Chapter Ins 17

HEALTH CARE LIABILITY INSURANCE PATIENTS COMPENSATION FUND

Ins 17.001 Definitions. In this chapter:

(1) "Board" means the board of governors established under s. 619.04 (3), Stats.

(1m) "Commissioner" means the commissioner of insurance or deputy commissioner acting under s. 601.11 (1) (b), Stats.

(2) "Fund" means the patients compensation fund established under s. 655.27 (1), Stats.

(3) "Hearing" has the meaning given in s. Ins 5.01 (1).

(4) "Plan" means the Wisconsin health care liability insurance plan, a nonprofit, unincorporated association established under s. 619.01 (1) (a), Stats.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; am. (intro.) to (4), cr. (1m), Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.005 Purpose. This chapter implements ss. 619.01 and 619.04 and ch. 655, Stats.

History: Cr. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.01 Payment of mediation fund fees. (1) PURPOSE. This section implements s. 655.61 (2), Stats., relating to the payment of mediation fund fees.

(2) FEE. (a) Each physician subject to ch. 655, Stats., except a resident, and each hospital subject to ch. 655, Stats., shall pay to the commissioner an annual fee to finance the mediation system created by s. 655.42, Stats.

(b) The fund shall bill a physician or hospital subject to this section under s. Ins 17.28 (7) (a). The entire annual fee under this section is due and payable 30 days after the fund mails the bill.

(d) The fund shall notify the medical examining board of each physician who has not paid the fee as required under par. (b).

(e) The fund shall notify the department of health and social services of each hospital which has not paid the fee as required under par. (b).

(f) Fees collected under this section are not refundable except to correct an administrative billing error.

(3) FEE SCHEDULE. The following fee schedule shall be effective July 1, 1992:

(a) For physicians — $ 60.00

(b) For hospitals, per occupied bed — $ 3.00

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; emerg. r. and recr. eff. 7-2-86; r. and recr., Register, September, 1986, No. 369, eff. 10-1-86; cr. (2) (f), am. (3), Register, June, 1987, No. 378, eff. 7-1-87; am. (1), (2) (a), (d) and (e), (3), r. and recr. (2) (b), r. (2) (c), Register, June, 1990, No. 414, eff. 7-1-90; emerg. am. (3), eff. 7-1-91; am. (3) (intro.), Register, July, 1991, No. 427, eff. 8-1-91; am. (3) (a) and (b), Register, October, 1991, No. 430, eff. 11-1-91; emerg. am. (3), eff. 4-28-92; am. (3), Register, July, 1992, No. 439, eff. 8-1-92.

Ins 17.24 Review of classification. (1) Any person insured by the plan or covered by the fund may petition the board for a review of its classification by the plan or fund. The petition shall state the basis for the petitioner's belief that its classification is incorrect. The board shall refer a petition for review to either of the following:

(a) If the petitioner is a hospital or a nursing home or other entity affiliated with a hospital, to a committee appointed by the commissioner consisting of 2 representatives of hospitals, other than the petitioner's hospital, and one other person who is knowledgeable about insurance classification.

(b) If the petitioner is any person other than a person specified in par. (a), to a committee appointed by the commissioner consisting of 2 physicians who are not directly or indirectly affiliated or associated with the petitioner and one other person who is knowledgeable about insurance classification.

(2) The plan, the fund or both shall provide the committee with any information needed to review the classification.

(2m) The committee shall review the classification and report its recommendation to the petitioner and the board within 5 days after completing the review.

(3) Any person that is not satisfied with the recommendation of the committee may petition for a hearing under ch. 227, Stats., and ch. Ins 5 within 30 days after the date of receipt of written notice of the committee's recommendation.

(4) At the hearing held pursuant to a petition under sub. (3), the committee report shall be considered and the members of the committee may appear and be heard.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. and recr. (1) and (2), cr. (2m), am. (3) and (4), Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.25 Wisconsin health care liability insurance plan. (1) FINDINGS. (a) Legislation has been enacted authorizing the commissioner to promulgate a plan to provide health care liability insurance and liability coverage normally incidental to health care liability insurance for risks in this state which are equitably entitled to but otherwise unable to obtain such coverage, or to call upon the insurance industry to prepare plans for the commissioner's approval.

Pediatrics - no surgery
Pharmacology - clinical
Physiatry
Physical medicine and rehabilitation
Physicians - no surgery
Psychiatry - including child
Psychoanalysis
Psychosomatic medicine
Public health
Pulmonary diseases - no surgery
Radiology - diagnostic - no surgery
Rheumatology - no surgery
Rhinology - no surgery

2. Class 2:

Anesthesiology -applicable to all physicians who perform general anesthesia or acupuncture anesthesia
Broncho-esophagology
Cardiology - including catheterization, but not including cardiac surgery
Cardiovascular disease - minor surgery
Dermatology - minor surgery
Diabetes - minor surgery
Emergency medicine - no major surgery — applicable to any family or general practitioner or other specialist primarily engaged in emergency practice at a clinic, hospital or other facility who does not perform major surgery
Endocrinology - minor surgery
Family practice and general practice - minor surgery - no obstetrics
Family practice or general practice - including obstetrics
Gastroenterology - minor surgery
Geriatrics - minor surgery
Gynecology - minor surgery
Hematology - minor surgery
Infectious diseases - minor surgery
Intensive care medicine - applicable to any family or general practitioner or other specialist employed in an intensive care hospital unit.
Internal medicine - minor surgery
Laryngology - minor surgery
Neoplastic diseases - minor surgery
Nephrology - minor surgery
Neurology - including child- minor surgery
Ophthalmology - minor surgery
Otology - minor surgery
Otorhinolaryngology - minor surgery
Pathology - minor surgery
Pediatrics - minor surgery
Physicians - minor surgery
Radiology - diagnostic - minor surgery
Rhinology - minor surgery
Surgery - colon and rectal
Surgery - endocrinology
Surgery - gastroenterology
Surgery - general practice or family practice - not primarily engaged in major surgery
Surgery - geriatrics
Surgery - neoplastic
Surgery - nephrology
Surgery - ophthalmology
Surgery - urological
Urgent care - practice in urgent care, walk-in or after hours facility

3. Class 3:

Emergency medicine - including major surgery
General surgery - as a specialty
Surgery - abdominal
Surgery - cardiac
Surgery - cardiovascular disease
Surgery - gynecology
Surgery - hand
Surgery - head and neck
Surgery - laryngology
Surgery - orthopedic
Surgery - otology
Surgery - otorhinolaryngology - no plastic surgery
Surgery - plastic
Surgery - plastic - otorhinolaryngology
Surgery - rhinology

Surgery - thoracic	Surgery - vascular
Surgery - traumatic	Weight control - bariatrics

4. Class 4:

Surgery - neurology - including child	Surgery - obstetrics and gynecology
Surgery - obstetrics	

(d) "Fiscal year" means each period beginning each July 1 and ending each June 30.

(e) "Permanently cease operation" means for a provider other than a natural person to stop providing health care services with the intent not to resume providing such services in this state.

(f) "Permanently cease practice" means to stop practicing as a medical or osteopathic physician or nurse anesthetist with the intent not to resume that type of practice in this state.

(g) "Primary coverage" means health care liability insurance meeting the requirements of subch. III of ch. 655, Stats.

(h) "Provider" means a health care provider, as defined in s. 655.001 (8), Stats.

(hm) "Resident" means a licensed physician engaged in an approved postgraduate medical education or fellowship program in any specialty specified in par. (c) 1 to 4.

(i) "Temporarily cease practice" means to stop practicing in this state for any period of time because of the suspension or revocation of a provider's license, or to stop practicing for at least 90 consecutive days for any other reason.

(3e) PRIMARY COVERAGE REQUIRED. Each provider shall ensure that primary coverage is in effect on the date the provider begins practice or operation and for all periods during which the provider practices or operates in this state. A provider does not have fund coverage for any period during which primary coverage is not in effect.

(3m) EXEMPTIONS; ELIGIBILITY. A medical or osteopathic physician licensed under ch. 448, Stats., or a nurse anesthetist licensed under ch. 441, Stats., may claim an exemption from ch. 655, Stats., if at least one of the following conditions applies:

(a) The provider will not practice more than 240 hours in the fiscal year.

(c) During the fiscal year, the provider will derive more than 50% of the income from his or her practice from outside this state or will attend to more than 50% of his or her patients outside this state.

(3s) LATE ENTRY TO FUND. (a) A provider that begins or resumes practice or operation during a fiscal year, has claimed an exemption or has failed to comply with sub. (3e) may obtain fund coverage during a fiscal year by giving the fund advance written notice of the date on which fund coverage should begin.

(b) The board may authorize retroactive fund coverage for a provider who submits a timely request for retroactive coverage showing that the failure to procure coverage occurred through no fault of the provider and despite the fact that the provider acted reasonably and in good faith. The provider shall furnish the board with an affidavit describing the necessity for the retroactive coverage and stating that the provider has no notice of any pending claim alleging malpractice or knowledge of a threatened claim or of any occurrence that might give rise to such a claim. The authorization shall be in writing, specifying the effective date of fund coverage.

(4) ANNUAL FEES; BILLING PROCEDURES. (a) *Definition.* In this subsection, "semimonthly period" means the 1st through the 14th day of a month or the 15th day through the end of a month.

(b) *Entry during fiscal year; prorated annual fee.* If a provider begins practice or operation or enters the fund under sub. (3s) (b) after the beginning of a fiscal year, the fund shall charge the provider one twenty-fourth of the annual fee for each semimonthly period or part of a semimonthly period from the date fund coverage begins to the next June 30.

(c) *Ceasing practice or operation; refunds.* A provider or person acting on the provider's behalf shall notify the fund in the form specified by the fund if any of the following occurs:

1. The provider is exempt under sub. (3m) (a) or (c).

2. The provider is no longer eligible to participate in the fund under s. 655.003 (1) or (3), Stats.

3. This state is no longer a principal place of practice for the provider.

4. The provider has temporarily or permanently ceased practice or has ceased operation.

5. The provider's classification under sub. (6) has changed.

(cm) *Eligibility for exemption; refund.* If a provider claims an exemption after paying all or part of the annual fee, the fund shall issue a refund equal to one twenty-fourth of the provider's annual fee for each full semimonthly period from the date the provider becomes eligible for the exemption to the due date of the next payment.

(cs) *Ineligibility for fund coverage; refund.* 1. If a provider who has paid all or part of the annual fee is or becomes ineligible to participate in the fund under s. 655.003 (1) or (3), Stats., or because he or she does not practice in this state, the fund shall issue a full refund of any amount the provider paid for fund coverage for which he or she was not eligible.

2. If a provider that has paid all or part of the annual fee is ineligible for fund coverage because the provider is not in compliance with sub. (3e), the fund shall issue a full refund of the amount paid for the period of noncompliance, beginning with the date the noncompliance began.

(d) *Change of classification; increased annual fee.* 1. If a provider's change of classification under sub. (6) during a fiscal year results in an increased annual fee, the fund shall adjust the provider's annual fee to equal the sum of the following:

a. One twenty-fourth of the annual fee for the provider's former classification for each full semimonthly period from the due date of the provider's first payment during the current fiscal year to the date of the change.

b. One twenty-fourth of the annual fee for the provider's new classification for each full or partial semimonthly period from the date of the change to the next June 30.

2. The fund shall bill the provider for the total amount of the increase under subd. 1 if the provider has already paid the total annual fee, or shall prorate the increase over the remaining installment payments.

(e) *Change of classification; decreased annual fee.* 1. If a provider's change of classification under sub. (6) during a fiscal year results in a decreased annual fee, the fund shall adjust the provider's annual fee to equal the sum of the following:

a. One twenty-fourth of the annual fee for the provider's former classification for each full or partial semimonthly period from the due date of the provider's first payment during the current fiscal year to the date of the change.

b. One twenty-fourth of the annual fee for the provider's new classification for each full semimonthly period from the date of the change to the next June 30.

2. The fund shall credit the amount of the decrease under subd. 1 over any remaining instalment payments. If the provider has already paid the total annual fee, the fund shall issue a refund if the amount of the refund is more than $10. The fund shall credit any amount of $10 or less to the provider's account. If the provider no longer participates in the fund, a credit of $10 or less shall lapse to the fund.

(f) *Refund of other charges.* If a provider is entitled to a refund or credit under this subsection, the fund shall also issue a refund or credit of the unearned portion of any amounts paid as administrative service charges, interest or surcharges, using the same method used to calculate a refund or credit of an annual fee. A mediation fund fee is refundable only if the provider did not participate in the patients compensation fund for any part of the fiscal year.

(g) *Refund for administrative error.* In addition to any refund authorized under par. (c), (cm), (cs), (e) or (f), the fund may issue a refund to correct an administrative error in the current or any previous fiscal year.

(h) *Billing; entire fiscal year.* Except as provided in sub. (6e) (b), for each fiscal year, the fund shall issue to each provider participating in the fund an initial bill which shall include all of the following:

1. The total annual fee due for the fiscal year.

2. Any applicable surcharge imposed under s. Ins 17.285.

3. The balance and accrued interest, if any, due from a prior fiscal year.

4. Notice of the provider's right to pay the amount due in full or in instalments.

5. The minimum amount due if the provider elects instalment payments.

6. The payment due date.

(i) *Billing; partial fiscal year.* The fund shall issue each provider entering the fund after the beginning of a fiscal year an initial bill which shall include all of the following;

1. The total amount due calculated under par. (b).

2. Notice of the provider's right to pay the amount due in full or in instalments.

3. The minimum amount due if the provider elects instalment payments.

4. The payment due date.

(j) *Balance billing.* If a provider pays at least the minimum amount due but less than the total amount due by the due date, the fund shall calculate the remainder due by subtracting the amount paid from the amount due and shall bill the provider for the remainder on a quarterly instalment basis. Each subsequent bill shall include all of the following:

1. The total of the remainder due.

2. Interest on the remainder due. The daily rate of interest shall be the average annualized rate earned by the fund on its short-term funds for the first 3 quarters of the preceding fiscal year, as determined by the state investment board, divided by 360.

3. A $3 administrative service charge.

4. The minimum amount due.

5. The payment due date.

(k) *Prompt payment required.* A provider shall pay at least the minimum amount due on or before each due date.

(n) *Application of payments.* All payments to the fund shall be applied in chronological order first to previous fiscal years for which a balance is due and then to the current fiscal year. The amounts for each fiscal year shall be credited in the following order:

1. Mediation fund fee imposed under s. Ins 17.01.

2. Administrative service charge under par. (j) 3.

3. Interest under par. (j) 2.

4. Surcharge imposed under s. Ins 17.285.

5. Annual fee under sub. (6).

(o) *Waiver of balance.* The fund may waive any balance of $50 or less, if it is in the economic interest of the fund to do so.

(5) FILING OF CERTIFICATES OF INSURANCE. An insurance company required under s. 655.23 (3) (b), Stats., to file a certificate of insurance on behalf of a provider shall file the certificate with the fund within 45 days after the original issuance and each renewal and within 45 days after a change of classification under sub. (6).

(6) FEE SCHEDULE. The following fee schedule shall be effective from July 1, 1992 to June 30, 1993:

(a) Except as provided in pars. (b) to (g), for a physician for whom this state is a principal place of practice:

Class 1	$2,674	Class 3	$13,370
Class 2	$5,348	Class 4	$16,044

(b) For a resident acting within the scope of a residency or fellowship program:

Class 1	$1,337	Class 3	$6,685
Class 2	$2,674	Class 4	$8,022

(c) For a resident practicing part-time outside the scope of a residency or fellowship program:

All classes	$1,604

(d) For a medical college of Wisconsin, inc., full-time faculty member:

Class 1	$1,070	Class 3	$5,348
Class 2	$2,139	Class 4	$6,418

(g) For a part-time physician with an office practice only and no hospital admissions who practices less than 500 hours in a fiscal year: $669

(gm) For a physician for whom this state is not a principal place of practice:

Class 1	$1,337	Class 3	$6,685
Class 2	$2,674	Class 4	$8,022

(h) For a nurse anesthetist for whom this state is a principal place of practice: $716.

(hm) For a nurse anesthetist for whom this state is not a principal place of practice: $358.

(i) For a hospital:

1. Per occupied bed $176; plus

2. Per 100 outpatient visits during the last calendar year for which totals are available $8.74

(j) For a nursing home, as described under s. 655.002 (1) (j), Stats., which is wholly owned and operated by a hospital and which has health care liability insurance separate from that of the hospital by which it is owned and operated:

Per occupied bed $33

(k) For a partnership comprised of physicians or nurse anesthetists, organized for the primary purpose of providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of partners and employed physicians or nurse anesthetists is from 2 to 10 $100.00

2. If the total number of partners and employed physicians or nurse anesthetists is from 11 to 100 $1,000.00

3. If the total number of partners and employed physicians or nurse anesthetists exceeds 100 $2,500.00

(l) For a corporation with more than one shareholder organized under ch. 180, Stats., for the primary purpose of providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of shareholders and employed physicians or nurse anesthetists is from 2 to 10 $100.00

2. If the total number of shareholders and employed physicians or nurse anesthetists is from 11 to 100 $1,000.00

3. If the total number of shareholders and employed physicians or nurse anesthetists exceeds 100 $2,500.00

(lm) For a corporation organized under ch. 181, Stats., for the primary purpose of providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of employed physicians and nurse anesthetists is from 1 to 10 $100.00

2. If the total number of employed physicians and nurse anesthetists is from 11 to 100 $1,000.00

3. If the total number of employed physicians and nurse anesthetists exceeds 100 $2,500.00

(m) For an operational cooperative sickness care plan:

1. Per 100 outpatient visits during the last calendar year for which totals are available $0.22; plus

2. 2.5% of the total annual fees assessed against all of the employed physicians.

(n) For an ambulatory surgery center, as defined in s. HSS 123.14 (2) (a), which is a separate entity not part of a hospital, partnership or corporation subject to ch. 655, Stats.:

Per 100 outpatient visits during the last calendar year for which totals are available $44

(o) For an entity affiliated with a hospital: $100 or 28.6% of the amount that is or would be paid to the plan for primary liability coverage for the specific type of entity, whichever is greater.

(6e) MEDICAL COLLEGE RESIDENTS' FEES. (a) The fund shall calculate the total amount of fees for all medical college of Wisconsin affiliated hospitals, inc., residents on a full-time-equivalent basis, taking into consideration the proportion of time spent by the residents in practice which is not covered by the fund, including practice in federal, state, county and municipal facilities, as determined by the medical college of Wisconsin affiliated hospitals, inc.

(b) Notwithstanding sub. (4) (h), the fund's initial bill for each fiscal year shall be the amount the medical college of Wisconsin affiliated hospitals, inc., estimates will be due for the next fiscal year for all its residents. At the end of the fiscal year, the fund shall adjust the fee to reflect

the residents' actual exposure during the fiscal year, as determined by the medical college of Wisconsin affiliated hospitals, inc., and shall bill the medical college of Wisconsin affiliated hospitals, inc., for the balance due, if any, plus accrued interest, as calculated under par. (j) 2, from the beginning of the fiscal year. The fund shall refund the amount of an overpayment, if any.

(6m) (a) The fund may require any provider to report, at the times and in the manner prescribed by the fund, any information necessary for the determination of a fee specified under sub. (6).

(b) For purposes of sub. (6) (k), (l) and (lm), a partnership or corporation shall report the number of partners, shareholders and employed physicians and nurse anesthetists on July 1 of the previous fiscal year.

(6s) SURCHARGE. (a) This subsection implements s. 655.27 (3) (bg) 1, Stats., requiring the establishment of an automatic increase in a provider's fund fee based on loss and expense experience.

(b) In this subsection:

1. "Aggregate indemnity" has the meaning given under s. Ins 17.285 (2) (a).

2. "Closed claim" has the meaning given under s. Ins 17.285 (2) (b).

3. "Provider" has the meaning given under s. Ins 17.285 (2) (d).

4. "Review period" has the meaning given under s. Ins 17.285 (2) (e).

(c) The following tables shall be used in making the determinations required under s. Ins 17.285 as to the percentage increase in a provider's fund fee:

1. For a class 1 physician or a nurse anesthetist:

Aggregate Indemnity During Review Period			Number of Closed Claims During Review Period			
			1	2	3	4 or more
Up to	$	67,000	0%	0%	0%	0%
$ 67,001 to	$	231,000	0%	10%	25%	50%
$ 231,001 to	$	781,000	0%	25%	50%	100%
Greater Than	$	781,000	0%	75%	100%	200%

2. For a class 2 physician:

Aggregate Indemnity During Review Period			Number of Closed Claims During Review Period			
			1	2	3	4 or more
Up to	$	123,000	0%	0%	0%	0%
$ 123,001 to	$	468,000	0%	10%	25%	50%
$ 468,001 to	$	1,179,000	0%	25%	50%	100%
Greater Than	$	1,179,000	0%	50%	100%	200%

3. For a class 3 physician:

Aggregate Indemnity During Review Period			Number of Closed Claims During Review Period				
			1	2	3	4	5 or more
Up to	$	416,000	0%	0%	0%	0%	0%
$ 416,001 to	$	698,000	0%	0%	10%	25%	50%
$ 698,001 to	$	1,275,000	0%	0%	25%	50%	75%
$ 1,275,001 to	$	2,080,000	0%	0%	50%	75%	100%
Greater Than	$	2,080,000	0%	0%	75%	100%	200%

4. For a class 4 physician:

Aggregate Indemnity During Review Period		Number of Closed Claims During Review Period				
		1	2	3	4	5 or more
Up to	$ 503,000	0%	0%	0%	0%	0%
$ 503,001 to	$ 920,000	0%	0%	10%	25%	50%
$ 920,001 to	$ 1,465,000	0%	0%	25%	50%	75%
$ 1,465,001 to	$ 2,542,000	0%	0%	50%	75%	100%
Greater Than	$ 2,542,000	0%	0%	75%	100%	200%

Note: Applicability. (1) Except as provided in sub. (2), the treatment of s. Ins 17.28 (4) (b), (c) 1 (intro.) and 2 to 4, (cs) 1, (f) and (h) to (n), (5), (6e) (b) and (7) by the March, 1992 revision first applies to patients compensation fund annual fee bills for fiscal year 1992-93.

(2) If the patients compensation fund's new computerized billing system becomes operational on or before March 1, 1992, the treatment of s. Ins 17.28 (4) (b), (c) 1 (intro.) and 2 to 4, (cs) 1, (f) and (h) to (n), (5), (6e) (b) and (7) by the March, 1992 revision first applies to patients compensation fund annual fee bills for the last quarter of fiscal year 1991-92.

History: Cr. Register, June, 1980, No. 294, eff. 7-1-80; am. (6), Register, June, 1981, No. 306, eff. 7-1-81; r. and recr. (6), Register, June, 1982, No. 318, eff. 7-1-82; am. (6) (h) and (i), Register, August, 1982, No. 320, eff. 9-1-82, am. (6), Register, June, 1983, No. 330, eff. 7-1-83; am. (6) (i), Register, September, 1983, No. 333, eff. 10-1-83; am. (6) (intro.), (a) to (h), (j) and (r), Register, June, 1984, No. 342, eff. 7-1-94; am. (6) (i), Register, August, 1984, No. 344, eff. 9-1-84; am. (3) (c) and (6) (intro.), (a) to (e) 1., (f) to (h), (j) and (k), r. (intro.), cr. (3) (c) 1. to 9. and (7), Register, July, 1985, No. 355, eff. 8-1-85; am. (7) (a) 2. and (c), r. (7) (a) 5., renum. (7) (a) 3. and 4. to be 4. and 5. and am., cr. (7) (a) 3., Register, December, 1985, No. 360, eff. 1-1-86; emerg. r. and recr. (3) (c) intro., 1. to 9., (4), (6) (intro.), (a) to (k) and (7), eff. 7-2-86; r. and recr. (3) (c) intro. and 1. to 9., (4), (6) (intro.), (a) to (k) and (7), Register, September, 1986, No. 369, eff. 10-1-86; am. (2), (4) (b) and (d), (6) and (7) (intro.), Register, June, 1987, No. 378, eff. 7-1-87; am. (6) (l) and (j), cr. (6) (k) to (o) and (6m), Register, January, 1988, No. 385, eff. 7-1-88; cr. (6s), Register, February, 1988, No. 386, eff. 3-1-88; am. (6) (intro.) to (j), (m) 1. and (n), Register, June, 1988, No. 390, eff. 7-1-88; renum. (3) (a) to be (3) (d), cr. (3) (a), (bm), (e) to (i), (3e), (3m) and (3s), r. and recr. (3) (b) and (4), r. (7) (intro.) and (b) 4., am. (7) (a), (b) (intro.) to 3. and (c), Register, April, 1989, No. 400, eff. 5-1-89; emerg. r. (4) (c) 1. b., am. (4) (c) 2. and 3., (6) (intro.) to (j), (l) (intro.), (m) 1., (n) and (o), cr. (4) (c) 4., (6) (k) 1. to 3. and (6) (l) 3. and (lm), renum. (6) (k) to be (6) (k) (intro.) and am., r. and recr. (6) (l) 1. and 2., eff. 6-1-89; r. (4) (c) 1. b., am. (4) (c) 2. and 3., (6) (intro.) to (j), (l) (intro.), (m) 1., (n) and (o), cr. (4) (c) 4., (6) (k) 1. to 3. and (6) (l) 3. and (lm), renum. (6) (k) to be (6) (k) (intro.) and am., r. and recr. (6) (l) 1. and 2., Register, July, 1989, No. 403, eff. 8-1-89; am. (1), (2), (3) (c) and (f), (3e), (6) (intro.), (a) (intro.), (b) (intro.), (c) (intro.), (d) (intro.), (e) (intro.), (f) (intro.), (g), (h), (i) (intro.), (j) (intro.), (k) (intro.), (l) (intro.), (lm) (intro.), (m) (intro.), (n) (intro.) and (o) and (6m), renum. (3m) (a) (intro.), 1., 2., 3. intro., b. and c., and (6m) to be (3m) (intro.), (a), (b), (c), and (6m) (a), r. (3m) (a) 3. a. and (b), r. and recr. (5), (6) (a) (intro.), (b) (intro.), (d) (intro.), (e) (intro.), (f) (intro.), (6s) (c) 1. intro., 2. intro., 3. intro. and 4. intro., cr. (3) (intro.) and (hm), (4) (cm) and (g), (6e) and (6m) (b), Register, June, 1990, No. 414, eff. 7-1-90; emerg. am. (6) (b) and (6e), r. (6) (e) and (f), eff. 7-1-90; am. (6) (b) and (6e), r. (6) (e) and (f), Register, October, 1990, No. 418, eff.11-1-90; cr. (4) (cs), am. and (3s) (b) (4) (g), Register, April, 1991, No. 424, eff. 5-1-91; emerg. am. (3) (c) 2. and 3., (6) (intro.), eff. 7-1-91; am. (3) (c) 2. and 3., (6) (intro.), Register, July, 1991, No. 427, eff. 8-1-91; am. (6s) (c) (intro.), Register, January, 1992, No. 433, eff. 2-1-92; am. (4) (b), (c) 1. intro., 2 to 4., (cs) 1. and (f), (5) and (6e) (b), cr. (4) (h) to (o), r. (7), Register, March, 1992, No. 435, eff. 4-1-92; emerg. am. (4) (cm), (e) 1., (f), (j) 3., (5), (6) (intro.), (a) to (j), (k) (intro.), (l) (intro.), 1., (lm) (intro.), (m) and (n), r. (3m) (b) and (4) (e) 2., cr. (6) (gm) and (hm), r. and recr. (4) (c), renum. (4) (d), (l) and (m) to be (4) (d) 1., 2. and (e) 2., eff. 4-28-92; am. (4) (cm), (e) 1., (f), (j) 3., (5), (6) (intro.), (a) to (j), (k) (intro.), (l), (intro.), 1. (lm) (intro.), (m) and (n), r. (3m) (b) and (4) (e) 2., cr. (6) (gm) and (hm), r. and recr. (4) (c), renum. (4) (d), (l) and (m) to be (4) (d) 1., 2. and (e) 2., Register, July, 1992, No. 439, eff. 8-1-92.

Ins 17.285 Peer review council. (1) PURPOSE. This section implements ss. 619.04 (5) (b) and (5m) (b), 655.27 (3) (a) 2m and (bg) 2 and 655.275, Stats.

(2) DEFINITIONS. In this section:

(a) "Aggregate indemnity" means the total amount attributable to an individual provider that is paid or owing to or on behalf of 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 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.

(c) "Council" means the peer review council appointed under s. 655.275, Stats.

(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.

(d) "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.

(f) "Surcharge" means the automatic increase in a provider's plan premium or fund fee established under s. Ins 17.25 (12m) or 17.28 (6s) or both.

(2m) TIME FOR REPORTING. In reporting claims paid under s. 655.26, Stats., each insurer or self-insurer shall report the required information by the 15th day of the month following the date on which there has been a final determination of the aggregate indemnity to be paid to or on behalf of any claimant.

(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: