IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Hamot Medical Center, Petitioner	:	
v.	:	
Medical Care Availability and Reduction of Error Fund, Respondent	:	No. 299 M.D. 2010
	:	Argued: December 7, 2010

BEFORE: HONORABLE RENÉE COHN JUBELIRER, Judge
HONORABLE JOHNNY J. BUTLER, Judge
HONORABLE KEITH B. QUIGLEY, Senior Judge

OPINION NOT REPORTED

MEMORANDUM OPINION BY
JUDGE BUTLER FILED: December 23, 2010

The Medical Care Availability and Reduction of Error Fund (Mcare Fund) filed Exceptions to a Proposed Decision recommending reversal of the order of the Mcare Fund which denied coverage under Section 715 of the Medical Care Availability and Reduction of Error Act (Act),[1] (Section 715) for Hamot Medical Center (the hospital). There is one issue before the Court: whether the Mcare Fund properly concluded that the Section 715 claim was "made" against the health care provider less than four years after the date of the alleged malpractice. For reasons that follow, we sustain the Exceptions and enter judgment in favor of the Mcare Fund.

[1] Act of March 20, 2002, P.L. 154, *as amended*, 40 P.S. § 1303.715(a).

On May 11, 2005, Patricia Wees filed a praecipe for a writ of summons against a number of medical providers including the hospital. On October 13, 2005, a Form C-416 claim reporting the lawsuit was submitted to the Mcare Fund on behalf of the hospital requesting Section 715 indemnity and defense coverage for the hospital. The C-416 form reported that the date of alleged malpractice was May 19, 2001. On November 1, 2005, the Mcare Fund denied Section 715 coverage because the claim was made less than four years after the alleged malpractice. The hospital appealed the decision and requested a hearing before the Pennsylvania Insurance Department (PID). Pursuant to a scheduling order, a joint stipulation of facts (joint stipulation) was filed on April 4, 2006.

Prior to the Insurance Commissioner issuing an adjudication, the Pennsylvania Supreme Court ruled that this Court has original jurisdiction over claims against the Mcare Fund.[2] As a result of various orders, the entire administrative record was forwarded to the Court on March 24, 2010. On June 30, 2010, a hearing examiner was appointed to prepare and file a proposed decision and order. On July 23, 2010, the hearing examiner filed a Proposed Decision recommending that the decision of the PID denying Section 715 coverage be reversed. The Mcare Fund timely filed Exceptions with this Court to the Proposed Decision.[3]

The Mcare Fund argues that under the plain language of the statute, a claim is "made" for purposes of Section 715 when it is first asserted, instituted, or comes into existence. Thus, the Mcare Fund contends that the claim was "made" on

---

[2] *Fletcher v. Pa. Property and Cas. Ins. Guar. Ass'n*, 603 Pa. 452, 985 A.2d 678 (2009).

[3] "On issues of statutory interpretation this Court's scope of review is plenary, and our standard of review is *de novo*." *Bender v. Pa. Ins. Dep't*, 893 A.2d 161, 162 (Pa. Cmwlth. 2006).

May 11, 2005, when the writ of summons was filed in the courthouse and a civil action was instituted. We agree.

Section 715(a) provides in pertinent part:

> If a medical professional liability claim against a health care provider . . . is *made* more than four years after the breach of contract or tort occurred and if the claim is filed within the applicable statute of limitations, the claim shall be defended by the department if the department received a written request for indemnity and defense within 180 days of the date on which *notice of the claim* is first given to the participating health care provider or its insurer.

(Emphasis added). In the case *In Re: Kimberly S. Harnist, MD*, MM06-02-014 (filed October 10, 2006), the Insurance Commissioner held in no uncertain terms that the date a writ of summons is filed, is the date a claim is "made." Although the hospital argued that the Commissioner included the date of service of the writ in making his determination that the claim was "made" before the four years, the Commissioner only referenced the service of the writ because had the writ not been served, the claim would have been a nullity. However, the Insurance Commissioner determined that since the writ was served, regardless of the date, the date of the filing of the writ was the date on which the claim was "made." We agree with the reasoning in *Harnist* and hold that the date the writ was filed is the date the claim was "made."

This Court notes that the hospital argued that this Court, in *Cope v. Insurance Commissioner*, 955 A.2d 1043 (Pa. Cmwlth. 2008), held that notice is required for a claim to be "made." However, this Court was not addressing the date on which a claim is "made" in that matter, rather it held that the notice requirement under Section 715 that triggers the 180 days from which the written request must be made is not satisfied by the filing of a writ.

Here, according to the joint stipulation, the ending date of the alleged malpractice was May 19, 2001, and the writ was filed on May 11, 2005, less than four years after the malpractice. Thus, the hospital is not entitled to Section 715 coverage. Accordingly, the Exceptions filed by the Mcare Fund are sustained, and judgment is entered in favor of the Mcare Fund.

_____

JOHNNY J. BUTLER, Judge

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Hamot Medical Center, Petitioner	:	
v.	:	
Medical Care Availability and Reduction of Error Fund, Respondent	:	No. 299 M.D. 2010

O R D E R

AND NOW, this 23rd day of December, 2010, the Exceptions filed by the Medical Care Availability and Reduction of Error (Mcare) Fund are sustained. Judgment is entered accordingly, in favor of the Mcare Fund as Petitioner is not entitled to Mcare coverage in the matter before the Court.

_____

JOHNNY J. BUTLER, Judge