Surgery - obstetrics and gynecology

(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 that type of practice 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.

(hm) "Resident" means a licensed physician engaged in an approved postgraduate medical education or fellowship program in any specialty specified in par. (c) 1 to 4.

(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 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; ELIGIBILITY. 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:

(a) The provider will not practice more than 240 hours in the fiscal year.

(b) The provider is a federal, state, county or municipal employe.

(c) During the fiscal year, the provider will derive more than 50% of the income from his or her practice from outside this state or will attend to more than 50% of his or her patients outside this state.

(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 submits a timely request for retroactive coverage showing that the failure to procure coverage occurred through no fault of the provider and despite the fact that the provider acted reasonably and in good faith. The provider shall furnish 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.

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 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 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 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).

4. If a provider who was in compliance with sub. (7) (b) dies, the fund, upon receipt of notice of the death, shall issue a refund equal to one twenty-fourth of the provider's annual fee for each full semimonthly period from the date of death to the date the next payment would have been due, except that no refund under this subdivision may exceed the total amount of the most recent annual fee paid by the provider.

(cm) *Eligibility for exemption; refund.* If a provider becomes eligible for an exemption under sub. (3m) (a) after paying all or part of the annual fee, 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 the provider becomes eligible for the exemption or the date the fund receives

the provider's signed exemption form, whichever is later, to the due date of the next payment.

(cs) *Ineligibility for fund coverage; refund.* 1. If a provider who has paid all or part of the annual fee is or becomes ineligible to participate in the fund because he or she is a federal, state, county or municipal employe, or does not practice in this state, the fund shall issue a full refund of any amount the provider paid for fund coverage for which he or she was not eligible.

2. If a provider that has paid all or part of the annual fee is ineligible for fund coverage because the provider is not in compliance with sub. (3e), the fund shall issue a full refund of the amount paid for the period of noncompliance, beginning with the date the noncompliance began.

(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) *Refund of interest.* 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.

(g) *Refund for administrative error.* In addition to any refund authorized under par. (c), (cm), (cs), (e) or (f), the fund may issue a refund to correct an administrative error in the current or any previous fiscal year.

(5) FILING OF CERTIFICATES OF INSURANCE. An insurance company required under s. 655.23 (3) (b), Stats., to file a certificate of insurance on

behalf of a provider shall file the certificate with the fund within 45 days after the original issuance and each renewal and within 45 days after a change of class or type that would affect the provider's fee under sub. (4).

(6) FEE SCHEDULE. The following fee schedule shall be effective from July 1, 1991 to June 30, 1992:

(a) Except as provided in pars. (b) to (g), for a physician:

Class 1	$2,571	Class 3	$12,854
Class 2	5,142	Class 4	15,425

(b) For a resident acting within the scope of a residency or fellowship program:

Class 1	$1,286	Class 3	$6,427
Class 2	2,572	Class 4	7,716

(c) For a resident practicing part-time outside the scope of a residency or fellowship program:

All classes	$1,543

(d) For a medical college of Wisconsin, inc., full-time faculty member:

Class 1	$1,028	Class 3	$5,140
Class 2	2,056	Class 4	6,168

(g) For a part-time physician with an office practice only and no hospital admissions who practices less than 500 hours in a fiscal year: $643

(h) For a nurse anesthetist: $688

(i) For a hospital:

1. Per occupied bed $169; plus

2. Per 100 outpatient visits during the last calendar year for which totals are available $8.40

(j) For a nursing home, as described under s. 655.001 (8), Stats., which is wholly owned and operated by a hospital and which has health care liability insurance separate from that of the hospital by which it is owned and operated:

Per occupied bed $32

(k) For a partnership comprised of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of partners and employed physicians or nurse anesthetists is from 2 to 10 $100.00

2. If the total number of partners and employed physicians or nurse anesthetists is from 11 to 100 $1,000.00

3. If the total number of partners and employed physicians or nurse anesthetists exceeds 100 $2,500.00

(l) For a corporation organized under ch. 180, Stats., providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of shareholders and employed physicians or nurse anesthetists is from 1 to 10 $100.00

2. If the total number of shareholders and employed physicians or nurse anesthetists is from 11 to 100 $1,000.00

3. If the total number of shareholders and employed physicians or nurse anesthetists exceeds 100 $2,500.00

(lm) For a corporation organized under ch. 181, Stats., providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of employed physicians and nurse anesthetists is from 1 to 10 $100.00

2. If the total number of employed physicians and nurse anesthetists is from 11 to 100 $1,000.00

3. If the total number of employed physicians and nurse anesthetists exceeds 100 $2,500.00

(m) For an operational cooperative sickness care plan:

1. Per 100 outpatient visits during the last calendar year for which totals are available $0.21; 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 an ambulatory surgery center, as defined in s. HSS 123.14 (2) (a), which is a separate entity not part of a hospital, partnership or corporation subject to ch. 655, Stats.:

Per 100 outpatient visits during the last calendar year for which totals are available $42

(o) For an entity affiliated with a hospital: $100 or 28.6% of the amount that is or would be paid to the plan for primary liability coverage for the specific type of entity, whichever is greater.

(6e) MEDICAL COLLEGE RESIDENTS' FEES. (a) The fund shall calculate the total amount of fees for all medical college of Wisconsin affiliated hospitals, inc., residents on a full-time-equivalent basis, taking into consideration the proportion of time spent by the residents in practice which is not covered by the fund, including practice in federal, state, county and municipal facilities, as determined by the medical college of Wisconsin affiliated hospitals, inc.

(b) Before the beginning of each fiscal year, the medical college of Wisconsin affiliated hospitals, inc., shall estimate the total amount of fund fees for the next fiscal year for all its residents and shall pay that amount to the fund. At the end of the fiscal year, the medical college of Wisconsin affiliated hospitals, inc., shall determine the residents' actual exposure during the fiscal year and shall pay the fund the amount of an deficiency, plus interest as determined under sub. (7) (c) 3. The fund shall refund the amount of an overpayment, if any.

(6m) (a) The fund may require any 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).

(b) For purposes of sub. (6) (k), (l) and (lm), a partnership or corporation shall report the number of partners, shareholders and employed physicians and nurse anesthetists on July 1 of the previous fiscal year.

(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 s. Ins 17.285 as to the percentage increase in a provider's fund fee:

1. For a class 1 physician or a nurse anesthetist:

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 a class 2 physician:

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 a class 3 physician:

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 a class 4 physician:

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.

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; emerg. r. (4) (c) 1. b., am. (4) (c) 2. and 3., (6) (intro.) to (j), (l) (intro.), (m) 1., (n) and (o), cr. (4) (c) 4., (6) (k) 1. to 3. and (6) (l) 3. and (lm), renum. (6) (k) to be (6) (k) (intro.) and am., r. and recr. (6) (l) 1. and 2., eff. 6-1-89; r. (4) (c) 1. b., am. (4) (c) 2. and 3., (6) (intro.) to (j), (l) (intro.), (m) 1., (n) and (o), cr. (4) (c) 4., (6) (k) 1. to 3. and (6) (l) 3. and (lm), renum. (6) (k) to be (6) (k) (intro.) and am., r. and recr. (6) (l) 1. and 2., Register, July, 1989, No. 403, eff. 8-1-89; am. (1), (2), (3) (c) and (f), (3e), (6) (intro.), (a) (intro.), (b) (intro.), (c) (intro.), (d) (intro.), (e) (intro.), (f) (intro.), (g), (h), (i) (intro.), (j) (intro.), (k) (intro.), (l) (intro.), (lm) (intro.), (m) (intro.), (n) (intro.) and (o) and (6m), renum. (3m) (a) (intro.), 1., 2., 3. intro., b. and c., and (6m) to be (3m) (intro.), (a), (b), (c), and (6m) (a), r. (3m) (a) 3. a. and (b), r. and recr. (5), (6) (a) (intro.), (b) (intro.), (d) (intro.), (e) (intro.), (f) (intro.), (6s) (c) 1. intro., 2. intro., 3. intro. and 4. intro., cr. (3) (intro.) and (hm), (4) (cm) and (g), (6e) and (6m) (b), Register, June, 1990, No. 414, eff. 7-1-90; emerg. am. (6) (b) and (6e), r. (6) (e) and (f), eff. 7-1-90; am. (6) (b) and (6e), r. (6) (e) and (f), Register, October, 1990, No. 418, eff.11-1-90; cr. (4) (cs), am. and (3s) (b) (4) (g), Register, April, 1991, No. 424, eff. 5-1-91; emerg. am. (3) (c) 2. and 3., (6) (intro.), eff. 7-1-91; am. (3) (c) 2. and 3., (6) (intro.), Register, July, 1991, No. 427, eff. 8-1-91; am. (6s) (c) (intro.), Register, January, 1992, No. 433, eff. 2-1-92.

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 attributable to an individual provider that is paid or owing to or on behalf of claimants for all closed claims arising out of one incident or course of conduct, 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 medical malpractice claim against a provider, or a claim against an employe of a health care provider for which the provider is vicariously liable, for which there has been either of the following:

1. A final determination based on a settlement, award or judgment that indemnity will be paid to or on behalf of a claimant.

2. A payment to a claimant by the provider or another person on the provider's behalf.

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

(cg) "Health care provider" has the meaning given in s. 146.81 (1), Stats.

(cr) "Patient health care records" has the meaning given in s. 146.81 (4), Stats.

(d) "Provider," when used without further qualification, means a health care provider subject to ch. 655, Stats., 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 first payment on 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.

(2m) TIME FOR REPORTING. In reporting claims paid under s. 655.26, Stats., each insurer or self-insurer shall report the required information by the 15th day of the month following the date on which there has been a final determination of the aggregate indemnity to be paid to or on behalf of any claimant.

(2s) INFORMATION FOR PROVIDER. Upon receipt of a report under sub. (2m), the council shall mail to the provider who is the subject of the report all of the following:

(a) A copy of the report, with a statement that the provider may contact the insurer that filed the report if the provider believes it contains inaccurate information.

(b) A statement that the council may use its authority under s. 146.82 (2) (a) 5, Stats., to obtain any patient health care records necessary for use in making determinations under this section.

(c) A request that the provider sign and return to the council an authorization for release of information form, authorizing the provider's insurer to provide the council with relevant factual information about the closed claim for use in making determinations under this section. A copy of the form shall be enclosed with the mailing.

(d) If necessary, a request that the provider verify the council's closed claim record and furnish the council with information on any additional closed claims not known to the council that have been paid by or on behalf of the provider during the review period.

(e) Notice that if the provider does not comply with a request under par. (c) or (d) within 40 days after the date of the request, the provider is in violation of s. 601.42 (4), Stats., and may be subject to a forfeiture of up to $1,000 for each week of continued violation, as provided in s. 601.64 (3), Stats.

(3) DETERMINATION OF NEED FOR REVIEW. Based on reports received under sub. (2m) and any additional closed claims reported in response to a request under sub. (2s) (d), the council, using the tables under ss. 17.25

(12m) (c) and 17.28 (6s) (c), shall determine when a provider has, during a review period, accumulated enough closed claims and aggregate indemnity to consider the imposition of a surcharge.

(4) RECORDS REQUESTS; NOTICE TO PROVIDER. (a) When the council makes a determination under sub. (3), it may request any of the following:

1. From any health care provider, patient health care records related to each closed claim subject to review as provided in s. 146.82 (2) (a) 5, Stats.

2. From the provider's insurer, relevant factual information about each closed claim subject to review. This subdivision applies only if the provider has complied with the request under sub. (2s) (c).

(b) A request under par. (a) shall be in writing and shall specify a reasonable time for response. Each person receiving a request shall provide the council with the records and information requested, unless the person no longer maintains or has access to them. If a person is unable to comply with a request, the person shall notify the council in writing of the reason for the inability to comply.

(c) The council shall notify a provider for whom a determination is made under sub. (3) that, after reviewing the patient health care records, consultants' opinions and other relevant information submitted by the provider and the provider's insurer, the council may recommend that a surcharge be imposed on the provider's plan premium, fund fee or both, and that the surcharge may be reduced or eliminated following a review as provided in this section. The notice shall include a description of the procedures specified in this section and a statement that the provider may submit in writing relevant information about any closed claim involved in the review and a description of mitigating circumstances that may reduce the future risk to the plan, the fund or both.

(5) PROCEDURE FOR REVIEW. (a) The council or a single council member may conduct a preliminary review of the records and information relating to each of a provider's closed claims. If the council or council member is able to determine, without a consultant, that the provider met the appropriate standard of care with respect to any closed claim, the council shall not refer that closed claim to a consultant and shall not use that closed claim in determining whether to impose a surcharge on that provider.

(b) Unless a determination under par. (a) reduces the number of closed claims and aggregate indemnity so that the provider is no longer subject to the imposition of a surcharge, the council shall refer all records and information relating to closed claims subject to review, including records and information in the custody of the plan and the fund, to one or more specialists as provided in s. 655.275 (5) (b), Stats.

(c) Each specialist consulted under par. (b) shall provide the council with a written opinion as to whether the provider met the appropriate standard of care with respect to each closed claim reviewed.

(d) At least 30 days before the meeting at which the council will decide whether or not to recommend that a surcharge should be imposed on a provider, the council shall notify the provider of the date of the meeting and furnish the provider with a copy of the consultant's opinions and a

list of any other documents on which the recommendation will be based. The council shall make all documents available to the provider upon request for inspection and copying, as provided under s. 19.35, Stats.

(e) In reviewing a closed claim, the council or a consultant may consider any relevant information except information from a juror who participated in a civil action for damages arising out of an incident under review. The council or a consultant may consult with any person except a juror, interview the provider, employes of the provider or other persons involved in an incident or request the provider to furnish additional information or records.

(f) The council, after taking into consideration all available information, shall decide whether each closed claim reviewed should be counted in recommending whether to impose a surcharge on the provider.

(7) REPORT TO BOARD. (a) If the total number of closed claims which the council determines should be included and the aggregate indemnity attributable to those claims would be sufficient to require the imposition of a surcharge under s. Ins 17.25 (12m) (c), 17.28 (6s) (c) or both, the council shall prepare a written report for the board recommending the surcharge that should be imposed. The report shall include the factual basis for the determination on each incident involved in the review and a description of any mitigating circumstances.

(b) If the council determines that one or more closed claims should not be counted and, as a result, the total number of closed claims remaining and the aggregate indemnity attributable to those claims is not sufficient to require the imposition of a surcharge, the council shall prepare a written report for the board recommending that no surcharge should be imposed. The report shall include a brief summary of the basis for the recommendation.

(c) The council shall furnish the provider with a copy of its report and recommendation to the board and with notice of the right to a hearing as provided in sub. (9).

(9) HEARING. (a) A provider has the right to a hearing under ch. 227, Stats., and ch. Ins 5 on the council's recommendation, if the provider requests a hearing within 30 days after receiving the notice under sub. (7) (c).

(am) The reports of the consultant and any other documents relied on by the council in making its recommendation to the board are admissible in evidence at a hearing under this section.

(b) Notice of the hearing examiner's proposed decision shall inform the provider that he or she may submit to the board written objections and arguments regarding the proposed findings of fact, conclusions of law and decision within 20 days after the date of the notice.

(10) FINAL DECISION; JUDICIAL REVIEW. The board shall make the final decision on the imposition of a surcharge. The final decision is reviewable by the circuit court as provided under ch. 227, Stats.

(11) SURCHARGE; IMPOSITION; REFUND; DURATION. (a) A surcharge imposed on a provider's plan premium, fund fee or both after a final decision by the board takes effect on the next billing date and remains in effect during any period of judicial review.

(c) If judicial review results in the imposition of no surcharge or a reduced surcharge, the plan, the fund or both shall refund the excess amount collected from the provider or apply a credit to the provider's next plan premium or fund fee bill or both.

(d) A surcharge remains in effect for 36 months. The percentage imposed shall be reduced by 50% for the 2nd 12 months and by 75% for the 3rd 12 months, if the provider does not accumulate any additional closed claims before the expiration of the surcharge. The time periods specified in this paragraph are tolled on the date a provider stops practicing in this state and remain tolled until the provider resumes practice in this state.

(e) If the provider accumulates additional closed claims while a surcharge is in effect, the provider is subject to the higher of the following:

1. The surcharge imposed under sub. (10) and par. (d).

2. The surcharge determined by the board following a new review of the provider's claims record under sub. (5).

(f) If the provider is a physician who changes from one class to another class specified in s. Ins 17.25 (12m) (c) or 17.28 (6s) (c) while a surcharge is in effect, the percentage imposed by the final decision of the board shall be applied to the plan premium, fund fee or both for the physician's new class effective on the date the class change occurs.

(12) REQUEST FROM PRIVATE INSURER. If the council receives a request for a recommendation under s. 655.275 (5) (a) 3, Stats., from a private insurer, the council shall follow the procedures specified in subs. (3) to (5) and notify the private insurer and the provider of the determination it would make under sub. (5) (f) if the provider's primary insurer were the plan. A provider is not entitled to a hearing on any determination reported under this subsection.

(13) CONFIDENTIALITY. The final decision of the board and all information and records relating to the review procedure are the work product of the board and are confidential.

History: Cr. Register, February, 1988, No. 386, eff. 3-1-88; am. (2) (a) and (b), (3) (a) and (c) 2., (5) (b) (intro.), (7) (a), (8), (9) (a), (11) (f) and (14), cr. (2m) and (4) (c) 2., renum. (4) (c) to be (4) (c) 1., Register, June, 1990, No. 414, eff. 7-1-90; am. (2) (a), (b), (d) and (e), (7) (b), (11) (a), (c) to (e) (intro.) and 1., (f) and (12), renum. (3) (a), (4) (b) (intro.) and 1., (5) (d), (8) to be (3), (4) (c), (5) (e) and (7) (c) and am. (3), (4) (c) and (7) (c), r. (3) (b) and (d), (4) (b) 2., (c) (d), (6) and (11) (b), cr. (2) (cg) and (cr), (2s), (4) (b), (5) (d) and (f), (9) (am), r. and recr. (4) (a), (5) (a) to (c) and (9) (a), Register, January, 1992, No. 433, eff. 2-1-92.

Ins 17.29 Servicing agent. (1) PURPOSE. This section implements s. 655.27 (2), Stats., relating to contracting for claim services for the fund.

(2) CRITERIA. The board shall establish the criteria for the selection of the servicing agent prior to the expiration of each contract term.

(3) SELECTION. The commissioner, with the approval of the board, shall select a servicing agent through the competitive negotiation process.

(4) CONTRACT TERM. The commissioner, with the approval of the board, shall establish the term of the contract with the servicing agent.

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