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.

Next page is numbered 400-5