

Surgery - plastic
Surgery - plastic -
otorhinolaryngology
Surgery - rhinology
Post Graduate Medical Education or Fellowship— This classification applies to physicians engaged in two through six years of an approved post graduate medical education specialty program indicated above.

Surgery - thoracic
Surgery - traumatic
Surgery - vascular
Weight Control - bariatrics

4. Class 4 health care providers are those engaged in the following medical specialties:

Surgery - neurology - including child
Surgery - obstetrics and gynecology
Surgery - obstetrics
Post Graduate Medical Education or Fellowship— This classification applies to physicians engaged in two through six years of an approved post graduate medical education specialty program indicated above.

(4) PRO RATA FEES. A health care provider may enter or exit the fund at a date other than July 1 or June 30. In this subsection, "semimonthly period" means the 1st through the 14th day, or the 15th day through the end of each month.

(a) If a health care provider enters the fund subsequent to July 1, the fund shall charge the provider a fee of one-twenty-fourth ($1/24$) the annual fee for that class of provider for each semimonthly period between the date of entry and the next June 30.

(b) If a health care provider exits the fund prior to June 30, the fund shall issue the provider a refund or credit of one-twenty-fourth ($1/24$) the annual fee for that class or provider for each full semimonthly period between the date of exit and the next June 30. Retroactive class changes resulting in refunds or credits shall be processed retroactively for a maximum of 60 days from the fund's receipt of the amended or renewal certificate. In no case shall the fund calculate refunds or credits on a previous fiscal year's assessment except to correct an administrative billing error.

(c) If a health care provider changes class or type, which results in an increased assessment, the fund shall charge the provider an adjusted fee, comprised of one-twenty-fourth ($1/24$) the annual assessment for the old provider class for each full semimonthly period between the original assessment date and the date of change, and one-twenty-fourth ($1/24$) annual assessment for the new provider class for each semimonthly period between the date of change and next June 30.

(d) If a health care provider changes class or type, which results in a decreased assessment, the fund shall issue the provider an adjusted fee, a refund or a credit to remaining payments comprised of one-twenty-fourth ($1/24$) the annual assessment for the old provider class for each semimonthly period between the original assessment date and the date of change, and one-twenty-fourth ($1/24$) the annual assessment for the new provider class for each full semimonthly period between the date of change and the next June 30. Retroactive class changes resulting in refunds or credits shall be processed retroactively for a maximum of 60 days from the fund's receipt of the amended or renewal certificate. In no case shall the fund calculate refunds or credits on a previous fiscal year's assessment except to correct an administrative billing error.

(e) The effective date of the proof of financial responsibility required under s. 655.23 (2), Stats., as it applies to each individual health care

provider, shall determine the date of entry to the fund. The cancellation or withdrawal of such proof shall establish the date of exit.

(5) **EFFECTIVE DATE AND EXPIRATION DATE OF FEE SCHEDULES.** The effective date of the fee schedule contained in this section shall be the current July 1 and shall expire the next subsequent June 30.

(6) **FEE SCHEDULE.** The following fee schedule shall be effective from July 1, 1987 to June 30, 1988:

(a) For physicians and surgeons:

Class 1	\$2,094	Class 3	\$10,470
Class 2	4,188	Class 4	12,564

(b) For resident physicians and surgeons involved in post graduate medical education or a fellowship:

Class 1	\$1,256	Class 3	\$6,280
Class 2	2,512	Class 4	7,536

(c) For resident physicians and surgeons who practice outside residency or fellowship:

All classes	\$1,256
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(d) For Medical College of Wisconsin full time faculty:

Class 1	\$ 838	Class 3	\$4,190
Class 2	1,676	Class 4	5,028

(e) For Medical College of Wisconsin resident physicians and surgeons:

1. Class 1	\$ 1,047	Class 3	\$5,235
Class 2	2,094	Class 4	6,282

(f) For government employes — state, federal, municipal:

1. Class 1	\$1,591	Class 3	7,855
Class 2	3,142	Class 4	9,426

(g) For retired or part time physicians and surgeons with an office practice only and no hospital admissions who practice less than 500 hours per fiscal year:

Physicians	\$1,256.00
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(h) For nurse anesthetists \$ 561.00

(i) For hospitals

1. Per occupied bed	\$ 137.00
2. Per 100 outpatient visits	\$ 6.75

(j) For nursing homes

1. Per occupied bed	\$ 26.00
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(7) **COLLECTION OF FEES.** Each health care provider permanently practicing or operating in the state may have the option to pay the assessment in a single lump sum, 2 semiannual payments, or 4 quarterly payments. This subsection implements s. 655.27 (3) (b), Stats.

(a) The fund shall issue an initial billing to each provider showing the assessment due, and the payment schedules available. Once the provider has selected a payment schedule, that schedule shall apply for the remainder of that fiscal year.

(b) All providers shall pay the billed assessment on or before the due date indicated on the assessment billing. Due dates vary according to type of assessment and date of assessment.

1. Renewal assessments. The payment due dates for renewal assessments are:

a. Annual payment - July 1;

b. Semiannual payments - July 1, January 1;

c. Quarterly payments - July 1, October 1, January 1, April 1.

2. Initial assessments or assessments written for providers no longer in exempt status. For a provider who is initially participating in the fund, and for a provider who can no longer claim an exempt status, the number of payment options shall be dependent on the date the fund processes the assessment billing.

a. The first payment, regardless of a lump sum, semiannual, or quarterly payment schedule, shall be due 30 days from the date the fund processes the assessment billing.

b. For semiannual payment schedules, the second payment shall be due on or before January 1. Any provider whose first payment due date is January 1 or later shall not be able to choose the semiannual payment schedule.

c. For quarterly payment schedules, payments shall be due on or before October 1, January 1, and April 1, respectively. In order for the provider to choose 4 quarterly payments, the first payment due date shall fall before October 1. If the first payment due date falls between October 1 and December 31, the provider shall have 3 quarterly payments, with the second and third payments due on or before January 1 and March 31, the provider shall have 2 quarterly payments, with the second payment due on or before April 1. Any provider whose first payment due date is April 1 or later shall not be able to choose the quarterly payment schedule.

3. Increases in assessments. If provider changes class or type, which results in an increased assessment, the first payment resulting from that increase shall be due 30 days from the date the fund processes the increased assessment billing. The provider shall follow the same payment schedule selected with the original assessment billing when making payments for the increased assessment billing.

4. Decreases in assessments. If a provider changes class or type, which results in a decreased assessment, or if a provider leaves the fund or becomes exempt, the provider may be entitled to a refund check or a credit to be applied to future payments during the current fiscal year. If the assessment amount already paid into the fund is greater than the recalculated assessment, the fund shall issue the provider a refund check. If the assessment amount already paid into the fund is less than the recalculated assessment, the fund shall credit the provider's account for any overpayment during the period(s) affected by the decreased assessment.

(c) The fund shall charge interest and an administrative service charge to each provider who chooses the semiannual or quarterly payment schedule. The rate of interest charged by the fund shall be the average annualized rate earned by the fund for the first 3 quarters of the preceding fiscal year as determined by the state investment board. The administrative service charge shall be used to offset costs of administering the payment plan. Interest and administrative service charges are not refundable.

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. 7-1-84; 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.

Ins 17.29 Servicing agent. (1) PURPOSE. The purpose of this section is to implement and interpret the provisions of s. 655.27 (2), Stats., relating to contracting for patients compensation fund services.

(2) **SCOPE.** This section applies to administration and staff services for the fund.

(3) **SELECTION.** The selection of a servicing agent shall conform with s. 16.765, Stats. The commissioner, with the approval of the board, shall select a servicing agent through the competitive negotiation process to provide services for the fund based on criteria established by the board.

(4) **TERM SERVED AND SELECTION FOR SUCCEEDING PERIODS.** The term served by the servicing agent shall be as established by the commissioner with the approval of the board but the contract shall include a provision for its cancellation if performance or delivery is not made in accordance with its terms and conditions.

(5) **FUNCTIONS. (a)** The servicing agent shall perform functions agreed to in the contract between the servicing agent and the office of the commissioner of insurance as approved by the board. The contract shall provide for an annual report to the commissioner and board of all expenses incurred and subcontracting arrangements.

(b) Additional functions to be performed by the servicing agent may include but are not limited to:

1. Hiring legal counsel.
2. Establishment and revision of case reserves.

3. Contracting for annuity payments as part of structured settlements.
4. Investigation and evaluation of claims.
5. Negotiation to settlement of all claims made against the fund except those responsibilities retained by the claim committee of the board.
6. Filing of reports to the board.
7. Review of panel decisions and court verdicts and recommendations of appeals as needed.

History: Cr. Register, February, 1984, No. 338, eff. 3-1-84.

Ins 17.30 Peer review council assessments. (1) **PURPOSE.** This section implements ss. 655.27 (3) (am) and 655.275 (6), Stats., relating to the assessment of fees sufficient to cover the costs, including the costs of administration, of the patients compensation fund peer review council appointed under s. 655.275 (2), Stats.

(2) **ASSESSMENTS.** (a) The following fees shall be assessed annually beginning with fiscal year 1986-87:

1. Against the patients compensation fund, one-half of the actual cost of the patients compensation fund peer review council for each fiscal year, less one-half of the amounts, if any, collected under subd. 3.

2. Against the Wisconsin health care liability insurance plan, one-half of the actual cost of the patients compensation fund peer review council for each fiscal year, less one-half of the amounts, if any, collected under subd. 3.

3. Against a private medical malpractice insurer, the actual cost incurred by the council for its review of any claim paid by the private insurer, if the private insurer requests a recommendation on premium adjustments with respect to that claim under s. 655.275 (5) (a) 3, Stats.

(b) Amounts collected under par. (a) 3 shall be applied to reduce, in equal amounts, the assessments under par. (a) 1 and 2 for the same fiscal year.

(3) **PAYMENT.** Each assessment under sub. (2) shall be paid within 30 days after the billing date.

History: Cr. Register, June, 1987, No. 378, eff. 7-1-87.