Chapter Ins 17

PATIENTS COMPENSATION FUND

Ins 17.001 Definitions. (ss. 619.04 and 655.003, Stats.) As used in this chapter:

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

(2) "Fund" means the patients compensation fund established pursuant to s. 655.27 (1), Stats., except as defined in s. Ins 17.24;

(3) "Hearing" includes both hearings and rehearings, and these rules shall cover both so far as applicable, except where otherwise specifically provided by statute or in chapter Ins 17.

(4) "Plan" means the Wisconsin health care liability insurance plan established by s. Ins 17.25 pursuant to s. 619.01 (1) (a), Stats.;

(5) "Commissioner" means the commissioner of insurance or deputy whenever detailed by the commissioner or discharging the duties and exercising the powers of the commissioner during an absence or a vacancy in the office of the commissioner, as provided by s. 601.11 (1) (b), Stats.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

Ins 17.01 Payment of mediation fund fees (1) PURPOSE. This rule implements the provisions of ch. 655.61, Stats., relating to the payment of mediation fund fees.

(2) PAYMENT OF FEES TO FINANCE THE MEDIATION SYSTEM. (a) Every physician practicing in the state, subject to ch. 655, Stats., excluding those in a residency or fellowship training program, and every hospital operating in the state, subject to ch. 655, Stats., shall pay to the commissioner of insurance an annual fee to finance the mediation system created by s. 655.42, Stats. The commissioner of insurance shall deposit all such fees collected in the mediation fund created by s. 655.68, Stats.

(b) The fee is due and payable upon receipt of the billing by the physician or hospital.

(c) Any physician or hospital who has not paid the fee within 30 days from the date the billing is received shall be deemed to be in noncompliance with s. 655.61 (1), Stats.

(d) The commissioner shall notify the department of regulation and licensing of each physician who has not paid the fee, and who is, therefore, in noncompliance with s. 655.61 (1), Stats.

(e) The commissioner shall notify the department of health and social services of each hospital which has not paid the fee, and which is, therefore, in noncompliance with s. 655.61 (1), Stats.

(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, 1987:

(a) For physicians — $-0-$

(b) For hospitals — $-0-$

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.

Ins 17.02 Petition for declaratory rulings. (ss. 619.04 and 655.003, Stats.) (1) Petitions for declaratory rulings shall be governed by s. 227.06, Stats.

(2) Such petitions shall be filed with the commissioner who shall investigate, give notice, etc.

(3) All final determinations shall be made by the board.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

Ins 17.03 How proceedings initiated. (ss. 619.04 and 655.003, Stats.) Proceedings for a hearing upon a matter may be initiated: (1) On a complaint by any individual, corporation, partnership or association which is aggrieved, filed in triplicate (original and 2 copies) with the commissioner.

(b), Stats. In the event more than one actuary is utilized, the health care providers represented on the board of governors shall jointly select the second actuary. Such actuarial reports shall be submitted on a timely basis.

History: Cr. Register, June, 1980, No. 294, eff. 7-1-80.

Ins 17.28 Health care provider fees. (1) PURPOSE. The purpose of this section is to implement and interpret the provisions of s. 655.27 (3), Stats., relating to fees to be paid by health care providers for participation in the Patients Compensation Fund.

(2) SCOPE. This section applies to fees charged health care providers as defined in s. 655.001 (8), Stats. Nothing in this section shall apply to operating fees charged for operation of the mediation system under s. 655.61, Stats.

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

(b) "Fees", "operating fees" or "annual fees" mean those fees charged for each fiscal year of participation, July 1 to June 30.

(c) "Class" of physicians or surgeons means those health care providers whose specialties are similar in their degree of exposure to loss and who are subject to a common fee in accordance with the provisions of s. 655.27 (3) (b) 2., Stats. Classes and included specialties are listed below:

1. Class 1 health care providers are those engaged in the following medical specialties:

Aerospace Medicine
Allergy
Cardiovascular Disease - no surgery
Dermatology - no surgery
Diabetes - no surgery
Endocrinology - no surgery
Family Practice and General Practice - no surgery
Forensic Medicine
Gastroenterology - no surgery
General Preventative Medicine - no surgery
Geriatrics - no surgery
Gynecology - no surgery
Hematology - no surgery
Hypnosis
Infectious Diseases - no surgery
Internal Medicine - no surgery
Laryngology - no surgery
Legal Medicine
Neoplastic Diseases - no surgery
Nephrology - no surgery
Neurology - including child - no surgery
Nuclear Medicine
Nutrition
Occupational Medicine
Ophthalmology - no surgery
Osteopathic Physicians - manipulation only
Otology - no surgery
Otorhinolaryngology - no surgery
Pathology - no surgery
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

Post Graduate Medical Education or Fellowship—This classification applies to all physicians engaged in the first year of post graduate medical education (interns). This classification also applies to physicians engaged in 2 through 6 years of an approved post graduate medical educa-

tion specialty program (residents) listed above which is not ordinarily involved in the performance of or assisting in the performance of obstetrical procedures or surgical (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia) procedures.

2. Class 2 health care providers are those engaged in the following medical specialties:

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 — This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue 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 - This classification applies to any general practitioner or 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 facilities
Post Graduate Medical Education or Fellowship— This classification applies to physicians engaged in 2 through 6 years of an approved post graduate medical education specialty program listed above.

3. Class 3 health care providers are those engaged in the following medical specialties:

Anesthesiology -This classification applies to all providers who perform general anesthesia or acupuncture anesthesia
Emergency Medicine - including major surgery
Surgery - abdominal
Surgery - cardiac
Surgery - cardiovascular disease
Surgery - general (specialists in general surgery)
Surgery - gynecology
Surgery - hand
Surgery - head and neck
Surgery - laryngology
Surgery - orthopedic
Surgery - otorhinolaryngology (no plastic surgery)

Surgery - plastic
Surgery - plastic - otorhinolaryngology
Surgery - rhinology
Surgery - thoracic
Surgery - traumatic
Surgery - vascular
Weight Control - bariatrics

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. 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

(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
(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

(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. 7-1-94; 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.

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 adminstration 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 fisal 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.