

ASSEMBLY BILL 614 (LRB -3837)

An Act to amend 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t) and 185.983 (1) (intro.); and to create 146.903, 609.71 and 632.798 of the statutes; relating to: disclosure of information by health care providers and insurers and providing a penalty. (FE)

2009

- 12-11. A. Introduced by Representatives **Richards, Staskunas, Turner, Pope-Roberts, Hebl, Roys, A. Williams, Soletski, Hraychuck, Krusick, Hilgenberg, Milroy and Dexter**; cosponsored by Senators **Sullivan, Cowles, Kreitlow, Miller, Lehman and Vinehout**.
- 12-11. A. Read first time and referred to committee on Health and Healthcare Reform 537
- 12-14. A. Fiscal estimate received.
- 12-17. A. Public hearing held.
- 12-29. A. Fiscal estimate received.

2010

- 02-02. A. Assembly substitute amendment 1 offered by Representative Richards (**LRB s0264**) 627
- 02-02. A. Assembly amendment 1 to Assembly substitute amendment 1 offered by Representative Richards (**LRB a1446**) 627
- 02-08. A. Assembly amendment 2 to Assembly substitute amendment 1 offered by Representative Richards (**LRB a1481**) 636
- 02-10. A. Executive action taken.
- 02-16. A. Report Assembly Amendment 2 to Assembly Substitute Amendment 1 adoption recommended by committee on Health and Healthcare Reform, Ayes 13, Noes 0 654
- 02-16. A. Report Assembly Substitute Amendment 1 adoption recommended by committee on Health and Healthcare Reform, Ayes 13, Noes 0 654
- 02-16. A. Report passage as amended recommended by committee on Health and Healthcare Reform, Ayes 13, Noes 0 654
- 02-16. A. Referred to committee on Rules 654
- 02-23. A. Placed on calendar 2-25-2010 by committee on Rules 0
- 02-25. A. Read a second time 700
- 02-25. A. Assembly amendment 2 to Assembly substitute amendment 1 **adopted** 700
- 02-25. A. Assembly substitute amendment 1 **adopted** 700
- 02-25. A. Ordered to a third reading 700
- 02-25. A. Rules suspended 700
- 02-25. A. Read a third time and **passed** 700
- 02-25. A. Ordered immediately messaged 700
- 02-26. S. Received from Assembly 600
- 03-01. S. Read first time and referred to committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue 602
- 03-02. S. Senator Wirch added as a cosponsor.
- 03-02. S. Rules suspended to withdraw from committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue and take up.
- 03-02. S. Read a second time.
- 03-02. S. Ordered to a third reading.
- 03-02. S. Senator Hansen added as a cosponsor.
- 03-02. S. Rules suspended.
- 03-02. S. Read a third time and **concurred in**, Ayes 31, Noes 0.
- 03-02. S. Ordered immediately messaged.
- 03-02. A. Received from Senate concurred in 715

50

2009
ENROLLED BILL

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ADOPTED DOCUMENTS:

Orig Engr A SubAmdt 1 09S0264/2

Amendments to above (if none, write "NONE"): AA2 - a 1481/2

Corrections - show date (if none, write "NONE"): None

Topic Rel

3-3-10

Date



Enrolling Drafter



State of Wisconsin
2009 - 2010 LEGISLATURE

LRBs0264/2
RLR&PJK:cjs:rs

**ASSEMBLY SUBSTITUTE AMENDMENT 1,
TO 2009 ASSEMBLY BILL 614**

February 2, 2010 – Offered by Representative RICHARDS.

1 **AN ACT** *to amend* 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 153.21 (title),
2 185.981 (4t) and 185.983 (1) (intro.); and *to create* 146.903, 153.21 (3), 609.71
3 and 632.798 of the statutes; **relating to:** disclosure of information by health
4 care providers, hospitals, and insurers and providing a penalty.

Analysis by the Legislative Reference Bureau

This substitute amendment requires a health care provider to disclose to a consumer the provider's median billed charge for a health care service, diagnostic test, or procedure, upon request. For purposes of the substitute amendment, a health care provider includes a physician, nurse, dentist, chiropractor, physical therapist, optometrist, pharmacist, psychologist, and clinic, among others, but does not include a hospital. However, the substitute amendment exempts health care providers that practice individually or in a group of less than three providers from the requirement to provide charge information for a particular service, test, or procedure.

The substitute amendment also requires both health care providers and hospitals to create a document that lists the following charge information for a specified set of conditions or procedures: 1) the provider's median billed charge; 2) the reimbursement amount under Medicare, except in the case of a provider who does not participate in Medicare; and 3) the average allowable payment from private, third-party payers. For health care providers, DHS must identify, by type of health

care provider, the 25 presenting conditions for which each type of provider most frequently provides health care services, and these are the conditions for which a health care provider must list charge information in the required document. Hospitals are required to list the charge information for the 75 conditions for which hospitals in this state most frequently provide inpatient care, as well as for the 75 outpatient surgical procedures that hospitals in this state most frequently perform. Health care providers and hospitals must, upon request, provide consumers a copy of their document listing charge information for the specified set of conditions or procedures. The substitute amendment exempts health care providers that practice individually or in a group of less than three providers from the requirement to create a document listing charges.

Under the substitute amendment, a self-insured health plan of the state or a county, city, village, town, or school district, or an insurer that provides coverage under a health insurance policy, including defined network plans and sickness care plans operated by cooperative associations, must provide to an insured under the health insurance policy or an enrollee under the self-insured health plan a good faith estimate of the insured's or enrollee's total out-of-pocket cost for a specified health care service in the geographic region in which the service will be provided. The estimate must be provided only if the insured or enrollee requests it, and it must be provided at no charge to the insured or enrollee. Before providing the estimate, the insurer or self-insured health plan may require the insured or enrollee to provide, in writing, the name of the provider providing the service, the facility at which the service will be provided, the date the service will be provided, the provider's estimate of the charges, and the Current Procedural Terminology code or Current Dental Terminology code for the service. The substitute amendment specifies that the estimate is not legally binding and is to be provided as of the date of the request and assuming no medical complications or changes to the insured's or enrollee's treatment plan. In addition, an insurer or self-insured plan is not required to provide an estimate if the provider providing the health care service practices alone or in association with only one or two other health care providers or is an association of three or fewer health care providers.

Under the substitute amendment a health care provider or hospital must prominently display notice regarding the availability of charge information that providers or hospitals are required to disclose and of the requirement that a insurer or self-insured health plan provide an an estimate of an insured's or enrollees out-of-pocket cost.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

1 **SECTION 1.** 40.51 (8) of the statutes, as affected by 2009 Wisconsin Act 28, is
2 amended to read:

1 40.51 (8) Every health care coverage plan offered by the state under sub. (6)
2 shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8)
3 and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855,
4 632.87 (3) to (6), 632.885, 632.895 (5m) and (8) to (17), and 632.896.

5 **SECTION 2.** 40.51 (8m) of the statutes, as affected by 2009 Wisconsin Act 28, is
6 amended to read:

7 40.51 (8m) Every health care coverage plan offered by the group insurance
8 board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,
9 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, and 632.895
10 (11) to (17).

11 **SECTION 3.** 66.0137 (4) of the statutes, as affected by 2009 Wisconsin Act 28,
12 is amended to read:

13 66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
14 a village provides health care benefits under its home rule power, or if a town
15 provides health care benefits, to its officers and employees on a self-insured basis,
16 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),
17 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87
18 (4), (5), and (6), 632.885, 632.895 (9) to (17), 632.896, and 767.513 (4).

19 **SECTION 4.** 120.13 (2) (g) of the statutes, as affected by 2009 Wisconsin Act 28,
20 is amended to read:

21 120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.
22 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
23 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.895 (9) to
24 (17), 632.896, and 767.513 (4).

25 **SECTION 5.** 146.903 of the statutes is created to read:

1 **146.903 Disclosures required of health care providers and hospitals.**

2 **(1) DEFINITIONS.** In this section:

3 (a) “Ambulatory surgical center” has the meaning given in 42 CFR 416.2.

4 (b) “Clinic” means a place, other than a residence or a hospital, that is used
5 primarily for the provision of nursing, medical, podiatric, dental, chiropractic, or
6 optometric care and treatment.

INSERT AA2-1

7 (c) “Health care provider” has the meaning given in s. 146.81 (1) (a) to (L) and
8 includes a clinic and an ambulatory surgical center but does not include a nursing
9 home, as defined in s. 50.01 (3).

10 (d) “Hospital” has the meaning given in s. 50.33 (2).

11 (e) “Median billed charge” means one of the following:

12 1. For a health care provider, the amount the health care provider charged,
13 before any discount or contractual rate applicable to certain patients or payers was
14 applied, during the first 2 calendar quarters of the most recently completed calendar
15 year, as calculated by arranging the charges in that reporting period from highest
16 to lowest and selecting the middle charge in the sequence or, for an even number of
17 charges, selecting the 2 middle charges in the sequence and calculating the average
18 of the 2.

19 2. For a hospital, the amount the hospital charged, before any discount or
20 contractual rate applicable to certain patients or payers was applied, during the 4
21 calendar quarters for which the hospital most recently reported data under ch. 153,
22 as calculated by arranging the charges in the reporting period from highest to lowest
23 and selecting the middle charge in the sequence or, for an even number of charges,
24 selecting the 2 middle charges in the sequence and calculating the average of the 2.

1 (f) “Medicare” means coverage under part A or part B of Title XVIII of the
2 federal Social Security Act, 42 USC 1395 to 1395dd. INS. AA2-2

3 (2) DEPARTMENT DUTIES. (a) The department shall do all of the following:

4 1. Categorize health care providers by type.

5 2. For each type of health care provider, annually identify the 25 presenting
6 conditions for which that type of health care provider most frequently provides
7 health care services.

8 3. Prescribe the methods by which health care providers shall calculate and
9 present median billed charges and Medicare and private 3rd-party payer payments
10 under sub. (3) (b).

11 (b) In performing the duties under par. (a), the department shall consult with
12 organizations in this state that do all of the following:

13 1. Develop performance measures for assessing the quality of health care
14 services.

15 2. Guide the collection, validation, and analysis of data related to measures
16 described under subd. 1.

17 3. Report results of assessments of the quality of health care services.

18 4. Share best practices of organizations that provide health care services.

19 (3) HEALTH CARE PROVIDER DISCLOSURE OF CHARGES. (a) Except as provided in
20 par. (g), a health care provider or the health care provider’s designee shall, upon
21 request by and at no cost to a health care consumer, disclose to the consumer within
22 a reasonable period of time after the request, the median billed charge, assuming no
23 medical complications, for a health care service, diagnostic test, or procedure that is
24 specified by the consumer and that is provided by the health care provider.

INS. AA2-3

1 (b) Except as provided in par. (g), a health care provider shall prepare a single
2 document that lists the following charge information, assuming no medical
3 complications, for diagnosing and treating each of the 25 presenting conditions
4 identified for the health care provider's provider type under sub. (2):

5 1. The median billed charge.

6 2. If the health care provider is certified as a provider of Medicare, the Medicare
7 payment to the provider.

8 3. The average allowable payment from private, 3rd-party payers.

INS. AA2-4

9 (c) Except as provided in par. (g), a health care provider or the health care
10 provider's designee shall, upon request by and at no cost to a health care consumer,
11 provide the consumer a copy of the document prepared under par. (b).

INS. AA2-5

12 (d) Except as provided in par. (g), a health care provider shall annually update
13 the document under par. (b).

14 (e) Information provided upon request under par. (a) or included on the
15 document under par. (b) does not constitute a legally binding estimate of the charge
16 for a specific patient or the amount that a 3rd-party payer will pay on behalf of the
17 patient.

18 (f) Except as provided in par. (g), a health care provider shall prominently
19 display, in the area of the health care provider's practice or facility that is most
20 commonly frequented by health care consumers, a statement informing the
21 consumers that they have the right to receive charge information as provided in pars.

INSERT AA2-6

22 (a) and (b) from the health care provider and, if the requirements, if any, under s.
23 632.798 (2) (d) are met, a good faith estimate, from their insurers or self-insured
24 health plans, of the insured's total out-of-pocket cost according to the insured's

1 benefit terms for the specified health care service in the geographic region in which
2 the health care service will be provided.

3 (g) The requirements under pars. (a) to (f) do not apply to any of the following:

4 1. A health care provider that practices individually or in association with not
5 more than 2 other individual health care providers.

6 2. A health care provider that is an association of 3 or fewer individual health
7 care providers.

8 (4) HOSPITAL DISCLOSURE OF CHARGES. (a) Each hospital shall prepare a single
9 document that lists the following charge information, assuming no medical
10 complications, for inpatient care for each of the 75 diagnosis related groups identified
11 under s. 153.21 (3) and the following charge information for each of the 75 outpatient
12 surgical procedures identified under s. 153.21 (3):

- 13 1. The median billed charge.
- 14 2. The average allowable payment under Medicare.
- 15 3. The average allowable payment from private, 3rd-party payers.

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AA2-7

16 (b) A hospital shall, upon request by and at no cost to a health care consumer,
17 provide the consumer a copy of the document prepared under par. (a).

INS. AA2-8

18 (c) A hospital shall update the document under par. (a) every calendar quarter.

19 (d) Information included on the document under par. (a) does not constitute a
20 legally binding estimate of the charge for a specific patient or the amount that a
21 3rd-party payer will pay on behalf of the patient.

22 (e) Each hospital shall prominently display, in the area of the hospital that is
23 most commonly frequented by health care consumers, a statement informing the
24 consumers that they have the right to receive a copy of the document under par. (a)
25 from the hospital and, if the requirements, if any, under s. 632.798 (2) (d) are met,

INS. AA2-9

1 a good faith estimate, from their insurers or self-insured health plans, of the
2 insured's total out-of-pocket cost according to the insured's benefit terms for the
3 specified health care service in the geographic region in which the health care service
4 will be provided.

5 (5) PENALTY. (a) Whoever violates sub. (3) or (4) may be required to forfeit not
6 more than \$250 for each violation.

7 (b) The department may directly assess forfeitures provided for under par. (a).
8 If the department determines that a forfeiture should be assessed for a particular
9 violation, the department shall send a notice of assessment to the alleged violator.
10 The notice shall specify the amount of the forfeiture assessed, the violation, and the
11 statute or rule alleged to have been violated, and shall inform the alleged violator of
12 the right to a hearing under par. (c).

13 (c) An alleged violator may contest an assessment of a forfeiture by sending,
14 within 10 days after receipt of notice under par. (b), a written request for a hearing
15 under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1).
16 The administrator of the division may designate a hearing examiner to preside over
17 the case and recommend a decision to the administrator under s. 227.46. The
18 decision of the administrator of the division shall be the final administrative
19 decision. The division shall commence the hearing within 30 days after receipt of the
20 request for a hearing and shall issue a final decision within 15 days after the close
21 of the hearing. Proceedings before the division are governed by ch. 227. In any
22 petition for judicial review of a decision by the division, the party, other than the
23 petitioner, who was in the proceeding before the division shall be the named
24 respondent.

1 (d) All forfeitures shall be paid to the department within 10 days after receipt
2 of notice of assessment or, if the forfeiture is contested under par. (c), within 10 days
3 after receipt of the final decision after exhaustion of administrative review, unless
4 the final decision is appealed and the order is stayed by court order. The department
5 shall remit all forfeitures paid to the secretary of administration for deposit in the
6 school fund.

7 (e) The attorney general may bring an action in the name of the state to collect
8 any forfeiture imposed under this subsection if the forfeiture has not been paid
9 following the exhaustion of all administrative and judicial reviews. The only issue
10 to be contested in any such action is whether the forfeiture has been paid.

11 **SECTION 6.** 153.21 (title) of the statutes is amended to read:

12 **153.21 (title) Consumer guide; list for hospital charge disclosures.**

13 **SECTION 7.** 153.21 (3) of the statutes is created to read:

14 153.21 (3) The entity under contract under s. 153.05 (2m) (a) shall, using data
15 collected under s. 153.05 (1) (b), annually identify the 75 diagnosis related groups for
16 which hospitals in this state most frequently provide inpatient care and the 75
17 outpatient surgical procedures most frequently performed by hospitals in this state,
18 and shall distribute a list of the identified diagnosis related groups and surgical
19 procedures to all hospitals in the state and to the department.

20 **SECTION 8.** 185.981 (4t) of the statutes, as affected by 2009 Wisconsin Act 28,
21 is amended to read:

22 185.981 (4t) A sickness care plan operated by a cooperative association is
23 subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.798,
24 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.895 (10) to
25 (17), and 632.897 (10) and chs. 149 and 155.

1 **SECTION 9.** 185.983 (1) (intro.) of the statutes, as affected by 2009 Wisconsin
2 Act 28, is amended to read:

3 185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be
4 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,
5 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93,
6 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85,
7 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.895 (5) and (9) to (17),
8 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring
9 association shall:

10 **SECTION 10.** 609.71 of the statutes is created to read:

11 **609.71 Disclosure of payments.** Limited service health organizations,
12 preferred provider plans, and defined network plans are subject to s. 632.798.

13 **SECTION 11.** 632.798 of the statutes is created to read:

14 **632.798 Out-of-pocket costs. (1) DEFINITIONS.** In this section:

15 (a) “Disability insurance policy” has the meaning given in s. 632.895 (1) (a).

16 (b) “Health care provider” has the meaning given in s. 146.903 (1) (c) and
17 includes a hospital, as defined in s. 50.33 (2).

18 (c) “Insured” includes an enrollee under a self-insured health plan and a
19 representative or designee of an insured or enrollee.

20 (d) “Self-insured health plan” means a self-insured health plan of the state or
21 a county, city, village, town, or school district.

22 **(2) PROVIDE ESTIMATE.** (a) A self-insured health plan or an insurer that
23 provides coverage under a disability insurance policy shall, at the request of an
24 insured, provide to the insured a good faith estimate, as of the date of the request and
25 assuming no medical complications or modifications in the insured’s treatment plan,

1 of the insured's total out-of-pocket cost according to the insured's benefit terms for
2 a specified health care service in the geographic region in which the health care
3 service will be provided.

4 (b) An estimate provided by an insurer or self-insured health plan under this
5 section is not a legally binding estimate of the out-of-pocket cost.

6 (c) An insurer or self-insured health plan may not charge an insured for
7 providing the information under this section.

8 (d) Before providing the information requested under par. (a), the insurer or
9 self-insured health plan may require the insured to provide in writing any of the
10 following information:

- 11 1. The name of the health care provider providing the service.
- 12 2. The facility at which the service will be provided.
- 13 3. The date the service will be provided.
- 14 4. The health care provider's estimate of the charge for the service.
- 15 5. The codes for the service under the Current Procedural Terminology of the
16 American Medical Association or under the Current Dental Terminology of the
17 American Dental Association.

18 (e) The requirement to provide the information requested under par. (a) does
19 not apply if the health care provider providing the health care service is any of the
20 following:

- 21 1. A health care provider that practices individually or in association with not
22 more than 2 other individual health care providers.
- 23 2. A health care provider that is an association of 3 or fewer individual health
24 care providers.

25 **SECTION 12. Initial applicability.**



**ASSEMBLY AMENDMENT 2,
TO ASSEMBLY SUBSTITUTE AMENDMENT 1,
TO 2009 ASSEMBLY BILL 614**

February 8, 2010 - Offered by Representative RICHARDS.

1 At the locations indicated, amend the substitute amendment as follows:

2 **1.** Page 4, line 6: after that line insert:

AA2-1

3 “(br) “Health care information organization” means an organization that
4 gathers data from health care providers or hospitals regarding utilization and
5 quality of health care services and that produces reports on the comparative quality
6 of health care services provided by health care providers or hospitals.”

7 **2.** Page 5, line 2: after that line insert:

AA2-2

8 “(g) “Public information” means information that any person may access from
9 a health care information organization, regardless of whether the organization
10 charges a fee for the information.”

11 **3.** Page 5, line 24: after that line insert:

AA2-3

1 (am) A health care provider that submits data to a health care information
 2 organization shall, when it makes a disclosure to a consumer under par. (a), make
 3 available to the consumer any public information reported by the health care
 4 information organization regarding the quality of health care services provided by
 5 the health care provider compared to the quality of health care services provided by
 6 other health care providers that is relevant to the health care service, diagnostic test,
 7 or procedure specified by the consumer under par. (a). A health care provider may
 8 make the information available to the consumer by providing the consumer a paper
 9 copy of the information or by providing the consumer the address of an Internet site
 10 where the information is posted. If the health care provider submits data to more
 11 than one health care information organization and more than one of the health care
 12 information organizations reports to the health care provider public information on
 13 comparative quality that is relevant to the health care service, diagnostic test, or
 14 procedure, the health care provider is required under this paragraph to make
 15 available to the consumer public information reported by only one of the health care
 16 information organizations.”.

4. Page 6, line 8: after that line insert:

AA2-4

18 (bm) A health care provider that submits data to a health care information
 19 organization shall make available with the document required under par. (b) any
 20 public information reported by the health care information organization regarding
 21 the quality of health care services provided by the health care provider compared to
 22 the quality of health care services provided by other health care providers that is
 23 relevant to a presenting condition for which the provider is required to list charge
 24 information under par. (b). A health care provider may make the information

AA2-4

1 available by attaching it to the document or by including the address of an Internet
2 site where the information is posted with the document. If the health care provider
3 submits data to more than one health care information organization and more than
4 one of the health care information organizations reports to the health care provider
5 public information on comparative quality that is relevant to a presenting condition,
6 the health care provider is required under this paragraph to make available public
7 information reported by only one of the health care information organizations for the
8 presenting condition.

AA2-5

9 **5.** Page 6, line 11: after “par. (b)” insert “and the information described under
10 par. (bm)”.

AA2-6

11 **6.** Page 6, line 22: after “(b)” insert “and, if applicable, the information
12 described under par. (bm)”.

AA2-7

13 **7.** Page 7, line 15: after that line insert:

14 (am) A hospital that submits data to a health care information organization
15 shall make available with the document required under par. (a) any public
16 information reported by the health care information organization regarding the
17 quality of health care services provided by the hospital compared to the quality of
18 health care services provided by other hospitals that is relevant to a diagnosis related
19 group or outpatient surgical procedure for which the hospital is required to list
20 charge information under par. (a). A hospital may make the information available
21 by attaching it to the document or by including the address of an Internet site where
22 the information is posted with the document. If a hospital submits data to more than
23 one health care information organization and more than one of the health care
24 information organizations reports to the hospital public information on comparative

AA2-7

1 quality that is relevant to a diagnosis related group or outpatient surgical procedure,
2 the hospital is required under this paragraph to make available public information
3 reported by only one of the health care information organizations for the diagnosis
4 related group or outpatient surgical procedure.”

AA2-8

5 **8.** Page 7, line 17: after “par. (a)” insert “and the information described under
6 par. (am)”.

AA2-9

7 **9.** Page 7, line 24: after “par. (a)” insert “and, if applicable, the information
8 described under par. (am)”.

9 (END)