Roles and Responsibilities of the INCAP Medical Review Panel

A medical review panel is composed of three health care professionals and one attorney who serves as chairman and facilitator but has no voting authority. The three panel members are chosen as follows: The plaintiff and defendant each choose one health care provider; these two providers choose a third. If the defendant is a health care professional who specializes in a limited area of medicine, two of the panelists selected must be from the same field as the defendant. Panel members are compensated for their efforts; health care providers receive no per diem and not more than $350 plus travel, while the attorney-chairman receives $250 per diem and not more than $2,000 plus travel. The side in whose favor the majority opinion is written pays these fees.

To begin the process, the claimant must file a complaint with the insurance commissioner. The commissioner then notifies the health care provider by registered mail within 10 days, and the panel may be formed within 20 days after filing of the complaint.

A panel opinion must be rendered within 180 days after selection of the last member of the panel. Once the panel has reviewed all evidence, it has 30 days to render an expert opinion, in writing, to be signed by the panelists. Though the panel's findings are not legally binding, each panel member can be called upon to provide expert testimony should the case proceed to court for a ruling. The report also is admissible as evidence in any action brought by the claimant in a court of law. The medical review panel must render its decision before any court action can take place, unless the claim is less than $15,000 or both parties agree to bypass this step. The filing of a complaint stops the statute of limitations until 90 days after receiving a panel decision.

All malpractice claims settled or adjudicated to final judgment against a health care provider must be reported to the commissioner by the plaintiff's attorney and by the health care provider, or his insurer or risk manager, within 60 days following final disposition of the claim.

The report must state:

- Nature of the claim
- Damages asserted
- Alleged injury
- Attorney's fees
- Expenses incurred in connection with the claim or defense
- Amount of any settlement or judgment

If a decision is rendered against the health care provider, the insurance commissioner is responsible for forwarding the health care provider's name to the appropriate board of professional registration and examination for review of the health care provider's fitness to practice his profession.