State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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STATE OF WISCONSIN
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SEP 25 1997
DOUGLAS LA FOLLETTE
SECRETARY OF STATE

STATE OF WISCONSIN |
| SS
OFFICE OF THE COMMISSIONER OF INSURANCE |

I, Randy Blumer, Deputy Commissioner of Insurance and custodian of the official records, certify that the annexed rule affecting Section Ins 17.01(3),17.28(3)(c)1.and 17.28(6), Wis. Adm. Code, relating to annual patients compensation fund and mediation fund fees for the fiscal year beginning July 1, 1997, is duly approved and adopted by this Office on September 25, 1997.

I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the original, and the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand at 121 East Wilson Street, Madison, Wisconsin, on September 25, 1997.

RECEIVED
SEP 25 1997
REVISOR OF STATUTES BUREAU

Randy Blumer
Deputy Commissioner of Insurance

97-071
12-1-97

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

AND THE BOARD OF GOVERNORS OF THE PATIENTS COMPENSATION FUND

AMENDING AND REPEALING AND RECREATING A RULE

The office of the commissioner of insurance and the board of governors of the patients compensation fund propose an order to amend s. Ins 17.01 (3) (intro.) and s. Ins 17.28 (3) (c) and (6e), repeal and recreate s. Ins 17.28 (6), and to create s. Ins 17.28 (6a), relating to annual patients compensation fund and mediation fund fees for the fiscal year beginning July 1, 1997, adding certain physician specialties to those currently listed in the rule and providing that UW hospital and clinics residents' fees be calculated on a full-time-equivalent basis in the same manner as medical college of Wisconsin resident fees are currently calculated.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3), 655.004, 655.23 (4), 655.27 (3) (b) and 655.61, Stats.

Statutes interpreted: ss. 655.27 (3), 655.23 (4), and 655.015, Stats.

The commissioner of insurance, with the approval of the board of governors (board) of the patients compensation fund (fund), is required to establish by administrative rule the annual fees which

participating health care providers must pay to the fund. This rule establishes those fees for the fiscal year beginning July 1, 1997. These fees represent an overall 17.7% decrease in the fees paid for the 1996-97 fiscal year. The board approved this decrease at its meeting on July 28, 1997, after eactment of 1997 Act 11 on July 14, 1997, based on the recommendation of the board's actuarial and underwriting committee.

1997 Act 11 was signed into law on July 14, 1997, but made effective as of July 1, 1997. Act 11 increased the required primary limits for health care providers subject to the fund from $400,000 to $1,000,000 for each occurrence and from $1,000,000 to $3,000,000 for an annual aggregate limit. An emergency rule effective June 20, 1997, set fund fees for the current fiscal year beginning July 1, 1997, based on the lower liability limits then in effect. The enactment of Act 11 on July 14, 1997, increasing the primary limits made revision of this permanent rule and issuance of a second emergency rule necessary to reduce fund fees as of July 1, 1997, the effective date of Act 11.

The board also at its February 26, 1997, meeting approved additional fees in this rule for partnerships, corporations, and cooperative HMOs as required by 1995 Act 473 (now s. 655.27 (3) (a) 4, Stats.) based on risk factors and past and prospective loss experience attributable to employes of these providers other than physicians and nurse anesthetists.

The board is also required to promulgate by rule the annual fees for the operation of the patients compensation mediation system, based on the recommendation of the director of state courts. This rule implements the director's funding level recommendation by establishing mediation panel fees for the next fiscal year at $32.00 for physicians and $2.00 per occupied bed for hospitals, representing a 16.7% decrease from 1996-97 fiscal year fees.

This rule also makes technical edits in ss. Ins 17.28 (3) (c) and 17.28 (6e) adding certain physician specialties to those currently listed in s. Ins 17.28 (3) (c) and providing UW hospital and clinics residents' fees be calculated on a full-time-equivalent basis in the same manner as medical college of Wisconsin resident fees are calculated as provided in s. Ins 17.28 (6e).

SECTION 1. Ins 17.01 (3) (intro.) is amended to read:

Ins 17.01 (3) FEE SCHEDULE. (intro.) The following fee schedule shall be effective July 1, ~~1996~~ 1997.

SECTION 2. Ins 17.28 (3) (c) is amended to read:

Ins 17.28 Health care provider fees. (3) DEFINITIONS. In this section: (c) "Class" means a group of physicians whose specialties or types of practice are similar in their degree of exposure to loss. The specialties and types of practice and the applicable insurance services office, inc., codes included in each fund class are the following:

1. Class 1:

Allergy	80254
Allergy (D.O.)	84254
Cardiovascular Disease—no surgery or catheterization	80255
Cardiovascular Disease—no surgery or catheterization (D.O.)	84255
Dermatology—no surgery	80256
Dermatology—no surgery (D.O.)	84256
Diabetes—no surgery	80237
Endocrinology—no surgery	80238
Endocrinology—no surgery (D.O.)	84238
Family or General Practice—no surgery	80420
Family or General Practice—no surgery (D.O.)	84420
Forensic Medicine—Legal Medicine	80240
Forensic Medicine—Legal Medicine (D.O.)	84240
Gastroenterology—no surgery	80241
Gastroenterology—no surgery (D.O.)	84241
General Preventive Medicine—no surgery	80231
General Preventive Medicine—no surgery (D.O.)	84231
Geriatrics—no surgery	80243

Geriatrics—no surgery (D.O.)	84243
Gynecology—no surgery	80244
Gynecology—no surgery (D.O.)	84244
Hematology—no surgery	80245
Hematology—no surgery (D.O.)	84245
Infectious Diseases—no surgery	80246
Infectious Diseases—no surgery (D.O.)	84246
Internal Medicine—no surgery	80257
Internal Medicine—no surgery (D.O.)	84257
Laryngology—no surgery	80258
Manipulator (D.O.)	84801
Neoplastic Disease—no surgery	80259
~~Neonatology~~	~~80298~~
Nephrology—no surgery	80260
Neurology—no surgery	80261
Neurology—no surgery (D.O.)	84261
Nuclear Medicine	80262
Nuclear Medicine (D.O.)	84262
Nutrition	80248
Occupation Medicine	80233
Occupation Medicine (D.O.)	84233
Ophthalmology—no surgery	80263
Ophthalmology—no surgery (D.O.)	84263
Osteopathy—manipulation only	84801
Otorhinolaryngology—no surgery	80265
Otorhinolaryngology—no surgery (D.O.)	84265
Pathology—no surgery	80266

Pathology—no surgery (D.O.)	84266
Pediatrics—no surgery	80267
Pediatrics—no surgery (D.O.)	84267
Pharmacology—Clinical	80234
Physiatry—Physical Medicine (D.O.)	84235
Physiatry—Physical Medicine & Rehabilitation	80235
Physicians—no surgery	80268
Physicians—no surgery (D.O.)	84268
Psychiatry	80249
Psychiatry—(D.O.)	84249
Psychoanalysis	80250
Public Health	80236
Pulmonary Disease—no surgery	80269
Pulmonary Disease—no surgery (D.O.)	84269
Radiology—diagnostic	80253
Radiology—diagnostic (D.O.)	84253
Radiopaque dye	80449
Radiopaque dye (D.O.)	84449
Rheumatology—no surgery	80252
Rheumatology—no surgery (D.O.)	84252
Shock Therapy	80431
Shock Therapy—insured	80162
Urgent Care—Walk-in or After Hours	80424
Urgent Care—Walk-in or After Hours (D.O.)	84424
2. Class 2:	
Anesthesiology	80151
Anesthesiology (D.O.)	84151

Angiography—Arteriography—catheterization	80422
Angiography—arteriography—catheterization (D.O.)	84422
Broncho—Esophagology	80101
Cardiovascular Disease—minor surgery	80281
Cardiovascular Disease—minor surgery (D.O.)	84281
Colonoscopy—ERCP—Pneu or mech esoph dil (D.O.)	84443
Colonoscopy—ERCP—pneu. or mech.	80443
Dermatology—minor surgery	80282
Dermatology—minor surgery (D.O.)	84282
Emergency Medicine—No Major Surgery	80102
Emergency Medicine—No Major Surgery (DO)	84102
Endocrinology—minor surgery	80272
Endocrinology—minor surgery (D.O.)	84272
Family Practice—and general practice minor surgery—No OB	80423
Family Practice—and general practice minor surgery—No OB (D.O.)	84423
Family or General Practice—including OB (D.O.)	84421
Family or General Practice—including OB	80421
Gastroenterology—minor surgery	80274
Gastroenterology—minor surgery (D.O.)	84274
Geriatrics—minor surgery	80276
Geriatrics—minor surgery (D.O.)	84276
Gynecology—minor surgery	80277
Gynecology—minor surgery (D.O.)	84277
Hematology—minor surgery	80278
Hematology—minor surgery (D.O.)	84278
Infectious Diseases—minor surgery	80279
Intensive Care Medicine	80283

Intensive Care Medicine (D.O.)	84283
Internal Medicine—minor surgery	80284
Internal Medicine—minor surgery (D.O.)	84284
Laryngology—minor surgery	80285
Nephrology—minor surgery	80287
~~Neonatology~~	~~80298~~
Neoplastic Disease—minor surgery	80286
Neurology—minor surgery	80288
Neurology—minor surgery (D.O.)	84288
Ophthalmology—minor surgery	80289
Ophthalmology—minor surgery (D.O.)	84289
Otorhinolaryngology—minor surgery	80291
Otorhinolaryngology—minor surgery (D.O.)	84291
Pathology—minor surgery	80292
Pathology—minor surgery (D.O.)	84292
Pediatrics—minor surgery	80293
Pediatrics—minor surgery (D.O.)	84293
Physicians—minor surgery	80294
Radiation Therapy—lasers	80425
Radiation Therapy—lasers (D.O.)	84425
Radiology—diagnostic-interventional procedures	80280
Radiology—diagnostic-interventional procedures (D.O.)	84280
Surgery—Colon & Rectal	80115
Surgery—Gastroenterology	80104
Surgery—General Practice or Family Practice	80117
Surgery—Neoplastic	80107
Surgery—Ophthalmology	80114

Surgery—Urological	80145
Surgery—Urological (D.O.)	84145
3. Class 3:	
Emergency Medicine—includes major surgery	80157
Emergency Medicine—includes major surgery (D.O.)	84157
Otology—surgery	80158
Surgery—Abdominal	80166
Surgery—Cardiac	80141
Surgery—Cardiovascular Disease	80150
Surgery—Cardiovascular Disease (D.O.)	84150
Surgery—General	80143
Surgery—General (D.O.)	84143
Surgery—Gynecology	80167
Surgery—Gynecology (D.O.)	84167
Surgery—Hand	80169
Surgery—Head & Neck	80170
Surgery—Orthopedic	80154
Surgery—Orthopedic (D.O.)	84154
Surgery—Otorhinolaryngology-no plastic surgery	80159
Surgery—Plastic	80156
Surgery—Plastic (D.O.)	84156
Surgery—Plastic-Otorhinolaryngology	80155
Surgery—Plastic-Otorhinolaryngology (D.O.)	84155
Surgery—Rhinology	80160
Surgery—Thoracic	80144
Surgery—Thoracic (D.O.)	84144
Surgery—Traumatic	80171

Surgery—Vascular	80146
Weight Control—Bariatrics	80180

4. Class 4:

Surgery—Neurology	80152
Surgery—Neurology (D.O.)	84152
Surgery—Obstetrics	80168
Surgery—OB/GYN	80153
Surgery—OB/GYN (D.O.)	84153

SECTION 3. Ins 17.28 (6) is repealed and recreated to read:

Ins 17.28 (6) FEE SCHEDULE. The following fee schedule is in effect from July 1, 1997, to June 30, 1998:

(a) Except as provided in pars. (b) to (g) and sub. (6e), for a physician for whom this state is a principal place of practice:

Class 1	$2,647	Class 3	$11,382
Class 2	$5,294	Class 4	$15,882

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

Class 1	$1,324	Class 3	$5,693
Class 2	$2,648	Class 4	$7,944

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

All classes	$1,588

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

Class 1	$1,059	Class 3	$4,554
Class 2	$2,118	Class 4	$6,354

(e) For a physician who practices fewer than 500 hours during the fiscal year, limited to office practice and nursing home and house calls, and who does not practice obstetrics or surgery or assist in surgical procedures: $662

(f) For a physician for whom this state is not a principal place of practice:

Class 1	$1,324	Class 3	$5,693
Class 2	$2,648	Class 4	$7,944

(g) For a nurse anesthetist for whom this state is a principal place of practice: $678

(h) For a nurse anesthetist for whom this state is not a principal place of practice: $339

(i) For a hospital:

1. Per occupied bed $167; plus

2. Per 100 outpatient visits during the last calendar year for which totals are available. $8.35

(j) For a nursing home, as described under s. 655.002 (1) (j), 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 $31

(k) For a partnership comprised of physicians or nurse anesthetists, organized for the primary purpose of providing the medical services of physicians or nurse anesthetists, all of the following fees:

1. a. If the total number of partners and employed physicians and nurse anesthetists is from 2 to 10 $95

b. If the total number of partners and employed physicians and nurse anesthetists is from 11 to 100 $947

c. If the total number of partners and employed physicians and nurse anesthetists exceeds 100 $2,368

2. The following fee for each of the following employes employed by the partnership as of July 1, 1997:

Employed Health Care Persons	July 1, 1997 Fund Fee
Nurse Practitioner	$ 662
Advanced Nurse Practitioner	926

Nurse Midwives	5,823
Advanced Nurse Midwives	6,088
Advanced Practice Nurse Prescribers	926
Chiropractors	1,059
Dentists	529
Oral Surgeons	3,971
Podiatrists-Surgical	11,250
Optometrists	529
Physician Assistant	529

(L) For a corporation, including a service corporation, with more than one shareholder organized under ch. 180, Stats., for the primary purpose of providing the medical services of physicians or nurse anesthetists, all of the following fees:

1. a. If the total number of shareholders and employed physicians and nurse anesthetists is from 2 to 10 $95

b. If the total number of shareholders and employed physicians and nurse anesthetists is from 11 to 100 $947

c. If the total number of shareholders and employed physicians or nurse anesthetists exceeds 100 $2,368

2. The following for each of the following employes employed by the corporation as of July 1, 1997:

Employed Health Care Persons	July 1, 1997 Fund Fee
Nurse Practitioner	$ 662
Advanced Nurse Practitioner	926
Nurse Midwives	5,823
Advanced Nurse Midwives	6,088
Advanced Practice Nurse Prescribers	926
Chiropractors	1,059

Dentists	529
Oral Surgeons	3,971
Podiatrists-Surgical	11,250
Optometrists	529
Physician Assistant	529

(m) For a corporation organized under ch. 181, Stats., for the primary purpose of providing the medical services of physicians or nurse anesthetists, all of the following fees:

1. a. If the total number of employed physicians and nurse anesthetists is from 1 to 10 $95

b. If the total number of employed physicians and nurse anesthetists is from 11 to 100 $947

c. If the total number of employed physicians or nurse anesthetists exceeds 100 $2,368

2. The following for each of the following employes employed by the corporation as of July 1, 1997:

Employed Health Care Persons	July 1, 1997 Fund Fee
Nurse Practitioner	$ 662
Advanced Nurse Practitioner	926
Nurse Midwives	5,823
Advanced Nurse Midwives	6,088
Advanced Practice Nurse Prescribers	926
Chiropractors	1,059
Dentists	529
Oral Surgeons	3,971
Podiatrists-Surgical	11,250
Optometrists	529
Physician Assistant	529

(n) For an operational cooperative sickness care plan as described under s. 655.002 (1) (f), Stats., all of the following fees:

1. Per 100 outpatient visits during the last calendar year for which totals are available $0.20.

2. 2.5% of the total annual fees assessed against all of the employed physicians.

3. The following for each of the following employes employed by the operational cooperative sickness plan as of July 1, 1997:

Employed Health Care Persons	July 1, 1997 Fund Fee
Nurse Practitioner	$ 662
Advanced Nurse Practitioner	926
Nurse Midwives	5,823
Advanced Nurse Midwives	6,088
Advanced Practice Nurse Prescribers	926
Chiropractors	1,059
Dentists	529
Oral Surgeons	3,971
Podiatrists-Surgical	11,250
Optometrists	529
Physician Assistant	529

(o) For a freestanding ambulatory surgery center, as defined in s. Ins 120.03 (10):

Per 100 outpatient visits during the last calendar year for which totals are available $40

(p) For an entity affiliated with a hospital, the greater of $100 or whichever of the following applies:

1. 7% of the amount the entity pays as premium for its primary health care liability insurance, if it has occurrence coverage.

2. 10% of the amount the entity pays as premium for its primary health care liability insurance, if it has claims-made coverage.

SECTION 4. Ins 17.28 (6a) is created to read:

Ins 17.28 (6a) FEES FOR OCI APPROVED SELF-INSURED HEALTH CARE PROVIDERS. The following fee schedule is in effect from July 1, 1997 to June 30, 1998 for OCI approved self-insured health care providers who elect, pursuant to s. 655.23 (4) (c) 2, Stats, to increase their per occurrence limit to $600,000 for each occurrence on or after July 1, 1997, provided such self-insured provider has filed an amended self-insured plan document reflecting the increased coverage levels with the office of the commissioner of insurance and with the patients compensation fund on or before August 15, 1997:

The fees set forth in sub. (6) multiplied by 1.161

SECTION 5. Ins 17.28 (6e) (a) is amended to read:

(6e) MEDICAL COLLEGE RESIDENTS' FEES. (a) The fund shall calculate the total amount of fees for all medical college of Wisconsin affiliated hospitals, inc., and UW hospital and clinics, 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 and documented by the medical college of Wisconsin affiliated hospitals, inc., and UW hospital and clinics, respectively.

SECTION 6. INITIAL APPLICABILITY. This rule first applies on July 1, 1997.

SECTION 7. EFFECTIVE DATE. This rule will take effect on the first day of the first month after publication, as provided in s. 227.22 (2) (intro), Stats.

Dated at Madison, Wisconsin, this 25th day of September 1997.

Randy Blumer
Deputy Commissioner of Insurance