauthorized attempts to view and/or change information, or otherwise cause damage to the system.

Information from these sources may be used to help identify an individual(s) in the event of authorized law enforcement investigation, and pursuant to any required legal process.

B.5 Violation of Rules of Behavior

In the event it is suspected that you have not complied with these rules of behavior your account will be frozen, resulting in denial of all access to the system; and criminal, civil and/or administrative action may be taken.

Use of the NPDB-HIPDB system signifies acknowledgement and understanding of the responsibilities and agreement to comply with the Rules of Behavior for the NPDB-HIPDB system.