Replaced June 1988 No. 390

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 *other than ambulatory surgery centers*:

1. Per occupied bed $137 plus

2. Per 100 outpatient visits during the last calendar year for which totals are available $ 6.75

(j) For nursing homes

Per occupied bed $26.00

(k) For partnerships comprised of physicians or nurse anesthetists: $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 $0.17; 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 $33.75

(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) Each health care provider permanently practicing or operating in this state may pay the assessment in a single lump sum, 2 semiannual payments or 4 quarterly payments. In this subsection, "assessment" includes any applicable surcharge imposed under sub. (6s) (b). 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; 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.

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.