

## **C-416 CLAIM REPORTING GUIDELINES**

The Form C-416 Claim Report (“C-416”) submitted by the basic coverage insurance carrier or the self-insured provider (“insurer”) must be submitted in order to properly place the Medical Care Availability and Reduction of Error Fund (Mcare) on notice of a claim. 31 Pa. Code § 242.6. These instructions are intended to provide insurers with guidance in completing the C-416. Certain sections of the C-416 require specific information be provided, and those sections are noted below.

1. The Form C-416 Claim Report shall be fully completed before submission, including date and signature. Phrases such as “see attached,” “unknown,” “see complaint,” and “not otherwise described” are not acceptable.

Failure to complete the C-416 may result in Mcare returning the C-416 form along with a request to fill in any section that is incomplete. Upon receiving a rejected C-416, the carrier should immediately correct/complete the form and return it to Mcare. If the carrier is unable to fully complete the C-416 at the time of filing, the form must indicate the reason(s) why and promptly obtain the missing information and, upon receipt, submit it to Mcare.

A. Form C-416 definitions for block 1b:

|                            |                        |
|----------------------------|------------------------|
| <b>CM</b> -Claims Made     | <b>RE</b> -Retroactive |
| <b>OC</b> -Occurrence      | <b>TA</b> -Tail        |
| <b>OP</b> -Occurrence Plus | <b>PA</b> -Prior Acts  |

B. Severity Codes for block 6a (see “Injury Severity Code Definitions”):

|                                  |  |
|----------------------------------|--|
| <b>0</b> -Unknown                | <b>5</b> -Minor Permanent Injury                                       |
| <b>1</b> -Emotional Injury Only  | <b>6</b> -Significant Permanent Injury                                 |
| <b>2</b> -Insignificant Injury   | <b>7</b> -Major Permanent Injury                                       |
| <b>3</b> -Minor Temporary Injury | <b>8</b> -Grave Permanent Injury (Brain Damage/Quadriplegia/Life Care) |
| <b>4</b> -Major Temporary Injury | <b>9</b> -Death  |

C. Instructions for completing “Serious Event” date in block 4b:

Section 308(b) of the Medical Care Availability and Reduction of Error Act, 40 P.S. §§1303.101 *et seq.* (the “Act”) requires “A medical facility...” to “provide written notification to a patient affected by a serious event or, with the consent of the patient, to an available family member or designee, within seven days of the occurrence or discovery of a serious event.” If notice of a serious event was given to a patient or patient’s family member or designee, as required, the date of notification should be entered in this section of the C-416.

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2. Block 3b - Date of Birth, gender and Social Security number of injured party are required by Medicare Secondary Payer by Mcare.
3. If a third-party claims administrator is completing the form and administering the claim, its name and address must be provided in block 1a with the name of the insurer of record above it.
4. The following additional information is required when an insurer that has coverage for a claim as a result of a novation and/or assumption agreement submits a C-416:
  - A. Block 1a – provide the current insurer’s name followed by the insurer of record from whom the coverage was assumed, *e.g.*, ABC Professional Liability Insurance Co./XYZ Insurance Company. Only the address of the reporting insurer or TPA should follow the names.
  - B. Block 1b – provide the current insurer’s policy number followed by the policy number of the insurer whose coverage was assumed and enter the word “Novation” after the last policy number, *e.g.*, ABC1234/XYZ5678 Novation.
5. The following materials must be submitted with the C-416 for excess and Section 715 claims:
  - A. Copy of the legal complaint, writ of summons, demand for damages, and/or details concerning the claim;
  - B. Copies of all correspondence received from plaintiff’s counsel;
  - C. Copies of all discovery materials or summaries thereof in the possession of the insurer; and
  - D. A copy of all applicable orders issued by the court in the possession of the insurer.
6. Section 715 of the Act provides an exception to Mcare’s role as a statutory excess carrier. Specifically, under Section 715, Mcare provides first dollar indemnity and cost of defense for a claim (“Section 715 status”) if certain requirements are met. For a claim to be eligible for Section 715 status, proper and complete documentation must be provided to Mcare that establishes (1) the claim is for medical professional liability in accordance with the Act; (2) the claim has been made more than four years after the last date of the continuing course of treatment and/or incident; and (3) the claim was filed within the applicable statute of limitations.

In addition to the above, Mcare must receive a written request for indemnity and defense from the insurer via a C-416 within 180 days of the date on which notice of the claim is first given to the health care provider or the insurer, whichever is earlier. Notice of the

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claim includes, but is not limited to, a demand letter, a writ of summons, or a complaint. The 180-day time period begins to run when any one of these documents is received by a health care provider or his insurer, whichever is earliest. In order to toll the 180-day time period, the insurer must send the demand letter, details concerning the claim, writ of summons, or complaint to Mcare, along with a C-416 requesting Section 715 status. It is imperative that the insurer forward to Mcare the demand letter, details concerning the claim, writ of summons, or complaint within 180 days of receipt regardless of whether the documentation is sufficient for Mcare to render a Section 715 status determination. If there is any doubt about whether the claim is one for which Mcare would provide first dollar indemnity and cost of defense, the insurer should err on the side of caution and submit the writ of summons, complaint, demand letter, or details concerning the claim to Mcare along with a C-416 requesting Section 715 status.

The tolling of the 180-day time period is separate and distinct from Mcare's determination of Section 715 status for the claim. After receipt of the first notice of the claim and the C-416, the 180 days will be tolled but Mcare may require additional documentation in order to determine whether it can provide Section 715 status.

7. After receipt of the Mcare Fund's C-416 acknowledgment letter, the insurer shall report the following information to Mcare within 30 days of receipt of the letter by the insurer:
  - A. The plaintiff's demand. A copy of any demand letter should be sent to Mcare.
  - B. A list of all special damages alleged including, but not limited to, past and/or future wage loss, all medical special damages and all related expert reports.
  - C. If a writ of summons was previously provided, a copy of the complaint and any response(s) thereto.
  - D. A copy of any amended complaint(s) and response(s) thereto.
  - E. A copy of any applicable scheduling orders issued by the court.
  - F. The hospital admission, operative, and discharge records of any claimant.
  - G. The office records of the insured health care provider(s) and corporate entity.
  - H. All other medical records obtained.
  - I. Copies of all medical expert reports (liability, causation, subsequent treating, etc.) of plaintiff and defendant(s) answers to expert witness interrogatories. Any for medical review reports secured by the insurer should be sent to Mcare.
  - J. Autopsy report, when applicable.
  - K. Defense counsel summaries of pertinent depositions.

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- L. Copies of all correspondence from the insurer or their representatives seeking consent to settle and the response thereto.
  - M. Defense counsel summaries of answers to interrogatories.
  - N. All significant correspondence received from defense counsel including, but not limited to, case evaluations and responses submitted as part of a periodic claim status/evaluation program.
  - O. All development and case evaluations prepared by the insurer.
  - P. All pretrial memoranda submitted by plaintiff and defense counsel to the court or any other official body.
  - Q. Copies of any stipulations dismissing any parties.
  - R. All other information and documentation that is pertinent to the analysis and evaluation of the claim.
8. Insurers and defense counsel shall promptly notify Mcare of the date of trial and the dates of any settlement or pretrial conferences, as soon as they are known.

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**INJURY SEVERITY CODE DEFINITIONS**

- 0 Unknown
- 1 Emotional Injury (upset, fright)  
Shock to nerves or nervous system with no physical injury alleged.
- 2 Insignificant Injury (small cuts, lacerations, contusions, minor scars, rash, etc)  
Physical injury involving minor treatment or no treatment.
- 3 Minor Temporary Injury (infections, fractures, minor burns, missed or delayed diagnosis and/or recovery without complications)  
Physical injury is minor, but treatment continued before recovery occurred.
- 4 Major Temporary Injury (retained foreign object, other burns, side effects from medication or treatment, brain damage that resolves, infection after surgery, etc.)  
Temporary injuries of a significant nature. Complications that result in a longer treatment regimen, but no residual injuries exist.
- 5 Minor Permanent Injury (loss of fingers, loss or damage to organs, heart damage with recovery, removal of bowel, loss of one testicle or ovary, etc.)  
Permanent injuries, which have no long-term effects on activities of daily living.
- 6 Significant Permanent Injury (deafness, complete or partial loss of limb, eye, one kidney or lung, brachial plexus injury, reflex sympathetic dystrophy which is disabling, etc.)  
Permanent injuries with long-term effects on activities of daily living.
- 7 Major Permanent Injury (paraplegia, blindness, loss of two limbs, brain damage, severe and visible disfigurement, permanent colostomy, aseptic necrosis of a joint, a central nervous system injury which is not totally disabling, etc.)  
Injury is severe or is an amplification of a significant permanent injury. Brain damage for which there are permanent residual effects.
- 8 Grave Permanent Injury (quadriplegia or severe brain damage requiring lifelong care, persistent coma, etc.)  
Most serious of injuries where all aspects of life are significantly compromised, but death has not occurred.
- 9 Death  
Allegations are that death occurred due to the actions of the health care provider.