December 22, 2010

Wisconsin Department of Health Services

Implementation Plan for 2009 Wisconsin Act 146

Background: Act 146 was enacted on March 9, 2010 and is effective as of January 1, 2011. Its goals are to increase the transparency of medical costs and anticipated out-of-pocket expenses for health care consumers. It establishes requirements on health care providers (described below), hospitals, and certain insurance plans, as well as on the Department of Health Services (DHS). No funding for implementation was created for any of these parties, including DHS.

DHS is directed to:

a. categorize health care providers (not hospitals or insurers) by type;
b. for each type of health care provider, annually identify the 25 presenting conditions for which that type of health care provider most frequently provides health care services;
c. prescribe the methods by which health care providers shall calculate and present, for each of the 25 conditions and assuming no medical complications,
    - median billed charges during the first two calendar quarters of the most recently completed calendar year,
    - Medicare payment, and
    - the average allowable payment from private third-party payers;
d. consult with organizations that develop measures for health care provider quality assessment; collect, validate and analyze such data; report quality assessments; and share best practices of health care providers

On July 1, 2010 a group of DHS staff, stakeholders representing various provider types, and legislative staff met at the offices of DHS to discuss implementation. The following points were learned:

a. A major intent of the bill was to increase the ability of patients to predict possible out-of-pocket expenses.
b. Bill language was influenced by how hospitals predominantly bill for inpatient services by a prospective-payment mechanism (diagnosis related groups) that link payment for services to a particular description of the patient's condition.
c. For health care providers (as opposed to hospitals), no such current system for linking patient condition to a particular billing code is commonly used by private payers or Medicaid in Wisconsin today (with very limited exceptions).
d. It may have been believed that the information needed by DHS to establish clear rules for health care providers, and for health care providers to obtain the needed information, was already contained in, and could be generated by, a single database. During the meeting doubt was placed on that supposition.

e. There was no intent to place a heavy cost burden for data acquisition, data analysis or reporting on either health care providers or on DHS.
f. Act 146 was not based specifically on another state's legislation or an operational model in practice elsewhere.

Given these points, it was concluded that DHS's implementation of reporting requirements by health care providers laid out in section 5(3) of the Act (which also impacts the duties of insurers in Section 5(11)) may need to be approached incrementally, using the best methods practically available within the time available, the funding parameters of the bill, and considerations of economic burdens on providers. The State Health Officer/Administrator of Public Health, the Wisconsin Medical Society (WMS), the Wisconsin Collaborative for Healthcare Quality (WCHQ) and the Wisconsin Health Information Organization (WHIO), in consultation with other stakeholder groups, collaborated to develop an implementation proposal for the year 2011. It was understood that the proposal represents only a first step toward more comprehensive implementation in later years.

Goals: In their approach, the workgroup attempted to meet several goals. It was understood that several of the goals potentially contradict one another, and thus seeking the best practical balance is necessary.

1. Develop a patient report that is understandable and meaningful to both patients and providers.
2. Develop a patient report that supports queries from patients to insurers regarding possible out-of-pocket costs. As such, it should provide information to patients in units of Current Procedural Terminology (CPT) of the American Medical Association or Current Dental Terminology (CDT) of the American Dental Association as specified in section 10(2).
3. The report should avoid a heavy burden of data retrieval and analysis by providers.
4. The report should permit comparison of the billed charges for similar services between different providers of the same type.

It became clear that no type of standard written report would likely predict the actual billed charges (or out-of-pocket costs) that any *individual* patient would experience. Thus at best such a written report would serve as a) a point of discussion between provider and patient; b) a tool for price comparison between providers, and c) only one of several information sources necessary to predict out-of-pocket costs for a health condition.

The proposal was presented to stakeholders on September 27, 2010, with a request for their suggestions for practical improvements prior to becoming official. It was also published on the DHS Act 146 website at http://www.dhs.wisconsin.gov/2009wisact146/index.htm. The public comment period ended on October 21, 2010; seven comments were received, with some representing multiple organizations' input.

DHS has carefully reviewed the comments received and has continued working with WCHQ, WHIO, WMS and other partners on technical aspects of implementation. Given time and resource constraints for all stakeholders, DHS has modified the original proposal so that consumers may have useful information available on request from health care providers as soon after January 1 as possible.

Issues Addressed:

1. Provider Types: Which types of health care providers would be addressed in 2011, and how would they be defined?
2. Most Frequent Conditions: How would the 25 conditions for which these provider types most frequently provide health care services be identified and defined?
3. Linking diagnostic and treatment services to conditions: How would a set of diagnostic and treatment services be linked to conditions in a way that is reasonably transparent to patients, providers and insurers and without creating an undue burden on providers or DHS?
4. Calculating and presenting "median billed charges."
5. Calculating and presenting Medicare payments.
6. Calculating and presenting "the average allowable payment from private, third-party payers.
7. How might the process be expanded to more provider types in 2012?
8. DHS responsibilities: Who inside DHS might perform which functions after implementation?

Issue 1: Provider types

Act 146 defines the "health care provider" to include:

A clinic
An ambulatory surgical center
A nurse licensed under ch. 441.
A chiropractor licensed under ch. 446.
A dentist licensed under ch. 447.
A physician, physician assistant, perfusionist, or respiratory care practitioner licensed or certified under subch. II of ch. 448.
A physical therapist licensed under subch. III of ch. 448.
A podiatrist licensed under subch. IV of ch. 448.
A dietitian certified under subch. V of ch. 448.
An athletic trainer licensed under subch. VI of ch. 448.
An occupational therapist or occupational therapy assistant licensed under subch. VII of ch. 448.
An optometrist licensed under ch. 449.
A pharmacist licensed under ch. 450.
An acupuncturist certified under ch. 451.
A psychologist licensed under ch. 455.
A social worker, marriage and family therapist, or professional counselor certified or licensed under ch. 457.
A speech−language pathologist or audiologist licensed under subch. II of ch. 459 or a speech and language pathologist licensed by the department of public instruction.
A massage therapist or bodyworker certified under ch. 460.

Act 146 specifically excludes nursing homes as defined in s. 50.01(3) as a health care provider but does not exclude the providers listed above who may practice in a nursing home setting. Act 146 has separate requirement for hospitals, detailed in s. 5(4).

Act 146 further excludes (1) providers who practice individually or *in* an association with not more than two other providers and (2) it excludes providers that *are* an association of three or fewer individual providers.

Issue 1A: Which types of health care providers will be included in implementation in 2011? Implementation for 2011 is focused on physicians (MDs and DOs), who are categorized as one type of provider. The physicians required to implement Act 146 are those working in a private practice, clinic or ambulatory surgery center that has four or more physician providers. Physicians employed by a hospital who do not bill directly or individually for services are covered by the hospital's reporting.

The rationale for defining physicians as one provider type and focusing the initial implementation on them is as follows:

- These providers are believed to be the largest source of health care provider costs for patients overall.
- Patients look to physicians as gatekeepers for most medical services, so they and their staffs are uniquely situated to address consumers' questions about which services will be recommended and who might provide them.
- They are the group for which data is best characterized in the extensive WHIO medical claims data mart and other major sources of information on the frequency of conditions and billed services. They are also the group with the best-developed organizational infrastructure for developing the consumer reports required by Act 146.
- Methodologies for analyzing conditions and the costs of services are most advanced for this group.

We believe there is little alternative to this approach for 2011. Implementation for other provider types would require expensive data collection, cleaning, and analysis for which neither authority nor funding are provided. Furthermore, for many of these categories, much billing is direct-to-consumer (and thus is not available from claims databases like WHIO), or is bundled into other costs by hospitals, clinics or other institutions. Therefore, we believe it is not practical to include other providers in the initial reporting implementation in 2011. This will also allow implementation problems to be worked out with the provider type for which methodologies are most developed and for whom the most significant payment claims are made.

In 2012, additional types of providers will be defined and reporting specifications will be developed. Nonetheless, we encourage other health care providers to make information on charges and payments readily available to and understandable by health care consumers, as many of them do now.

Issue 1B: Will physicians be subdivided into specialty types?
The proposed implementation plan envisioned taking advantage of the WHIO data's "peer group" concept in order to sub-divide physicians into practice specialties. For each of fourteen peer groups, a Top 25 list of conditions would be generated. For each condition, a "market basket" of medical services would be selected. Providers would select their specialty and report on the services for each condition in that specialty.

Most comments from groups representing physicians argued that this was burdensome. Our analyses supported that judgment, particularly given the brief time available for report definition and development before the Act is scheduled for implementation. It also was not clear how the set of services for each condition could be defined with an objective and efficient methodology. Further, we discovered that the source data was unable to assign about half of the medical episodes to any physician specialty and that a number of specialties were not yet defined and operationalized in the WHIO system. This all led us to conclude that sub-dividing the physician provider type into specialties was impractical and methodologically unsupported at this time for the purposes of Act 146.

For at least the initial phase of Act 146 implementation, *physicians will be treated as one provider type.* This means that only one set of Top 25 conditions (and the related services for each) will be necessary.

There are downsides to this approach:

- Patients will be less likely to find the condition for which they are receiving treatment on their physician's report.
- Many physicians will not provide any medical services for some - perhaps many - of the reportable conditions.

Issue 2: Most Frequent Conditions

Act 146 requires DHS to "annually identify the 25 presenting conditions for which that type of health care provider most frequently provides health care services." The proposed implementation plan evaluated some empirical options and recommended using Ingenix' Impact Intelligence product's organization of the WHIO claims data into "Episode Treatment Groups" (ETGs©).

The well-documented Episode Treatment Group methodology groups payment claims for treatments over a limited span of time for the same patient that are related to a particular diagnosis. Thus it groups treatments and their associated claims for payment into episodes of care.

The use of ETGs to identify the most common presenting conditions has a number of advantages. First, the ETG condition categories are relatively intuitively understandable and holistic, and account for situations where multiple conditions are being cared for simultaneously, as is common in primary care. Second, the lists of condition frequencies can be rapidly generated with much less labor, programming or software acquisition costs than the alternatives.

Third, Wisconsin stakeholder organizations like the Wisconsin Medical Society and insurers are already familiar with the system and its outputs. Fourth, it will increase the exposure to ETG concepts by both providers and patients, which may be useful as they are utilized for other reporting and analytical processes. Using ETGs aligns the process with other analyses and reports (current and future) that utilize episode treatment groups; this is the predominant technology utilized by WHIO.

We do recognize that ETGs are relatively well-established for physician-provided care but may not be appropriate for use with other classes of providers.

We used the WHIO Data Mart Version 4 ("DMV4") database, which has 200 million claims records for about 3.5 million Wisconsin residents. It includes Medicaid claims, but not Medicare participants, not some privately insured residents, and not uninsured residents. Because Act 146 is focused on information about medical and out-of-pocket costs for consumers with private, third-party payers, we excluded the Medicaid claims from our analyses.

The DMV4 database was queried for the most common 25 episode treatment groups using the following criteria:

- The episodes were completed.
- The episodes began and ended within the most current available period: April 1, 2009 through March 31, 2010.
- The episodes were limited to those with the lowest rated severity level, since the Act calls for charge information "assuming no medical complications."
- Medicaid claims were excluded.
- The patients were Wisconsin residents.

The WHIO Data Mart Version 4 (DMV4) database was queried using Ingenix' Impact Intelligence tool by analysts at the Department. The results were independently confirmed by WCHQ and WMS staff. Not surprisingly, the most common episode is the routine exam, a self-contained episode of care.

The 25 most common episode treatment groups are listed in Appendix 1. Each physician's report need only include the conditions diagnosed, managed or treated in the physician's own practice.

Issue 3: Linking conditions to the costs of diagnostic and treatment services

Act 146 requires health care providers to list certain "charge information, assuming no medical complications, for diagnosing and treating each of the 25 presenting conditions" identified as the most common. The Department's duty under the Act to prescribe methods for calculating that charge information is complicated by the nature of billing for the diagnosis and treatment of a patient's condition.

The care provided hospital patients by a hospital and its staff can be summarized for billing purposes by the CMS' Medical Severity Diagnosis-Related Group (MS-DRG) system, which is

largely based on the principal diagnosis and other diagnoses of the patient. However, billing for health care provider services by physicians usually is based on service units of visits and procedures. These units are typically defined for physicians' and other providers' services using the Common Procedural Terminology (CPT) coding system. CPTs are usually independent of diagnoses; a single service code, such as one for a 20-minute office visit for a new patient, may be used for many different conditions.

Importantly, a single condition often generates a widely varying collection of CPT service codes in the process of diagnosing and treating an episode. The services may be billed by more than one physician and by other professional providers as well. Thus there is no one-to-one mapping of "condition" to "billing for diagnosis or therapy" for outpatients as there is for inpatients, with the DRG system.

A physician will not necessarily be in the position to know any charge information for the services and procedures that another physician or other health care provider will provide or may provide in the diagnosis and treatment of a presenting condition. *Therefore, physicians will report charge information for the individual services – defined by CPT codes – that (a) are identified by the Department as among the most important services in terms of total billed charges for physician-provided services in the context of each of the identified conditions and (b) are services they themselves provide.*

Health care consumers who wish to understand the likely costs of treatment to themselves and to their insurer may ask their physician's office for this report, which details the common services, the charges, the CPT codes, and typical charges in the area. This will give consumers the CPT codes with which, in turn, Act 146 requires third party payers to provide benefit and out-of-pocket cost information to inquiring consumers.

Consumers may receive this information on request from each physician whom they consult or consider consulting. They may also wish to ask about other services that may be recommended by their physician and provided by that physician, another physician, or another health care provider. Consumers may thus obtain the CPT codes for those services and pursue inquiries about potential out-of-pocket costs with their insurer. Consumers also will better understand their treatment options.

> Note: In addition to this charge information (detailed below) on the most important physician-provided services, Act 146 s.5(3)(a) requires all health care providers to disclose on request the median billed charge for any "health care service, diagnostic test, or procedure that is specified by the consumer and that is provided by the health care provider."

In order to identify the most important physician-provided services and procedures for each of the top 25 conditions, the Department asked the Wisconsin Medical Society to utilize its capacity to drill down into the full WHIO claims database. WMS queried the most current data for CPT codes attached to all claims for physician-provided services related to each of the 25 top ETGs with the lowest severity level. WMS sorted each group of CPT codes by the total billed charges and provided the Department with the services and procedures that had the ten largest total billed

charges. On inspection, the first five in each group accounted for a substantial share of the top ten's total billing and generally accounted for a large share of the overall total billing for each ETG. Our conclusion is that five CPTs for each condition are an adequate number for the physicians' reports.

The selected CPT-coded services and procedures for the reports that physicians are required to disclose to consumers under Act 146 s.5(3)(b) are listed in Appendix 2. As noted above, physicians are only required to report on those conditions that they diagnose or treat. Similarly, they need only report charges for those services they personally provide. Other services may be noted as 'Not applicable for this practice' or similar on their report.

Practices may wish to create labels for some services that are more consumer-friendly than the sometimes-cryptic CPT abbreviations used by billing systems.

Issue 4: Calculating median billed charges

Providers will report the median charge billed for each of the identified CPT codes under the medical conditions that they diagnose or treat and for those services they personally provide. As specified in the Act, the *median billed charge* is:

> "the amount the health care provider charged, before any discount or contractual rate applicable to certain patients or payers was applied, during the first 2 calendar quarters of the most recently completed calendar year, as calculated by arranging the charges in that reporting period from highest to lowest and selecting the middle charge in the sequence or, for an even number of charges, selecting the 2 middle charges in the sequence and calculating the average of the 2." [Wis. Stat. 146.903(1)(e)]

For reports to consumers in calendar 2011, the median is for the period January 1, 2010 through June 30, 2010. The Department strongly encourages physicians to disclose their current charge as well.

Issue 5: Medicare payments

Physicians who are certified Medicare providers are required by Act 146 to report "the Medicare payment to the provider." The Department takes this to mean the current Medicare payment for applicable CPT-coded services.

Issue 6: Average allowable payments from private, third-party payers

The Department found it difficult to define the average allowable payments from private, third-party payers. From the perspective of such a payer, allowable payments refer to the amount of potential reimbursement for a particular service to a particular provider after the application of discounts and other contractual rates. However, this is not the actual final settled reimbursement

for a particular patient, since it does not take into account the contractual arrangement between the insurer and the consumer. For example, the final reimbursement will reflect the status of deductibles and co-payments and other cost-sharing arrangements in any individual policy at the time of the service or claim for payment. These arrangements and their status are not known to the provider.

An alternative might be reporting the average reimbursement received by a physician for a service or procedure from all private third-party payers over some recent period. However, physician provider organizations tell us that extracting these payments from accounting systems and calculating an average for each physician is technically difficult and requires an intensive use of resources.

The Department's proposed Act 146 implementation plan envisioned using the WHIO DataMart to calculate the average third-party payment for each CPT code for each county. However, the DataMart contains only the billed claims, not the actual reimbursement payment data.

At least as an interim measure until this issue is better understood, physician providers shall report the typical reimbursement or discounted price or typical charge in the physicians' geographic area of the state by private third-party payers, for each applicable service and procedure in the CPT list for the conditions which the physician diagnoses or treats. Physicians should draw upon any of the available standard reference sources that provide such data. The Ingenix' Customized Fee Analyzer is one example of such a source. One example of an acceptable statistic is the median charge in the local area for the CPT-coded service. The source and statistic chosen should be clearly documented for consumers in the report's notes.

Issue 7: Implementation for other provider types

Once the reporting process is operational for physicians early in 2011, there will be opportunity to assess some of the problems with the methods of calculation and presentation. Additional provider types should be selected and methods for identifying their twenty-five most common presenting conditions explored. The WHIP DataMart may be helpful with some other provider types, such as chiropractors, nurse practitioners, and physician assistants. Other provider types may require other approaches to defining the type, identifying most common conditions, and defining the methodologies for calculating and presenting charge- and payment-related information.

Issue 8: DHS responsibility for enforcement

Enforcement during calendar year 2011 will be on a complaint-driven basis through the Division of Quality Assurance, which currently operates similar procedures for certain of the entities covered by Act 146. The Department will have telephone and web-based services for registering consumer complaints and will prepare response procedures involving inquiry and education. Subsequent enforcement, the levying of forfeitures and the hearing of appeals is proposed to be undertaken by the Division of Quality Assurance.

Appendix 1. The 25 Most Common Medical Conditions without Complications

(Episode Treatment Groups)

Top 25 Episode Treatment Groups (Only ETGs with Lowest Severity Level)	**Number of Episodes**	**Total Billed**
Routine exam	475,567	$212,114,128
Hyperlipidemia, other	165,209	$142,782,753
Hypertension	149,793	$171,904,216
Tonsillitis, adenoiditis or pharyngitis, w/o surgery	116,265	$36,681,922
Visual disturbances, w/o surgery	106,816	$18,213,675
Mood disorder, depressed	69,328	$130,828,145
Isolated signs, symptoms & non-specific diagnoses or conditions	65,206	$30,085,823
Otitis media, w/o surgery	61,695	$18,904,864
Diabetes, w/o surgery	59,220	$137,861,712
Hypo-functioning thyroid gland, w/o surgery	56,648	$57,317,247
Acute bronchitis	56,441	$21,524,790
Acute sinusitis, w/o surgery	54,301	$17,434,111
Chronic sinusitis, w/o surgery	52,225	$37,152,941
Routine inoculation	50,785	$11,816,644
Cataract, w/o surgery	49,518	$11,965,508
Otolaryngology diseases signs & symptoms	48,673	$12,386,743
Other minor orthopedic disorders - back	43,677	$30,621,198
Contraceptive management	43,142	$29,391,242
Other neuropsychological or behavioral disorders	42,386	$49,183,386
Joint degeneration, localized - back, w/o surgery	40,639	$114,192,591
Gastroenterology diseases signs & symptoms	39,929	$56,389,401
Fungal skin infection	35,554	$8,470,677
Obesity, w/o surgery	32,526	$29,833,981
Inflammatory eye disease, w/o surgery	31,984	$11,427,819
Acne	30,923	$25,420,848
Total - Top 25 ETGs (severity = 1)	**1,978,450**	**$1,423,906,365**
Total completed episodes (all ETGs, all severity levels)	**4,411,910**	**$10,306,557,879**
Top 25 as % of all ETGs with all severity levels	45%	14%

From the Ingenix Impact Intelligence DataMart V4 - Nov 16, 2010
Note: excludes Medicaid FFS and HMO claims.

Appendix 2		
Top 5 CPTs for each of Top 25 ETGs, by total billed		
Medical Condition (Episode Treatment Group)	**CPT Code**	**Medical Service or Procedure (CPT)**
Routine exam	99396	Periodic Preventive Med, Established Patient - Age 40-64
	99392	Periodic Preventive Med, Established Patient - Age 1-4
	99395	Periodic Preventive Med, Established Patient - Age 18-39
	77057	Screening Mammography Bilateral
	99393	Periodic Preventive Med, Established Patient - Age 5-11
Hyperlipidemia, other	80061	Lipid Panel
	99214	Office Outpatient, Established Patient, 25 Min
	99396	Periodic Preventive Med, Established Patient, Age 40-64
	99213	Office Outpatient, Established Patient, 15 Min
	80053	Comprehensive Metabolic Panel
Hypertension	99214	Office Outpatient, Established Patient, 25 Min
	99213	Office Outpatient, Established Patient, 15 Min
	99396	Periodic Preventive Med, Established Patient, Age 40-64
	93306	Echo Tthrc R-T 2d -+M-Mode Compl Spec&Color Dop
	80053	Comprehensive Metabolic Panel
Other minor orthopedic disorders - back	98941	Cmt Spi 3-4 Regions
	98940	Cmt Spi 1-2 Regions
	99213	Office Outpatient, Established Patient, 15 Min
	97110	Ther Px 1+ Areas Ea 15 Min Ther Xerss
	72148	MRI Spi Canal&Cnts Lmbr C-Matrl
Joint degeneration, localized - back, w/o surgery	72148	MRI Spi Canal&Cnts Lmbr C-Matrl
	98941	Cmt Spi 3-4 Regions
	98940	Cmt Spi 1-2 Regions
	99213	Office Outpatient, Established Patient, 15 Min
	97110	Ther Px 1+ Areas Ea 15 Min Ther Xerss
Isolated signs, symptoms & non-specific diagnoses or conditions	99213	Office Outpatient, Established Patient, 15 Min
	99214	Office Outpatient, Established Patient, 25 Min
	70553	MRI Brn Brn Stem C-/C+
	77057	Screening Mammography Bilateral
	71020	Radex Ch 2 Views Frnt&Lat

Medical Condition (Episode Treatment Group)	CPT Code	Medical Service or Procedure (CPT)
Diabetes, w/o surgery	99214	Office Outpatient, Established Patient, 25 Min
	83036	Hgb Glycosylated
	99213	Office Outpatient, Established Patient, 15 Min
	82043	Albumin Urine Microalbumin Quan
	80061	Lipid Panel
Obesity, w/o surgery	80061	Lipid Panel
	99214	Office Outpatient, Established Patient, 25 Min
	95811	Polysm Sleep Staging 4/> Addl Param W/Cpap Tx
	99213	Office Outpatient, Established Patient, 15 Min
	99396	Periodic Preventive Med, Established Patient, Age 40-64
Hypo-functioning thyroid gland, w/o surgery	84443	Thyroid Stimulating Hormone
	99214	Office Outpatient, Established Patient, 25 Min
	80061	Lipid Panel
	99213	Office Outpatient, Established Patient, 15 Min
	99396	Periodic Preventive Med, Established Patient, Age 40-64
Acne	99213	Office Outpatient, Established Patient, 15 Min
	99214	Office Outpatient, Established Patient, 25 Min
	99202	Office Outpatient New Patient, 20 Minutes
	99212	Office Outpatient, Established Patient, 10 Min
	99203	Office Outpatient, New Patient, 30 Min
Acute bronchitis	99213	Office Outpatient, Established Patient, 15 Min
	99214	Office Outpatient, Established Patient, 25 Min
	71020	Radex Ch 2 Views Frnt&Lat
	99284	Emer Dept Hi Severity&Urgent Eval
	94640	Press/N-Press Inhlj Tx F/Aao/Sptm Indctj
Acute sinusitis, w/o surgery	99213	Office Outpatient, Established Patient, 15 Min
	99214	Office Outpatient, Established Patient, 25 Min
	70486	Ct Maxlfcl Area C-Matrl
	99203	Office Outpatient, New Patient, 30 Min
	95165	Supvj Prepj&Prv Ags F/Allg Immntx 1/Mlt Ags
Chronic sinusitis, w/o surgery	99213	Office Outpatient, Established Patient, 15 Min
	99214	Office Outpatient, Established Patient, 25 Min
	70486	Ct Maxlfcl Area C-Matrl
	95004	Percutaneous Tests with Allergenic Extracts
	31231	Nasal Endoscopy Diagnostic Uni/Bi Spx

Medical Condition (Episode Treatment Group)	CPT Code	Medical Service or Procedure (CPT)
Tonsillitis, adenoiditis or pharyngitis, w/o surgery	99213	Office Outpatient, Established Patient, 15 Min
	87880	Iaadiadoo Streptococcus Grp
	99214	Office Outpatient, Established Patient, 25 Min
	87081	Cul Prsmptv Pthgnc Organisms Scr
	99284	Emer Dept Hi Severity&Urgent Eval
Otitis media, w/o surgery	99213	Office Outpatient, Established Patient, 15 Min
	99214	Office Outpatient, Established Patient, 25 Min
	99283	Emergency Dept, Moderate Severity
	99212	Office Outpatient, Established Patient, 10 Min
	69436	Tmpst Anes
Otolaryngology diseases signs & symptoms	99213	Office Outpatient, Established Patient, 15 Min
	99214	Office Outpatient, Established Patient, 25 Min
	30901	Control Nasal Hemorrhage Anterior Simple
	31238	Nsl/Sinus Ndsc Surg W/Ctrl Nsl Hemrrg
	99283	Emergency Dept, Moderate Severity
Routine inoculation	99396	Periodic Preventive Med, Established Patient, Age 40-64
	90715	Tdap Vaccine 7 Yr + Im
	99395	Periodic Preventive Med, Established Patient, Age 18-39
	90471	Imadm Prq Id Subq/Im Njxs 1 Vacc
	90649	Human Papilloma Virus Vaccine Quadriv 3 Dose Im
Contraceptive management	99395	Periodic Preventive Med, Established Patient, Age 18-39
	58300	Insj Intrauterine Dev
	99213	Office Outpatient, Established Patient, 15 Min
	99214	Office Outpatient, Established Patient, 25 Min
	76830	Us Trvg
Gastroenterology diseases signs & symptoms	45378	Scope Of Colon For Diagnosis
	72193	Ct Pelvis C+ Matrl
	74160	Ct Abd C+ Matrl
	99213	Office Outpatient, Established Patient, 15 Min
	99214	Office Outpatient, Established Patient, 25 Min

Medical Condition (Episode Treatment Group)	CPT Code	Medical Service or Procedure (CPT)
Fungal skin infection	11721	Debridement Nail Any Method 6/>
	99213	Office Outpatient, Established Patient, 15 Min
	11750	Excision Nail Matrix, Permanent Removal
	99214	Office Outpatient, Established Patient, 25 Min
	99212	Office Outpatient, Established Patient, 10 Min
Mood disorder, depressed	90806	Ipi-Ob-M/S Office 45-50 Min
	90801	Psychiatric Diagnosis Interview Xm
	99214	Office Outpatient, Established Patient, 25 Min
	90862	Pharmacologic Mgmt Min Medical Psyctx
	90805	Ipi-Ob-M/S Office 20-30 Min Medical E/M
Other neuropsychological or behavioral disorders	90806	Ipi-Ob-M/S Office 45-50 Min
	90801	Psychiatric Diagnosis Interview Xm
	90847	Fam Psyctx W/Pt Present
	99214	Office Outpatient, Established Patient, 25 Min
	99213	Office Outpatient, Established Patient, 15 Min
Visual disturbances, w/o surgery	92014	Oph Medical Xm&Eval Compre, Established Patient, 1+ Visits
	92004	Oph Medical Xm&Eval Compre, New Patient, 1+ Visits
	92015	Deter Refractive State
	92012	Oph Medical Xm&Eval Intrm Established Patient
	99213	Office Outpatient, Established Patient, 15 Min
Cataract, w/o surgery	92014	Oph Medical Xm&Eval Compre Established Patient, 1+ Visits
	92015	Deter Refractive State
	99214	Office Outpatient, Established Patient, 25 Min
	92004	Oph Medical Xm&Eval Compre New Patient, 1+ Visits
	99213	Office Outpatient, Established Patient, 15 Min
Inflammatory eye disease, w/o surgery	92014	Oph Medical Xm&Eval Compre Established,Patient, 1+ Visits
	99213	Office Outpatient, Established Patient, 15 Min
	92015	Deter Refractive State
	99214	Office Outpatient, Established Patient, 25 Min
	92004	Oph Medical Xm&Eval Compre New Patient, 1+ Visits

Appendix 3.
Template for the Physician Provider Report for Consumers

Cost and Quality Information for Health Care Consumers Required by 2009 Wisconsin Act 146

2009 Wisconsin Act 146 seeks to make health care costs and charges clearer to consumers. It requires health care providers to disclose, upon request, certain charge and payment information for health care services, tests, and procedures.

Health insurance plans will often reimburse your provider for less than the full charge. Consumers may be responsible for some or all of the rest. How much you are responsible for depends on the details of your insurance, such as your deductable and your co-payment responsibilities.

> Your insurance plan is required to advise you on your possible actual costs. You must tell your insurer the exact health care services you are considering. Your health care provider can give you the technical descriptions ("CPT codes").

Act 146 also requires health care providers to offer information on charges, payments, and possibly on their comparative quality. The Wisconsin Department of Health Services determined that this requirement will be phased in, beginning in 2011 with physicians.

This physicians' report is based on the 25 most common medical conditions (without complications) treated by physicians in Wisconsin among those under age 65. For each medical condition, the five "Related Medical Services" are listed that account for most charges by physicians. (Again, assuming there are no complications.)

- You probably will not require all of these services or even any of them, depending on your physician's judgment and your decisions. Your physician also may recommend other services and supplies from some other health care provider.
- Patients should ask their physician what might be provided or recommended for their unique situation. Charges for other specific services ("CPT codes") are available from this practice on request, if it is a service provided by this practice.

Please note: There are important notes and definitions following the table below.

Practice: Dr. Bucky Badger

Common Medical Conditions Seen by This Practice **Related medical services provided by a physician (CPT code)**	**Current billed charge**	**Median billed charge (Jan-June 2010)**	**Medicare pays this practice**	**Typical charge in this area**	**Information on comparative quality is available at…**
Hypertension					
Office Outpatient, Established Patient, 25 Min (99214)	$ [practice inserts]	$ [practice inserts]	$ [practice inserts]	$ [practice inserts]	http://www.wchq.org/reporting/ [practice inserts only if public reports available on this condition or this service]
Office Outpatient, Established Patient, 25 Min Min (99213)	$...	$ …	$...	$...	
Periodic Preventive Med, Established Patient, Age 40-64 (99396)	$...	$ …	$ …	$ …	
Echo Tthrc R-T 2d -+M-Mode Compl Spec&Color Dop (93306)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Comprehensive Metabolic Panel (80053)	$...	$...	$...	$ ….	

Notes: Practices may substitute CPT descriptions that effectively communicate the service to their patients.

Important Notes:

The most common conditions and related medical services. If your condition is listed, you can see some common services provided by physicians to diagnosis and treat that condition, assuming there are no medical complications. The "CPT code" is used by insurers to determine their reimbursement to the physician. If you provide this code to your insurer, they will tell you what part of the charge they will pay and how much you may be responsible for at this time. The actual services for a given condition may be different from those listed.

Other related services and supplies. Many conditions require medical services and supplies from other physicians and other providers (prescription drugs, for example). Your physician can tell you what other services and supplies may be recommended for your treatment, but you should consult the others and your insurer if you want an estimate of the cost to you. Additional charges may include facility costs, diagnostic testing (such as radiology or lab work), anesthesia administration, and so on. Your financial responsibility will depend on your insurance plan and on payment plans negotiated between insurers and providers.

'Not applicable' or 'NA' – this physician either does not treat this condition or does not provide this service.

The current charge is the standard amount this physician charges for this service. Individual charges may be lower or higher, depending on the individual's medical condition. *This is not a required part of this report.*

The "median billed charge" is required by Act 146. It is this physician's charge in effect during the first half of 2010. If the charge changed during this period, it is the middle of the charges that were in effect.

The Medicare payment is how much Medicare will pay this physician for the listed service, each time.

The typical charge in this area is the average or median charge for this service by physicians in this part of Wisconsin, according to one of the standard sources. This practice used the _____[cite source]_____. The average payment to this practice by private third-party payers (such as insurance companies) will be less than this.

Reports on quality may be publically available for this physician's services. If so, here is how you can obtain them.

The Wisconsin Department of Health Services defined the methods for calculating this information and determined that this report will be phased in, beginning in March 2011 with physicians. More information is available at http://www.dhs.wisconsin.gov/2009wisact146.