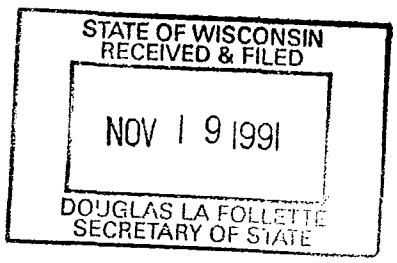
CR 91-131



STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

I, John W. Torgerson, Deputy Commissioner of Insurance and custodian of the official records of this Office, certify that the attached rule-making order affecting s. Ins 17.285, Wis. Adm. Code, relating to revising the procedures of the Patients Compensation Fund Peer Review Council, was issued by this Office on November 18, 1991.

I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the whole of the original.

Dated at Madison, Wisconsin, this 18th day of November, 1991.

John Torgerson

John W. Torgerson
Deputy Commissioner of Insurance

25229T3

2-1-92

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

AND THE BOARD OF GOVERNORS OF THE PATIENTS COMPENSATION FUND

REPEALING, RENUMBERING, RENUMBERING AND AMENDING, CONSOLIDATING, RENUMBERING AND AMENDING, AMENDING, REPEALING AND RECREATING, AND CREATING A RULE

To repeal Ins 17.285 (3) (b) to (d), (4) (b) 2, (c) and (d), (6), (8) (title), (11) (b) and (14); to renumber Ins 17.285 (5) (d); to renumber and amend Ins 17.285 (3) (a) and (8); to consolidate, renumber and amend Ins 17.285 (4) (b) (intro.) and 1; to amend Ins 17.25 (12m) (c) (intro.), 17.28 (6s) (c) (intro.) and 17.285 (2) (a), (b), (d) and (e), (4) (title), (7) (b), (11) (a), (c), (d), (e) (intro.) and 1 and (f) and (12); to repeal and recreate Ins 17.285 (3) (title), (4) (a), (5) (a) to (c) and (9) (a); and to create Ins 17.285 (2) (cg) and (cr), (2s), (4) (b), (5) (d) and (f) and (9) (am), relating to revising the procedures of the patients compensation fund peer review council.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3) and 655.004, Stats.

Statutes Interpreted: ss. 146.82 (2) (a) 5, 601.42 (1g) and (4) and 655.275 (5) and (8), Stats.

The patients compensation fund (fund) peer review council (council) was established to review medical malpractice claims paid for health care providers who are fund participants, and to make recommendations to the fund's board of governors about whether to impose a surcharge on a provider's Wisconsin health care liability insurance plan premium or fund fee. The procedures used by the council are established by administrative rule. This rule revises those procedures to clarify responsibilities and provide better notice to providers who may be subject to a surcharge. The rule makes the following changes:

1. Makes the council itself, rather than consultants retained by the council, responsible for considering the mitigating circumstances that may reduce or eliminate a surcharge. A consultant provides the council only with an opinion as to whether the provider met the appropriate standard of care with respect to each medical incident involved in the review.

2. Expressly authorizes the council to use its existing statutory authority to obtain patient health care records for use in reviewing claims.

3. Repeals the existing penalty of an automatic surcharge for a provider's failure to respond to the council's written requests. Instead, a provider who fails to respond to the council will be referred to the enforcement section of the office of the commissioner of insurance for administrative action which may result in a forfeiture, in addition to any surcharge that may be imposed.

4. Eliminates the council's authority to obtain information from defense attorneys. A provider may still furnish the council with information from the defense attorney's files, if the provider chooses to do so.

5. Revises and clarifies the procedures for requesting information from and providing notice to providers, and specifies the provider's right to inspect and copy the council's records.

6. Changes the time period during which a surcharge remains in effect from 3 years to 36 months in order to eliminate the possibility that a provider who leaves the state or stops practicing for all or part of a 3-year period may avoid payment of the surcharge upon returning to practice in this state.

7. Repeals a provision requiring the fund board to annually review the tables establishing the thresholds that trigger a surcharge review.

SECTION 1. Ins 17.25 (12m) (c) (intro.) is amended to read:

Ins 17.25 (12m) (c) (intro.) The following tables shall be used in making the determinations required under ~~this subsection and~~ s. Ins 17.285 ~~(3) (a), (4) (a), (7) and (9)~~ as to the percentage increase in a provider's plan premium:

SECTION 2. Ins 17.28 (6s) (c) (intro.) is amended to read:

Ins 17.28 (6s) (c) (intro.) The following tables shall be used in making the determinations required under ~~this subsection and~~ s. Ins 17.285 ~~(3) (a), (4) (a), (7) and (9)~~ as to the percentage increase in a provider's fund fee:

SECTION 3. Ins 17.285 (2) (a), (b), (d) and (e) are amended to read:

Ins 17.285 (2) (a) "Aggregate indemnity" means the total amount attributable to an individual provider that is paid or owing to or on behalf of ~~any claimant~~ claimants for all closed claims arising out of one incident or course of conduct, including amounts held by the fund under s. 655.015, Stats. "Aggregate indemnity" does not include any expenses paid in the defense of the claim.

(b) "Closed claim" means a medical malpractice claim against a provider, or a claim against an employe of a health care provider for which

the provider is vicariously liable, for which there has been a either of the following:

1. A final determination based on a settlement, award or judgment that indemnity will be paid to or on behalf of a claimant.

2. A payment to a claimant by the provider or another person on the provider's behalf.

(d) ~~"Provider"~~ "Provider," when used without further qualification, means a health care provider subject to ch. 655, Stats., who is a natural person. "Provider" does not include a hospital or other facility or entity that provides health care services.

(e) "Review period" means the 5-year period ending with the date of the first payment on the most recent closed claim reported under s. 655.26, Stats., for a specific provider.

SECTION 4. Ins 17.285 (2) (cg) and (cr) and (2s) are created to read:

Ins 17.285 (2) (cg) "Health care provider" has the meaning given in s. 146.81 (1), Stats.

(cr) "Patient health care records" has the meaning given in s. 146.81 (4), Stats.

(2s) INFORMATION FOR PROVIDER. Upon receipt of a report under sub. (2m), the council shall mail to the provider who is the subject of the report all of the following:

(a) A copy of the report, with a statement that the provider may contact the insurer that filed the report if the provider believes it contains inaccurate information.

(b) A statement that the council may use its authority under s. 146.82 (2) (a) 5, Stats., to obtain any patient health care records necessary for use in making determinations under this section.

(c) A request that the provider sign and return to the council an authorization for release of information form, authorizing the provider's insurer to provide the council with relevant factual information about the closed claim for use in making determinations under this section. A copy of the form shall be enclosed with the mailing.

(d) If necessary, a request that the provider verify the council's closed claim record and furnish the council with information on any additional closed claims not known to the council that have been paid by or on behalf of the provider during the review period.

(e) Notice that if the provider does not comply with a request under par. (c) or (d) within 40 days after the date of the request, the provider is in violation of s. 601.42 (4), Stats., and may be subject to a forfeiture of up to $1,000 for each week of continued violation, as provided in s. 601.64 (3), Stats.

SECTION 5. Ins 17.285 (3) (title) is repealed and recreated to read:

Ins 17.285 (3) (title) DETERMINATION OF NEED FOR REVIEW.

SECTION 6. Ins 17.285 (3) (a) is renumbered Ins 17.285 (3) and amended to read:

Ins 17.285 (3) ~~Each month the council shall examine all claims paid reports received under s. 655.26, Stats., to~~ Based on reports received under sub. (2m) and any additional closed claims reported in response to a request under sub. (2s) (d), the council, using the tables under ss. 17.25 (12m) (c) and 17.28 (6s) (c), shall determine ~~whether each~~ when a provider ~~for whom a closed claim is reported~~ has, during ~~the~~ a review period, accumulated enough closed claims and aggregate indemnity to ~~require~~ consider the imposition of a surcharge~~, based on the tables under ss. Ins 17.25 (12m) (c) and 17.28 (6s) (c). In determining the number of closed claims accumulated by a provider,~~

~~the council shall count all claims arising out of one incident or course of conduct as one claim.~~

SECTION 7. Ins 17.285 (3) (b) to (d) are repealed.

SECTION 8. Ins 17.285 (4) (title) is amended to read:

Ins 17.285 (4) (title) RECORDS REQUESTS; NOTICE TO PROVIDER.

SECTION 9. Ins 17.285 (4) (a) is repealed and recreated to read:

Ins 17.285 (4) (a) When the council makes a determination under sub. (3), it may request any of the following:

1. From any health care provider, patient health care records related to each closed claim subject to review as provided in s. 146.82 (2) (a) 5, Stats.

2. From the provider's insurer, relevant factual information about each closed claim subject to review. This subdivision applies only if the provider has complied with the request under sub. (2s) (c).

SECTION 10. Ins 17.285 (4) (b) (intro.) and 1 are consolidated, renumbered Ins 17.285 (4) (c) and amended to read:

Ins 17.285 (4) (c) The council shall notify ~~each~~ a provider ~~subject to a review~~ for whom a determination is made under sub. (3) that, after reviewing the patient health care records, consultants' opinions and other relevant information submitted by the provider and the provider's insurer, the council may recommend that a surcharge ~~may~~ be imposed on the provider's plan premium, fund fee or both, and that the surcharge may be reduced or eliminated following a review as provided in this section. The notice shall ~~also~~ include: ~~1.~~ A a description of the procedures specified in this section and a statement that the provider may submit in writing relevant information about any ~~incident~~ closed claim involved in the review and a description of mitigating circumstances that may reduce the future risk to the plan, the fund or both.

SECTION 11. Ins 17.285 (4) (b) 2, (c) and (d) are repealed.

SECTION 12. Ins 17.285 (4) (b) is created to read:

Ins 17.285 (4) (b) A request under par. (a) shall be in writing and shall specify a reasonable time for response. Each person receiving a request shall provide the council with the records and information requested, unless the person no longer maintains or has access to them. If a person is unable to comply with a request, the person shall notify the council in writing of the reason for the inability to comply.

SECTION 13. Ins 17.285 (5) (a) to (c) are repealed and recreated to read:

Ins 17.285 (5) (a) The council or a single council member may conduct a preliminary review of the records and information relating to each of a provider's closed claims. If the council or council member is able to determine, without a consultant, that the provider met the appropriate standard of care with respect to any closed claim, the council shall not refer that closed claim to a consultant and shall not use that closed claim in determining whether to impose a surcharge on that provider.

(b) Unless a determination under par. (a) reduces the number of closed claims and aggregate indemnity so that the provider is no longer subject to the imposition of a surcharge, the council shall refer all records and information relating to closed claims subject to review, including records and information in the custody of the plan and the fund, to one or more specialists as provided in s. 655.275 (5) (b), Stats.

(c) Each specialist consulted under par. (b) shall provide the council with a written opinion as to whether the provider met the appropriate standard of care with respect to each closed claim reviewed.

SECTION 14. Ins 17.285 (5) (d) is renumbered Ins 17.285 (5) (e).

SECTION 15. Ins 17.285 (5) (d) and (f) are created to read:

Ins 17.285 (5) (d) At least 30 days before the meeting at which the council will decide whether or not to recommend that a surcharge should be imposed on a provider, the council shall notify the provider of the date of the meeting and furnish the provider with a copy of the consultant's opinions and a list of any other documents on which the recommendation will be based. The council shall make all documents available to the provider upon request for inspection and copying, as provided under s. 19.35, Stats.

(f) The council, after taking into consideration all available information, shall decide whether each closed claim reviewed should be counted in recommending whether to impose a surcharge on the provider.

SECTION 16. Ins 17.285 (6) is repealed.

SECTION 17. Ins 17.285 (7) (b) is amended to read:

Ins 17.285 (7) (b) If the council determines that~~, because of mitigating circumstances,~~ one or more closed claims should not be counted and, as a result, the total number of closed claims remaining and the aggregate indemnity attributable to those claims ~~would~~ is not ~~be~~ sufficient to require the imposition of a surcharge, the council shall prepare a written report for the board recommending that no surcharge should be imposed. The report shall include a brief summary of the basis for the recommendation.

SECTION 18. Ins 17.285 (8) (title) is repealed.

SECTION 19. Ins 17.285 (8) is renumbered Ins 17.285 (7) (c) and amended to read:

Ins 17.285 (7) (c) The council shall furnish the provider with a copy of its report and recommendation to the board and~~, except as provided in~~

~~sub.-(4)-(c)-2.,-shall-also-notify-the-provider-of-the-right-to-request-a hearing-under-ch.-227,-Stats.,-and-ch.-Ins-5-within-30-days-after-receipt-of the-notice~~ with notice of the right to a hearing as provided in sub. (9).

SECTION 20. Ins 17.285 (9) (a) is repealed and recreated to read:

Ins 17.285 (9) (a) A provider has the right to a hearing under ch. 227, Stats., and ch. Ins 5 on the council's recommendation, if the provider requests a hearing within 30 days after receiving the notice under sub. (7) (c).

SECTION 21. Ins 17.285 (9) (am) is created to read:

Ins 17.285 (9) (am) The reports of the consultant and any other documents relied on by the council in making its recommendation to the board are admissible in evidence at a hearing under this section.

SECTION 22. Ins 17.285 (11) (a) is amended to read:

Ins 17.285 (11) (a) A surcharge imposed on a provider's plan premium, fund fee or both after a final decision by the board takes effect on the next ~~policy-renewal~~ billing date and remains in effect during any period of judicial review.

SECTION 23. Ins 17.285 (11) (b) is repealed.

SECTION 24. Ins 17.285 (11) (c), (d), (e) (intro.) and 1 and (f) and (12) are amended to read:

Ins 17.285 (11) (c) If judicial review results in the imposition of no surcharge or a reduced surcharge, the plan, the fund or both shall refund the excess amount collected from the provider or apply a credit to the provider's next ~~annual~~ plan premium~~,~~ or fund fee bill or both ~~with-the-excess amount~~.

(d) A surcharge remains in effect for ~~3 years~~ 36 months. The percentage imposed ~~under par. (a) or (b)~~ shall be reduced by 50% for the 2nd ~~year~~ 12 months and by 75% for the 3rd ~~year~~ 12 months, if the provider does not accumulate any additional closed claims ~~during the 3 year period~~ before the expiration of the surcharge. The time periods specified in this paragraph are tolled on the date a provider stops practicing in this state and remain tolled until the provider resumes practice in this state.

(e) (intro.) If the provider accumulates additional closed claims ~~during the 3 year period~~ while a surcharge is in effect, the provider is subject to the higher of the following:

1. The surcharge ~~determined~~ imposed under sub. 10 and par. (d).

(f) If the provider is a physician who~~, during the 3 year period,~~ changes from one class to another class specified in ~~ss.~~ s. Ins 17.25 (12m) (c) or 17.28 (6s) (c) while a surcharge is in effect, the percentage ~~surcharge~~ imposed by the final decision of the board shall be applied to the plan premium, fund fee or both for the physician's new class effective on the date the class change occurs.

(12) REQUEST FROM PRIVATE INSURER. If the council receives a request for a recommendation under s. 655.275 (5) (a) 3, Stats., from a private insurer, the council shall follow the procedures specified in subs. (3) to (5) and notify the private insurer and the provider of the determination it would make under sub. ~~(6) (b)~~ (5) (f) if the provider's primary insurer were the plan. A provider is not entitled to a hearing on any determination reported under this subsection.

SECTION 25. Ins 17.285 (14) is repealed.

SECTION 26. INITIAL APPLICABILITY. The treatment of section Ins 17.285 by this rule applies to claims closed before, on and after the effective date of this rule.

SECTION 27. EFFECTIVE DATE. This rule will take effect on the first day of the first month after publication, as provided in s. 227.22 (2) (intro.), Stats.

Dated at Madison, Wisconsin, this 18 day of NOV., 1991.

John W. Torgerson
Deputy Commissioner of Insurance