Wisconsin Department of Health Services Issues New Guidance on the Preparation of Consumer Reports Required Under the New Health Care Transparency Law

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The legislation commonly known as Wisconsin's "Health Care Transparency" law (HCT law), 2009 Wisconsin Act 146, was enacted on March 9, 2009, and becomes effective January 1, 2011. It generally requires many health care providers, hospitals and insurers to provide greater transparency to consumers with regard to charges and reimbursement. The Wisconsin Department of Health Services (DHS) has issued new information regarding the implementation of one component of this law: the requirement that health care providers issue to consumers, upon request, a report regarding cost information for 25 common health conditions identified by DHS. Although further final guidance is still pending, DHS describes the new information it has released as a "near-final" implementation plan. (The implementation plan focuses specifically on the development of the required standard reports. Hospitals, insurance plans and health care providers must still be mindful of other requirements under the HCT law that exceed the scope of this alert and the new implementation plan.)

Under the HCT law, health care providers must prepare a single document that lists the following charge information, assuming no medical complications, for diagnosing and treating each of 25 conditions identified by the DHS relevant to that "type" of provider: (1) the median billed charge; (2) the Medicare payment to the provider (if the provider is certified under Medicare); and (3) the average allowable payment from private, third-party payers. This "standard report" must be provided upon request and at no cost to a health care consumer.

The requirement to develop such a standard report and make it available to consumers upon request extends to all "health care providers," as that term is statutorily defined. The term "health care providers" does not include hospitals, for example, which are governed by a separate set of transparency requirements under the HCT law. Under the law, the definition of "health care providers" does include providers such as physical therapists, chiropractors, psychologists, pharmacists and others. However, DHS has confirmed that implementation for 2011 will be focused on physicians only. Consistent with the statutory text, physicians practicing individually or in associations of three or fewer are exempt.

Previously, DHS proposed that physicians would be subdivided into specialties, and a list of 25 conditions would be identified for each specialty. To the contrary, however, DHS has now indicated in its new implementation plan that all physicians will be considered one single "type" of provider, and a single list of 25 conditions has been generated for all physicians to use in standard reports in 2011.

The conditions DHS has identified (each Severity-1) are as follows:

1. Routine exam
2. Hyperlipidemia
3. Hypertension
4. Tonsillitis, adenoiditis or pharyngitis without surgery
5. Mood Disorder, depressed
6. Visual disturbances, without surgery
7. Isolated signs, symptoms & non specific diagnoses or conditions
8. Otitis media, without surgery
9. Diabetes, without surgery
10. Hypo-functioning thyroid gland, without surgery
11. Acute bronchitis
12. Acute sinusitis, without surgery
13. Chronic sinusitis, without surgery
14. Routine inoculation
15. Cataract, without surgery
16. Otolaryngology diseases
17. Other minor orthopedic disorders – back
18. Contraceptive management
19. Other neuropsychological or behavioral disorders
20. Joint degeneration, localized - back, without surgery
21. Gastroenterology diseases signs & symptoms
22. Fungal skin infection
23. Obesity, without surgery
24. Inflammatory eye disease, without surgery
25. Acne

The HCT requires providers to report on cost information for the identified conditions. DHS has acknowledged in its implementation plan that billing by physicians is usually based on service units of visits and procedures, defined using the common procedural terminology (CPT) coding system. Therefore, DHS will require physicians to report charge information for 5 to 10 CPT codes that DHS will identify for each of the 25 conditions. The CPT codes will be identified as those contributing the most to the total billed charges for each condition. Physicians will only be required to report on services that they themselves provide. DHS has not yet issued the list of selected CPT-coded services and procedures that physicians will be required to report. Such a list is reportedly still in preparation. DHS has clarified, however, that if a physician does not diagnose or treat a particular condition on the list,

or does not personally provide one or more of the services on the list of applicable CPT codes, the physician may indicate on the report provided to a consumer that such conditions or services are "not applicable to this practice."

Once the relevant CPT codes are identified, physicians will need to report the relevant "median billed charge" and the "Medicare payment" for the identified services and procedures. The median charge billed is defined under Wisconsin Statutes Section 146.903(1)(e) as "the amount the health care provider charged, before any discount or contractual rate applicable to certain patients or payers was applied" during the relevant reporting period, "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 two middle charges in the sequence and calculating the average of the two." For reports to consumers in 2011, the relevant reporting period is January 1, 2010 through June 30, 2010. DHS mentions in its plan that it "strongly encourages" physicians to disclose current charges as well. The Medicare payment to be reported is defined by DHS as the current Medicare payment for applicable CPT-coded services.

DHS has recognized that various difficulties arise out of the HCT law's mandate that health care providers must also report "the average allowable payment from private, third-party payers." To date, DHS has explained only that until further analysis of this issue can be undertaken, it plans to require physicians to report "the typical reimbursement or discounted price 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."

DHS has reaffirmed that enforcement during 2011 will be on a complaint-driven basis, and the DHS will be preparing response procedures focused on inquiry and education. DHS is still in the process of finalizing its implementation plan, which will include further information such as the CPT codes to be reported, and a template for physician provider reports.

For further information, please contact Angela M. Rust, or your regular Hinshaw attorney.

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