2009 Wisconsin Act 146
Cost and Quality Information for Health Care Consumers
Frequently Asked Questions (FAQ)

Implementation Date

When did the physician reporting and disclosure requirements take effect?

March 1, 2011, was the implementation date for the physicians' requirements to (1) post signage, (2) disclose median charge and available quality information on request, and (3) provide a standard report covering services for 25 common medical conditions.

Hospitals have reporting and disclosure requirements that took effect January 1, 2011.

Which Physicians Are Covered?

Physicians practicing in a business arrangement with more than two other physicians are included. Physicians are exempt if they practice individually or in an association with not more than two other physicians. Also exempt are physicians employed by any organization and whose professional services are not billed or itemized separately in claims for payment.

What Are Covered Physicians Required to Do?

1. Disclose median billed charges: Physicians are required to respond to requests for their median billed charge with the median charge during the period January-June 2010 and, if they submit data to a health care information organization, any related publicly available quality information.

2. Provide a standard report on charges and reimbursement: If physicians treat or diagnose any of the 25 top medical conditions listed in the Implementation Plan and provide any of the CPT-coded services listed

under those conditions, then they are required to provide the report specified in the Implementation Plan on request (and related publicly available quality information, as above). If none of the 25 conditions apply to a physician or none of the services are provided, then no report is required. A physician in such a 'Not Applicable' position might want to have a handout available explaining why no report is available on request.

3. Post signage for consumers telling them that items 1 and 2 are available on request and that an estimate of their out-of-pocket cost is available from their insurer if certain requirements are met. If only item 1 applies, then signage can be limited to that and the out-of-pocket cost estimate opportunity. Hospitals also have signage requirements for their part of Act 146. The Department encourages hospitals to coordinate or combine signage with their hospital-based physicians.

Standard Report for 25 Common Medical Conditions

Where can I find the report template?

The report template is Appendix 3 in the Act 146 Implementation Plan, available at http://www.dhs.wisconsin.gov/2009wisact146. The report template is also available as a separate document at http://www.dhs.wisconsin.gov/2009wisact146/pdf/act146appendix3201012.pdf.

What flexibility do I have with the report template?

You should use the explanatory notes and caveats from the first and last page in the template. You may rephrase or edit them to fit your practice's situation. You may add other notes to explain or illuminate your practice's situation.

You should add or modify any notes necessary in order to explain and document the statistics you are reporting.

You may tailor a report to a particular physician or to a specialty practice group by including only the conditions treated by that physician or group. You may also include only the CPT-coded services, tests or procedures provided by that physician or group.

Median Billed Charge

How do I calculate the median billed charges in effect during the first 6 months of the previous year? What is the purpose of reporting this statistic?

The calculation is specified in the Act. List the billed charges in effect for a CPT-coded service, procedure, or test during the period January – June of last year, in order by dollar amount. The median is the middle one.

- If the charge did not change during the period and there was only one rate, then that's it.
- If the rate or charge changed once during the period, then there were two different charges. In that case, split the difference by adding them together and dividing by two.
- If there were three different charges during the period, then the median charge is the middle one.

The purpose is to give consumers some benchmark for recent charges in a practice. Physicians are encouraged to also provide the current billed charge for any item in the standard report or any service for which the median billed charge is requested.

Note that whenever a median billed charge is disclosed on request, any publicly available quality information about the service must also be provided.

If a consumer requests the current charge for a service, must we also provide the median billed charge for the first 6 months of last year?

A request for a current charge, if not made in the context of Act 146, does not require disclosure of the median charge statistic or related quality information.

Medicare Payments

How do we report the "Medicare payment to the provider" considering that the amount varies throughout the year due to a patient's deductible and co-insurance?

You may report the "Medicare Allowable Payment" for your practice for each CPT-coded service. The column should be clearly labeled as such and an asterisked note below should clarify that this is the "Amount paid to provider after any annual deductible is met by the patient. Medicare will also pay 20% less than this if the patient is responsible for a 20% co-payment."

Some practices may already have calculated their average or median actual Medicare payments over some recent time period. This is also acceptable. Again, a note in the report should document how the

calculation was done and describe how this relates to the consumer's potential out-of-pocket cost.

Average Allowable Payments from Private, Third-Party Payers

What are the alternative ways of meeting the requirement to include in the standard report an "average allowable payment" for each CPT-coded service provided?

Act 146 envisions reporting "*the average allowable payment from private, third-party payers*," while requiring the Department to prescribe how that is to be calculated.

This is a calculation that some practices are able to do in a straightforward manner. In that situation the Department certainly encourages them to do so and to report it. The time period over which claims would be averaged has not been specified, but some recent period comprising at least three months would be adequate. Notes to the report should educate consumers that "allowable payments" do not include the effects of deductibles and co-payments, vary from payer to payer, and do not necessarily enable consumers to estimate out-of-pocket costs.

The Department noted in the Act 146 Implementation Plan that reporting the *average actual reimbursement received from third-party payers* for a service is an acceptable alternative.

The Department has suggested that, as an interim measure, practices have the option of reporting (a) one of the above measures or (b) some measure of their own *typical reimbursement* for a service or (c) some measure of their own *typical discounted price* for a service or (d) some measure of the *typical charge for that service for that condition in the local area.* "Typical" may be calculated as either the average or the median reimbursement or charge.

One measure of the "*typical charge for that service for that condition in the local area"* is the 50th percentile charge in a market area, as for example provided by a practice management information product, such as the Ingenix Custom Fee Analyzer. That may be proprietary information, depending on the vendor, so practices should verify the use terms of such products.

The Department and the Wisconsin Medical Society (WMS) have developed a standard measure of typical charges by calculating the average billed charges in broad regions of the state, using the WHIO database.

Using the same claims for episodes of care that were used to identify the top 25 medical conditions (by numbers of episodes) and the top 5 CPT-coded services for each (by total dollars billed), WMS calculated the average billed charges for each condition-CPT combination for each of the 18 Wisconsin regions defined by 3-digit ZIP codes of the place of service. Contact WMS and ask for the *Average Billed Charge Report*.

Comparative Information on Quality of Health Care Services

When must a practice report comparative quality information?

Act 146 only requires comparative quality information if (a) the provider submits data to a health care information organization and (b) the health care information organization reports public information on comparative quality. If such information is available for a service, test or procedure for which a consumer asks for median charge information, then it must be provided directly or by reference to an Internet site. If such information is relevant for any of the 25 top conditions in the charge report, it must be provided with the report.

Must the actual quality information be included in the report?

No. The comparative quality information may be included directly in the report or it may be provided by an Internet site that is referenced in the report.

If a practice does not have quality-related information, should the report include a column for it and state “N/A” or not include the column at all?

You can drop the column. You might consider a footnote noting that such information is not available for any of your relevant conditions, to forestall any consumer questions.

Signage

Is the “right” to request these records considered a “new patient right” and do patient rights documents distributed or posted in hospitals need to be modified as a result of this regulation?

The right to receive information about charges and the quality of health care services is a right of consumers under 2009 Wisconsin Act 146. The right to receive this information must be prominently displayed in an area

most commonly frequented by health care consumers. This right is not a patient right as covered under DHS 124.05 (3) (a) or under federal regulations 42 CFR 482.13 and as such is not required to be included in any patient rights document prepared by the hospital.

Will DHS produce a model sign and guidance about placement?

The Department traditionally has not provided sample signs for providers to use to comply with statutes.

Are there any specific guidelines available to determine where signs must be posted in hospitals or clinics?

Wis. Stats. ss. 146.903 (3) (f) and (4) (e) requires facilities, such as a clinic, and hospitals to prominently display, in the area of the clinic or hospital that is most commonly frequented by health care consumers, a statement informing consumers that they have the right to receive information regarding charges and the quality of health care services. The area of the clinic or hospital that is most commonly frequented by health care consumers is a place such as a lobby or an entrance area to the clinic or hospital where individuals entering the clinic or hospital are able to view a posted sign. It is the responsibility of the clinic or hospital to determine the area most commonly frequented by their consumers.