(cm) The board may authorize retroactive coverage by the plan for a health care provider, as defined in s. 655.001 (8), Stats., if the provider furnishes 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 occurence that might give rise to such a claim.

(d) If the risk is accepted by the Plan, a policy shall be delivered to the applicant upon payment of the premium. The Plan shall

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notice of cancellation or nonrenewal shall allow ample time for application to the Plan and for the issuance of coverage. A copy of such cancellation or nonrenewal notice shall be filed with the office of the commissioner of insurance.

(14) PLAN BUSINESS - CANCELLATION AND NONRENEWAL. (a) The Plan may not cancel or refuse to renew a policy issued under the Plan except for one or more of the following reasons:

1. Nonpayment of premium.

2. Revocation of the license of the insured by the appropriate licensing board.

3. Revocation of accreditation, registration, certification or other approval issued to the insured by a state or federal agency or national board, association or organization.

4. If the insured is not licensed, accredited, registered, certified or otherwise approved, failure to provide evidence that the insured continues to provide health care in accordance with the code of ethics applicable to the insured's profession, if the board requests such evidence.

(b) Notice of cancellation or nonrenewal under par. (a), containing a statement of the reasons therefor, shall be sent to the insured with a copy to the Plan. Any cancellation or nonrenewal notice to the insured shall be accompanied by a conspicuous statement that the insured has a right of appeal as provided in sub. (16).

(15) COMMISSION. Commission to the licensed agent designated by the applicant shall be 15% for each new or renewal policy issued to medical or osteopathic physicians, nurse anesthetists, nurse midwives, cardiovascular perfusionists, podiatrists, and partnerships comprised of or corporations or general partnerships organized for the primary purpose of providing the medical services of physicians, podiatrists, nurse anesthethists, nurse midwives or cardiovascular perfusionists subject to a maximum of $150 per policy; and 5% of the annual premium for each new or renewal policy issued to operating cooperative sickness care plans, or to teaching facilities, or to hospitals, or to entities specified in sub. (5) (a) 7m, or to health care facilities owned and operated by a political subdivision of the state of Wisconsin, not to exceed $2,500.00 per policy period. The agent need not be licensed with the servicing company.

(16) RIGHT OF APPEAL. Any affected person may appeal to the board of governors within 30 days after notice of any final ruling, action or decision of the Plan. Decisions of the board of governors may be further appealed in accordance with ch. 227, Stats. This subsection does not apply to a decision relating to an automatic increase in a provider's plan premium under sub. (12m), which is appealable as provided under s. Ins 17.285.

(17) REVIEW BY COMMISSIONER. The board of governors shall report to the commissioner the name of any member or agent which fails to comply with the provisions of the Plan or with any rules prescribed thereunder by the board of governors or to pay within 30 days any assessment levied.

(18) INDEMNIFICATION. Each person serving on the board of governors or any subcommittee thereof, each member of the Plan, and the manager and each officer and employe of the Plan shall be idemnified by the Plan against all cost, settlement, judgment, and expense actually and necessarily incurred by him or it in connection with the defense of any action, suit, or proceeding in which he or it is made a party by reason of his or its being or having been a member of the board of governors, or a member or manager or officer or employe of the Plan except in relation to matters as to which he or it has been judged in such action, suit, or proceeding to be liable by reason of willful or criminal misconduct in the performance of his or its duties as a member of such board of governors, or a member or manager or officer or employe of the Plan. This indemnification shall not apply to any loss, cost, or expense on insurance policy claims under the Plan. Indemnification hereunder shall not be exclusive of other rights to which the member, manager, officer, or employe may be entitled as a matter of law.

History: Emerg. cr. eff. 3-20-75; cr. Register, June, 1975, No. 234, eff. 7-1-75; emerg. am. eff. 7-28-75; emerg. r. and recr. eff. 11-1-75; r. and recr. Register, January, 1976, No. 241, eff. 2-1-76; am. (1) (b), (2), (4) (c), and (5) (a), Register, May, 1976, No. 245, eff. 6-1-76; emerg. am. (4) (b), eff. 6-22-76; am. (1) (b), (2), (4) (b) and (c) and (5) (a), Register, September, 1976, No. 249, eff. 10-1-76; am. (1)(b), (2), (4)(c), (5)(a), (5)(f), (10)(a) and (15), cr. (4)(h), Register, May, 1977, No. 257, eff. 6-1-77; am. (1)(b), (2), (4)(c), (5)(a), (10)(a) and (15), Register, September, 1977, No. 261, eff. 10-1-77; am. (1)(b), (2), (4)(b) and (c), (5)(a) and (f), and (15), Register, May, 1978, No. 269, eff. 6-1-78; am. (7) (b) 1.a., Register, March, 1979, No. 279, eff. 4-1-79; renum. from. Ins 3.35, am. (1) (b), (2), (5) (a) and (10) (a), Register, July, 1979, No. 283, eff. 8-1-79; r. and recr. (5) (a), Register, April, 1980, No. 292, eff. 5-1-80; am. (1) (b), (2), (4) (c), (5) (a), (10) (a), (12) (a) 3. and 4. and (15), r. (12) (a) 11. renum. (12) (a) 5. through 10. and 12. to be 7. through 12. and 13., cr. (12)(a) 5. and 6., Register, May, 1985, No. 353, eff. 6-1-85; emerg. am. (1)(b), (2), (4)(c) and (5)(a) 2., eff. 7-29-86; am. (1)(b), (2), (4)(c) and (5)(a) 2., Register, January, 1987, No. 373, eff. 2-1-87; emerg. am. (1) (b), (2), (4) (c), (5) (a) 3., 4. and 7., (7) (b) 2., 3. and 5., (10) (a), (12) (intro.), (14) (a) (intro.) and 1. and (15), cr. (5) (a) 11., (7m) and (14) (a) 3. and 4., renum. (5) (a) 11., (b) and (7) (b) 1. intro. to be (5) (am), (b) (intro.) and (7) (b) and am., r. (7) (b) 1. a. and b. eff. 2-16-87; am. (1) (b), (2), (4) (c), (5) (a) 3., 4. and 7., (7) (b) 2., 3. and 5., (10) (a), (12) (intro.), (14) (a) (intro.) and 1. and (15), renum. (5) (a) 11, (b) and (7) (b) 1. to be (5) (am), (b) (intro.) and (7) (b) 1. and am., cr. (5) (a) 7m and 11., (b) 1. to 3., (7) (b) 2m. and (14) (a) 3. and 4., r. (7) (b) 1. a. and b., Register, July, 1987, No. 379, eff. 8-1-87; r. (12) (a) 13. and (b) 5., cr. (5) (a) 2m. and (12m), am. (16), Register, February, 1988, No. 386, eff. 3-1-88; r. (4) (g) and (9) (b), renum. (9) (a) to be (9), Register, March, 1988, No. 387, eff. 4-1-88; cr. (10) (cm), Register, April, 1989, No. 400, eff. 5-1-89.

Ins 17.26 Future medical expense funds. (1) PURPOSE. This rule is intended to implement the provisions of s. 655.015, Stats.

(2) SCOPE. This rule shall apply to all insurers, organizations and persons subject to ch. 655, Stats.

(3) DEFINITIONS. In this section:

(a) "Account" means the portion of the fund allocated specifically for future medical expense of an injured person.

(b) "Claimant" means the injured person, the individual legally responsible for any medical expenses sustained by the injured person, or the legally designated representative of such injured person.

(c) "Medical expense" means those charges for medical services, nursing services, medical supplies, drugs or rehabilitation services which are necessary to the comfort and well being of the individual and incidental to the injury sustained.

(4) ADMINISTRATION. (a) When any settlement, award or judgement provides an amount in excess of $25,000 for future medical expense, the

insurer, organization or person responsible for such payment shall forward to the commissioner the amount in excess of $25,000 within 30 days of any such settlement, award or judgment, and shall enclose an appropriately executed copy of the document setting forth the terms under which the payment is to be made.

(b) The commissioner shall credit each account with a pro rata share of interest earned, if any, based on the remaining value of each account at the time such interest earning is declared by the investment board. The commissioner shall maintain an individual record of each account showing the original allocation, payments made, credits and the balance remaining.

(c) Upon receipt of a request for reimbursement of medical expense of an injured person, the commissioner shall make appropriate investigation and inquiries to determine that the medical supplies or services provided are necessary and incidental to the injury sustained by the person for whom the account was established, and if satisfied that this is the case, shall pay these expenses out of the fund, using standard bookkeeping and accounting records and transactions established by ss. 16.40 (5) and 16.41, Stats.

(d) If the commissioner is not satisfied that a provider of service has been reimbursed for services or supplies provided to the injured person, payments of any medical expense may be made jointly to the claimant and to the provider. The claimant may, in writing, direct that payment be made directly to the provider. If the claimant has paid for medical supplies or services the claimant shall be reimbursed upon receipt of proof of payment.

(e) The commissioner shall not less than once annually inform the claimant of the status to date of the account including the original amount, payments made, and the balance remaining.

(f) Payment shall be made to the claimant for reasonable and necessary medical expense until such time as the allocated amount is exhausted or until the injured person is deceased. Should the injured person become deceased and there is a balance in his account allocation, that amount shall be returned to the insurer, organization or person responsible for establishing the account.

History: Cr. Register, November, 1976, No. 251, eff. 12-1-76; renum. from Ins 3.37, Register, July, 1979, No. 283, eff. 8-1-79; am. (3), r. (4) (b) and (f), renum. (4) (d), (e), (g) and (h) to be (4) (e) (b), (d) and (f) and am., Register, April, 1984, No. 340, eff. 5-1-84.

Ins 17.27 Filing of financial statement. (1) PURPOSE. This rule is intended to implement and interpret ss. 655.21, 655.27 (3) (b), 655.27 (4) (d) and 655.27 (5) (e), Stats., for the purpose of setting standards and techniques for accounting, valuing, reserving and reporting of data relating to financial transactions of the Patients Compensation Fund.

(2) DEFINITIONS. (a) "Amounts in the fund" as used in s. 655.27 (5) (e), Stats., means the sum of cash and invested assets as reported in the financial report.

(b) "Fiscal year" as used in s. 655.27 (4) (d) means a year commencing July 1 and ending June 30.

(3) FINANCIAL REPORTS. Annual financial reports required by s. 655.27 (4) (d), Stats., shall be furnished within 60 days after the close of each

fiscal year. In addition, quarterly financial reports shall be prepared as of September 30, December 31 and March 31 of each year and furnished within 60 days after the close of each reporting period. These financial reports shall be prepared on a format prescribed by the board of governors in accordance with statutory accounting principles for fire and casualty companies. Reserves for reported claims and reserves for incurred but not reported claims shall be maintained on a present value basis with the difference from full value being reported as a contra account to the loss reserve liability. Any funds for administration of the Patients Compensation Panels derived from fees collected under s. 655.21, Stats., shall be included in these financial reports but shall not be regarded as assets or liabilities or otherwise taken into consideration in determining assessment levels to pay claims.

(4) The board of governors shall select one or more actuaries to assist in the determination of reserves and the setting of fees under s. 655.27 (3) (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 17.275 Claims information; confidentiality. (1) PURPOSE. This section interprets ss. 19.35 (1) (a), 19.85 (1) (f), 146.82, 655.26 and 655.27 (4) (b), Stats.

(2) DEFINITION. In this section, "confidential claims information" means any document or information relating to a claim against a health care provider in the possession of the commissioner, the board or an agent thereof, including claims records of the fund and the plan and claims paid reports submitted under s. 655.26, Stats.

(3) DISCLOSURE. Confidential claims information may be disclosed only as follows:

(a) To the medical examining board as provided under s. 655.26, Stats.

(b) As needed by the peer review council, consultants and the board under s. 655.275, Stats., and rules promulgated under that section.

(c) As provided under s. 804.01, Stats.

(d) To an individual, organization or agency required by law or designated by the commissioner or board to conduct a management or financial audit.

History: Cr. Register, March, 1988, No. 387, eff. 4-1-88.

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) "Annual fee" means the amount established under sub. (6) for each class or type of provider.

(b) "Begin operation" means for a provider other than a natural person to start providing health care services in this state.

(bm) "Begin practice" means to start practicing in this state as a medical or osteopathic physician or nurse anesthetist or to become ineligible for an exemption from ch. 655, Stats.

(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 education 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 - plastic
Surgery - plastic - otorhinolaryngology
Surgery - rhinology
Surgery - general (specialists in general surgery)
Surgery - gynecology
Surgery - hand
Surgery - head and neck
Surgery - laryngology
Surgery - orthopedic
Surgery - otorhinolaryngology (no plastic surgery)
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.

(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 practicing 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.

(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 subject to ch. 655, Stats., 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; NOTICE TO FUND. (a) 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:

1. The provider will not practice more than 240 hours in the fiscal year.

2. The provider is a federal, state, county or municipal employe.

3. During the fiscal year:

a. More than 50% of the provider's practice will be performed outside this state;

b. More than 50% of the income from the provider's practice will be derived from outside this state; or

c. More than 50% of the provider's patients will be seen outside this state.

(b) If a provider does not claim an exemption under par. (a) 1 by the date of the first payment due under sub. (7) (b) 1 or 2, the provider waives the right to claim the exemption for that fiscal year.

(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 shows that circumstances previously unknown to him or her require retroactive participation in the fund if the provider furnishes 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) BEGINNING AND CEASING PRACTICE AND OPERATION; LATE ENTRY; CLASS CHANGES; REFUNDS; PRORATED FEES. (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's fund coverage begins after July 1, 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.* 1. If a provider is in compliance with sub. (7) (b) and one of the following conditions exists, 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 practice or operation ceased to the due date of the next payment:

a. The provider has temporarily or permanently ceased practice or has permanently ceased operation and has given the fund advance written notice of the cessation.

b. The provider has died and the fund has received written notice within 45 days of the death.

c. The provider's license to practice medicine and surgery or nursing has been revoked or suspended and the provider has given the fund written notice within 45 days of the revocation or suspension.

d. The provider has temporarily ceased practice because of a physical or mental impairment and has given the fund written notice within 135 days of the cessation.

2. If a provider that dies or temporarily or permanently ceases practice or operation is in compliance with sub. (7) (b), but none of the conditions described in subd. 1 exists, the fund shall issue a refund equal to one twenty-fourth of the provider's fee for each full semimonthly period from the date the fund receives notice of the death or cessation of practice or operation, plus a retroactive refund equal to no more than 3 twenty-fourths of the provider's annual fee.

3. If a provider that dies or temporarily or permanently ceases practice or operation is not in compliance with sub. (7) (b), the fund shall reduce the provider's arrearage for the remainder of the fiscal year by any amount that would be due as a refund under subd. 1 or 2 if the provider were in compliance with sub. (7) (b).

(d) *Change of class or type; increased annual fee.* If a provider changes class or type, including a change from part-time to full-time practice, resulting in an increased annual fee, the fund shall adjust the provider's annual fee to equal the sum of the following:

1. One twenty-fourth of the annual fee for the provider's former class or type 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.

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

(e) *Change of class or type; decreased annual fee.* 1. If a provider changes class or type, including a change from full-time to part-time practice, resulting 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 class or type 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 class or type for each full semimonthly period from the date of the change to the next June 30.

2. The fund may issue a refund or may credit the provider's account for amounts due under subd. 1. If the provider or the provider's insurer does not give the fund advance notice of the change, the refund or credit may not exceed 3 twenty-fourths of the annual fee for the provider's former class.

(f) If a provider entitled to a refund or credit under this subsection has paid interest under sub. (7) (c) 1, the fund shall issue a refund or credit of the interest using the same method used to calculate a refund or credit of an annual fee.

(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, 1988 to June 30, 1989:

(a) For physicians and surgeons:

Class 1	$2,316	Class 3	$11,580
Class 2	4,632	Class 4	13,896

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

Class 1	$1,390	Class 3	$6,950
Class 2	2,780	Class 4	8,340

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

All classes	$1,390

(d) For Medical College of Wisconsin full time faculty:

Class 1	$ 26	Class 3	$4,630
Class 2	1,852	Class 4	5,556

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

Class 1	$ 1,158	Class 3	$5,790
Class 2	2,316	Class 4	6,948

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

Class 1	$1,737	Class 3	8,685
Class 2	3,474	Class 4	10,422

(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: $1,390.00

(h) For nurse anesthetists: $620.00

(i) For hospitals other than ambulatory surgery centers:

1. Per occupied bed $152.00; plus

2. Per 100 outpatient visits during the last calendar year for which totals are available $7.60

(j) For nursing homes

Per occupied bed $29.00

(k) For partnerships comprised of physicians of nurse anesthtists: $50.00

(l) For corporations providing the medical services of physicians or nurse anesthetists:

1. With one shareholder $0

2. With more than one shareholder $50.00

(m) For operational cooperative sickness care plans:

1. Per 100 outpatient visits during the last calendar year for which totals are available $0.19; plus

2. 2.5% of the total annual fund fees assessed against all physicians employed on July 1 of the previous fiscal year

(n) For ambulatory surgery centers:

Per 100 outpatient visits during the last calendar year for which totals are available $38.00

(o) For an entity owned or controlled by a hospital or hospitals: 28.6% of the amount that is or would be paid to the plan for primary liability coverage for the specific type of entity

(6m) The fund may require any health care 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).

(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 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:

1. For Class 1 health care providers specified under sub. (3) (c) 1 and nurse anesthetists:

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 Class 2 health care providers specified under sub. (3) (c) 2:

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 Class 3 health care providers specified under sub. (3) (c) 3:

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 Class 4 health care providers specified under sub. (3) (c) 4:

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%

(7) BILLING; PAYMENT SCHEDULES. (a) For each fiscal year, the fund shall issue an initial bill to each provider showing the amount due, including any applicable surcharge imposed under s. Ins 17.285, and the payment schedules available and shall bill the provider according to the payment schedule selected. Each bill shall indicate the payment due dates. Once the provider has selected a payment schedule, that schedule shall apply for the remainder of that fiscal year.

(b) A provider shall pay the amount due on or before each due date.

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

a. Annual payment - 30 days after the fund mails the initial bill.

b. Semiannual payments - 30 days after the fund mails the initial bill; January 1.

c. Quarterly payments - 30 days after the fund mails the initial bill; October 1; January 1; April 1.

2. Fees for providers that begin practice or operation after the beginning of a fiscal year. For a provider that begins practice or operation or enters the fund under sub. (3s) (b) after July 1 of any fiscal year, the due dates are as follows:

a. The first payment is due 30 days from the date the fund mails the initial bill.

b. For semiannual payment schedules, the 2nd payment is due on January 1. Any provider whose first payment due date is January 1 or later may not choose the semiannual payment schedule.

c. For quarterly payment schedules, if the first payment is due before October 1, the subsequent payments are due on October 1, January 1 and April 1. If the first payment is due from October 1 to December 31, the subsequent payments are due on January 1 and April 1. If the first payment is due from January 1 to March 31, the subsequent payment is due on April 1. Any provider whose first payment is due after March 31 may not choose the quarterly payment schedule.

3. Increased annual fees. If a provider changes class or type, which results in an increased annual fee, the first payment resulting from that increase is due 30 days from the date the fund mails the bill for the adjusted annual fee.

(c) 1. The fund shall charge interest and an administrative service charge of $3 to each provider who chooses the semiannual or quarterly payment schedule.

2. The fund shall charge interest and a late payment fee of $10 to each provider whose payment is not received on or before a due date or whose fund coverage is retroactive under sub. (3s) (b).

3. The daily rate of interest under subds. 1 and 2 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, divided by 360. Late payment fees and administrative service charges are not refundable.

Note: Initial applicability. The treatment of s. Ins 17.28 (3) (e), (f), and (i), (3m), (4) and (7) first applies to patients compensation fund fees for fiscal year 1989-90.

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) (i) 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.

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 paid to or on behalf of claimants, 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 claim against a provider, or a claim against an employe of a health care provider for which the provider is vicariously liable, which results in any payment to or on behalf of a claimant.

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

(d) "Provider" means a health care provider 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 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.

(3) EXAMINATION OF CLAIMS PAID. (a) Each month the council shall examine all claims paid reports received under s. 655.26, Stats., to determine whether each provider for whom a closed claim is reported has, during the review period, accumulated enough closed claims and aggregate indemnity to require the imposition of a surcharge, based on the tables under s. Ins 17.25 (12m) (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.

(b) If the board does not have a provider's claims record for the entire review period, the council may request from the provider a statement of the number and amounts of all closed claims that have been paid by or on behalf of the provider during the review period. The request shall include notice of the provisions of par. (c).

(c) If the provider fails to comply with the request under par. (b), the provider shall be assessed a surcharge for a 3-year period as follows:

1. If the provider has practiced in this state for the entire review period, 10 % of the next annual plan premium, fund fee or both, subject to sub. (11) (d) to (f).

2. If the provider has practiced in any place other than this state for any part of the review period, 50% of the next annual plan premium, fund assessment or both, subject to sub. (11) (d) to (f).

(d) A provider who does not comply with the request under par. (b) is not entitled to a review of his or her claims record as provided in this section nor to a hearing on the imposition of a surcharge.

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