CHAPTER 153

HEALTH CARE INFORMATION

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153.01 Definitions. In this chapter:

(1) "Ambulatory surgery center" has the meaning given under 42 CFR 416.2.

(2) "Board" means the board on health care information.

(3) "Charge element" means any service, supply or combination of services or supplies that is specified in the categories for payment under the charge revenue code for the uniform billing form HCFA–1450.

(4m) "Commissioner" means the commissioner of insurance of this state.

(5) "Hospital" has the meaning given under s. 50.33 (2).

(5m) "Insurer" has the meaning given under s. 600.03 (27).

(6) "Office" means the office of health care information.

(7) "Patient" means a person who receives health care services from a health care provider.

(8) "Payer" means a 3rd party payer, including an insurer, federal, state or local government or another who is responsible for payment of a hospital charge.

(9) "Uniform patient billing form" means, for a hospital, the uniform billing form HCFA–1450 developed by the national uniform billing committee, or the equivalent electronic billing format, or, for an ambulatory surgery center or noninstitutional or outpatient health care provider, the health insurance claim form HCFA–1500 or the equivalent electronic billing format.

History: 1987 a. 399; 1993 a. 16, 185, 491.

153.05 Collection and dissemination of health care and related information. (1) In order to provide to hospitals, health care providers, insurers, consumers, governmental agencies and others information concerning hospital service utilization, charges, revenues, expenditures, mortality and morbidity rates and uncompensated health care services, and in order to provide information to assist in peer review for the purpose of quality assurance, the office shall collect, analyze and disseminate, in language that is understandable to lay persons, health care information obtained from the following data sources:

(a) Uniform patient billing forms.

(b) Federal medicare cost reports.

(c) Hospital reports that include all of the following:

1. Identification of charges in each hospital's most recent entire fiscal year for up to 100 charge elements, as selected by the office, and identification of the increase or decrease in charges for each of these charge elements from amounts charged during the hospital's entire fiscal year that is nearest in time to the hospital's most recent entire fiscal year.

2. The dollar amount of total gross and net revenue increases or decreases from each hospital's most recent entire fiscal year.

3. The dollar amount of gross and net revenue increases or decreases from each hospital's most recent entire fiscal year that is attributable to the sum of increases or decreases in all charge elements.

(d) Hospital–specific uncompensated health care services reports, plans and projections.

(e) Final audited financial statements of hospitals that include, for a hospital's most recent entire fiscal year, as dollar amounts, the amounts of revenue and expenditures for the hospital, in categories specified in rules promulgated by the commissioner.

(2) The office shall provide copies of reports published under ss. 153.10 to 153.35 at no charge to hospitals assessed under s. 153.60 (1) and, if assessed, at no charge to ambulatory surgery centers assessed under s. 153.60 (2). The office shall provide copies of the reports to any person, upon the person's request, and the board shall advise the office as to whether the copies shall be provided at no charge or at a charge not to exceed the cost of printing, copying and mailing the report to the person.

(3) Upon request of the office, state agencies shall provide health care information to the office for use in preparing reports under ss. 153.10 to 153.35.

(4) (a) The office, under rules promulgated by the commissioner, shall require hospitals to use, and private–pay patients and payers who are insurers to accept, uniform patient billing forms, shall require hospitals to submit to the office the information provided on the billing forms, including, for an injury, the external cause of the event, and may require payers who are insurers to use a standard set of definitions for base data reporting under a uniform patient billing form.

(b) The office, under rules promulgated by the commissioner, may require ambulatory surgery centers to use uniform patient billing forms and other information, and, if so requiring, shall require ambulatory surgery centers to submit to the office the information provided on the billing forms, including, for an injury, the external cause of the event, using a standard set of definitions for base data reporting.

(5) The office:

(a) Shall require hospitals to submit information regarding medical malpractice, staffing levels and patient case–mix, and expenditures related to labor relations consultants, as specified by the office.

(b) May require hospitals to submit to the office information from sources identified under sub. (1) (a) to (e) that the office deems necessary for the preparation of reports, plans and recommendations under ss. 153.10 to 153.35 and any other reports required of the office in the form specified by the office.

(bm) Shall require a hospital to submit to the office information from sources identified under sub. (1) (e) by the date that is 4 months following the close of the hospital's fiscal year unless the office grants an extension of time to file the information.

(6) If the requirements of s. 153.07 (2) are first met, the office may contract with a public or private entity that is not a major purchaser, payer or provider of health care services in this state for the provision of data processing services for the collection, analysis and dissemination of health care information under sub. (1) or the

department of health and family services shall provide the services under s. 153.07 (2).

(6m) If the requirements of s. 153.07 (2) are first met, the office may contract with the group insurance board for the provision of data collection and analysis services related to health maintenance organizations and insurance companies that provide health insurance for state employes or the commissioner shall provide the services under s. 153.07 (2). The office shall establish contract fees for the provision of the services. All moneys collected under this subsection shall be credited to the appropriation under s. 20.145 (8) (kx).

(7) The office may require each insurer authorized to write disability insurance to submit to the office information obtained on uniform patient billing forms regarding reported claims for health care services which insureds who are residents of this state obtain in another state.

(8) Beginning April 1, 1992, the office shall collect, analyze and disseminate, in language that is understandable to lay persons, health care information under the provisions of this chapter, as determined by rules promulgated by the commissioner, from health care providers, as defined by rules promulgated by the commissioner, other than hospitals and ambulatory surgery centers. Data from physicians shall be obtained through sampling techniques in lieu of collection of data on all patient encounters and data collection procedures shall minimize unnecessary duplication and administrative burdens.

(9) The office shall provide orientation and training to physicians, hospital personnel and other health care providers to explain the process of data collection and analysis and the procedures for data verification, interpretation and release.

(11) In order to elicit public comment concerning the reports required under ss. 153.10 to 153.35, the office shall, following the release of the reports and by a date that is determined by the board provide notice of and hold public hearings.

(12) The office shall, to the extent possible and upon request, assist members of the public in interpreting data in health care information disseminated by the office.

History: 1987 a. 399; 1989 a. 18, 56; 1991 a. 250, 269; 1993 a. 16, 104, 185, 491; 1995 a. 27 ss. 4393, 9126 (19).

153.07 Board powers and duties. **(1)** The board shall advise the director of the office with regard to the collection, analysis and dissemination of health care information required by this chapter.

(2) The board, upon advice of the office, shall first determine whether to contract for services pursuant to s. 153.05 (6) or (6m). If the board determines to contract for such services, it shall approve specifications for a contract including the length of the contract and the standards for determining potential contractor conflicts with the purposes of the office as specified under s. 153.05 (1). In the alternative, the board may direct the office to have the department of health and family services provide the services under s. 153.05 (6) or (6m). The board may subsequently determine to contract for these services in subsequent years. If the board decides to bid the contract for services under s. 153.05 (6) or (6m), the department of health and family services may offer a bid as would any other potential contractor. The board shall evaluate a contractor's performance 6 months prior to the close of each existing contract.

(3) The board shall approve all rules which are proposed by the commissioner for promulgation to implement this chapter.

History: 1987 a. 399; 1991 a. 269; 1993 a. 16; 1995 a. 27 s. 9126 (19).

153.08 Hospital rate increases or charges in excess of rates. **(1)** In this section:

(a) "Consumer price index" has the meaning given in s. 16.004 (8) (e) 1.

(b) Notwithstanding s. 153.01 (5), "hospital" has the meaning given in s. 50.33 (2), except that "hospital" does not include a center for the developmentally disabled as defined in s. 51.01 (3).

(c) "Rates" means individual charges of a hospital for the services that it provides.

(2) No hospital may increase its rates or charge any payer an amount exceeding its rates that are in effect on May 12, 1992, unless the hospital first does all of the following:

(a) Causes to be published a class 1 notice under ch. 985 in the official newspaper designated under s. 985.04 or 985.05 or in a newspaper likely to give notice in the area where the hospital is located, no sooner than 45 days and no later than 30 days before the proposed rate change is to take effect. The notice shall describe the proposed rate change and the time and place for the public hearing required under sub. (2).

(b) No sooner than 15 days after a notice is published under par. (a) and no later than 15 days before the date of the proposed rate change, conducts a public hearing on the proposed rate change. The hearing shall be on the expected impact of the proposed rate change on health care costs, the expected improvement, if any, in the local health care delivery system, and any other issue related to the proposed rate change. Management staff, if any, of the hospital proposing the rate change and, if possible, at least 3 members of the governing board of any not–for–profit hospital proposing the rate change shall attend the public hearing to review public testimony. The hospital shall record accurate minutes of the meeting and shall provide copies of the minutes and any written testimony presented at the hearing to the office of health care information in the office of the commissioner of insurance within 10 days after the date of the public hearing.

(3) This section does not apply to a hospital that proposes to increase its rates during the course of the hospital's fiscal year by any amount or amounts that, in the aggregate, do not exceed the percentage amount that is the percentage difference between the consumer price index reported for the 12–month period ending on December 31 of the preceding year and the consumer price index reported for the 12–month period ending on December 31 of the year prior to the preceding year.

(4) A hospital shall publish a class 1 notice under ch. 985 at least 10 days prior to the institution by the hospital of a rate increase.

History: 1993 a. 16 ss. 2644 to 2646; 1993 a. 104 ss. 3, 5m, 7, 8, 9; 1993 a. 491.

153.10 Health care data reports. **(1)** Beginning in 1990 and quarterly thereafter, the office shall prepare and submit to the governor and the chief clerk of each house of the legislature for distribution to the legislature under s. 13.172 (2), in a manner that permits comparisons among hospitals, a report setting forth all of the following for every hospital for the preceding quarter:

(a) The charges for up to 100 health care services or diagnostic–related groups selected by the office.

(b) The utilization and charge information for ambulatory surgery and other outpatient health care services selected by the office.

(2) Beginning in 1990 and annually thereafter, the office shall prepare and submit to the governor and the chief clerk of each house of the legislature for distribution to the legislature under s. 13.172 (2) a report analyzing the relative rate of growth of health care costs in this state compared to the rest of the nation and compared to the midwest region. The report shall include, to the extent the data are available, comparisons among this state, the rest of the nation and the midwest region of all of the following for the preceding year:

(a) Health care costs per person.

(b) Hospital revenues and expenditures per person.

(c) Changes in total hospital revenues and expenditures.

(d) Average charges for health care services provided by hospitals and for diagnostic–related groups provided by hospitals.

History: 1987 a. 399.

153.15 Small area analysis reports. Beginning in 1990 and annually thereafter, the office shall prepare and submit to the governor and the chief clerk of each house of the legislature for

distribution to the legislature under s. 13.172 (2) reports identifying health care services or procedures provided by one or more hospitals in specific areas of the state for which the rate of utilization of the service or procedure is significantly different than the state or area average.

History: 1987 a. 399.

153.20 Uncompensated health care services report. **(1)** Beginning in 1990 and annually thereafter, the office shall prepare and submit to the governor and to the chief clerk of each house of the legislature for distribution to the legislature under s. 13.172 (2) a report setting forth the number of patients to whom uncompensated health care services were provided by each hospital and the total charges for the uncompensated health care services provided to the patients for the preceding year, together with the number of patients and the total charges that were projected by the hospital for that year in the plan filed under sub. (2).

(2) Beginning in 1990 and annually thereafter, every hospital shall file with the office a plan setting forth the projected number of patients to whom uncompensated health care services will be provided by the hospital and the projected total charges for the uncompensated health care services to be provided to the patients for the ensuing year.

History: 1987 a. 399; 1989 a. 18.

153.25 Mortality and morbidity report. Beginning in 1990 and annually thereafter, the office shall prepare and submit to the governor and to the chief clerk of each house of the legislature for distribution to the legislature under s. 13.172 (2) reports setting forth mortality and morbidity rates for every hospital. Before the release of a report under this section, the office shall provide the physicians, hospitals or other health care providers identified in the report with the opportunity to review and comment under s. 153.40 (6).

History: 1987 a. 399.

153.30 Health care insurance report. Beginning in 1990 and annually thereafter, the office may prepare and submit to the governor, and to the legislature under s. 13.172 (2), a report specifying, to the extent possible, on a regional basis, the number, nature of coverage and costs of health care coverage plans covering residents of this state during the preceding year.

History: 1987 a. 399; 1993 a. 16.

153.35 Report by the office. The office shall annually, by October 1, under rules promulgated by the commissioner, submit under s. 13.172 (3) a report to the legislature for distribution to standing committees with jurisdiction over health matters, that shall include all of the following:

(1) The range, median and mean of charges and increases or decreases in specific charges by hospitals for up to 100 charge elements, as selected by the office, as reported to the office under s. 153.05 (1) (c) 1.

(2) Comparisons, among hospitals, of increases or decreases in gross revenues, net revenues, revenues and expenditures, as reported under s. 153.05 (1) (c) 2. and 3. and (e).

History: 1987 a. 399; 1993 a. 16.

153.40 Procedures for data verification and review. **(1)** Prior to data submission, hospitals, ambulatory surgery centers or other health care providers shall review discharge data for accuracy and shall obtain verification by the physician of the principal and secondary diagnoses and primary and secondary procedures. The verification shall occur within the time specified by rules promulgated by the commissioner for data submission to the office. If the verification is not made on a timely basis, the hospital or other health care provider shall submit the data noting the lack of verification.

(2) The office shall be responsible for assuring that appropriate editing is conducted for all submitted data to identify systematic errors, missing data, values beyond an allowed range, illegal codes within a range, illogical sequence of dates, diagnoses and procedures inconsistent with age and sex, other data failing internal consistency checks and other patterns inconsistent with what would be expected. The office shall notify hospitals, ambulatory surgery centers or, beginning April 1, 1992, other health care providers of missing or incorrect information under this subsection.

(3) Hospitals, ambulatory surgery centers or, beginning April 1, 1992, other health care providers shall be responsible for resolving the errors found by the editing under sub. (2) and shall resubmit corrected data within 10 working days after receiving written notification from the office of the errors.

(4) The office shall send edited and corrected data to hospitals, ambulatory surgery centers or, beginning April 1, 1992, other health care providers for a 10–working–day review period before the data are released.

(5) The office may, by rules promulgated by the commissioner, require that other forms of data verification, including reabstracting studies and comparisons with information collected from other data systems, be conducted prior to the release of physician–specific data.

(6) At least 30 calendar days prior to the release of a report under s. 153.25, the office shall notify a physician, hospital or other health care provider identified in the report of the office's intent to release the report. The notification shall include a copy of the draft report and a statement that those identified may submit comments on the report to the office. If the office receives comments prior to the release of the report, the office shall append the comments to the report. If the office receives comments after the report is released, the office shall make the comments available to anyone requesting the comments.

History: 1987 a. 399; 1989 a. 18; 1993 a. 16.

153.45 Release of data. **(1)** After completion of data verification and review procedures under s. 153.40, the office shall release data in the following forms:

(a) Standard reports in accordance with ss. 153.10 to 153.35.

(b) Public use tapes which do not permit the identification of specific patients, physicians, employers or other health care providers, as defined by rules promulgated by the commissioner. The identification of these groups shall be protected by all necessary means, including the deletion of patient identifiers and the use of calculated variables and aggregated variables.

(c) Custom–designed subfile tapes, other electronic media, special data compilations or reports containing portions of the public use tape data under par. (b).

(2) The office shall provide to other entities the data necessary to fulfill their statutory mandates for epidemiological purposes or to minimize the duplicate collection of similar data elements.

(3) The office shall release physician–specific and employer–specific data, except in public use tapes as specified under sub. (1) (b), in a manner that is specified in rules promulgated by the commissioner.

History: 1987 a. 399; 1989 a. 18; 1993 a. 16.

153.50 Protection of patient confidentiality. Patient–identifiable data obtained under this chapter and contained in the discharge data base of the office is not subject to inspection, copying or receipt under s. 19.35 (1) and may not be released by the office, except to the patient or to a person granted permission for release by the patient and except that a hospital, a physician, the agent of a hospital or physician or the commissioner may have access to patient–identifiable data to ensure the accuracy of the information in the discharge data base. The department of health and family services may have access to the discharge data base for the purposes of completing epidemiological reports and eliminating the need to maintain a data base that duplicates that of the office, if the department of health and family services does not release or otherwise provide access to the patient–identifiable data.

History: 1987 a. 399; 1989 a. 18; 1993 a. 16; 1995 a. 27 s. 9126 (19).

153.60 Assessments to fund operations of office and board. **(1)** The office shall, by the first October 1 after the commencement of each fiscal year, estimate the total amount of expenditures for the office and the board for that fiscal year. The office shall assess the estimated total amount for that fiscal year less the estimated total amount to be received under s. 20.145 (8) (hi), (hj), (kx) and (mr) during the fiscal year and the unencumbered balances of the amounts received under s. 20.145 (8) (hi), (hj) and (mr) from the prior fiscal year, to hospitals in proportion to each hospital's respective gross private–pay patient revenues during the hospital's most recently concluded entire fiscal year. Each hospital shall pay the assessment on or before December 1. All payments of assessments shall be deposited in the appropriation under s. 20.145 (8) (hg).

(2) The office may assess ambulatory surgery centers under this section, using as the basis for individual ambulatory surgery center assessments the methods and criteria promulgated by rule by the commissioner under s. 153.75 (1) (k).

History: 1987 a. 399; 1989 a. 18, 56; 1991 a. 178; 1993 a. 16.

153.65 Provision of special information; user fees. The office may provide, upon request from a person, a data compilation or a special report based on the information collected by the office under s. 153.05 (1), (3), (4) (b), (5), (7) or (8) or 153.08. The office shall establish user fees for the provision of these compilations or reports, payable by the requester, which shall be sufficient to fund the actual necessary and direct cost of the compilation or report. All moneys collected under this section shall be credited to the appropriation under s. 20.145 (8) (hi).

History: 1987 a. 399; 1993 a. 16, 104.

153.75 Rule making. **(1)** Following approval by the board, the commissioner shall promulgate the following rules:

(a) Providing procedures to ensure the protection of patient confidentiality under s. 153.50.

(b) Establishing procedures under which hospitals and health care providers are permitted to review and verify patient–related information prior to its submission to the office.

(c) Regarding the scope of health care information required under s. 153.05 (8) from health care providers other than hospitals and ambulatory surgery centers, defining the term "health care provider" for this purpose and for purposes of s. 153.45 (1) (b) and specifying forms to be used to collect the information.

(d) Determining the diagnostic–related groups or up to 100 charge elements, based on those most frequently used by hospitals in the aggregate, for purposes of the reports under ss. 153.05 (1) (c) and 153.10 (1) (a).

(e) Implementing requirements for use of uniform patient billing forms and other information under s. 153.05 (4).

(f) Governing the release of physician–specific and employer–specific data under s. 153.45 (3).

(g) Establishing criteria for the publication and contents of notices under s. 153.08.

(h) Defining the term "major purchaser, payer or provider of health care services" for the purposes of s. 153.05 (6).

(i) Regarding the scope and implementation of the reporting requirements under s. 153.35.

(j) Specifying the categories for reporting revenue and expenditures under s. 153.05 (1) (e).

(k) Establishing methods and criteria for assessing hospitals and ambulatory surgery centers under s. 153.60.

(L) Defining the term "uncompensated health care services" for the purposes of ss. 153.05 (1) (d) and 153.20.

(2) With the approval of the board, the commissioner may promulgate all of the following rules:

(a) Exempting certain classes of health care providers from providing all or portions of the data required under this chapter.

(b) Establishing forms of data verification which may be required under s. 153.40 (5).

(c) Providing for the efficient collection, analysis and dissemination of health care information which the office may require under this chapter.

History: 1987 a. 399; 1989 a. 18; 1993 a. 16.

153.85 Civil liability. Any person violating s. 153.50 or rules promulgated under s. 153.75 (1) (a) is liable to the patient for actual damages and costs, plus exemplary damages of up to $1,000 for a negligent violation and up to $5,000 for an intentional violation.

History: 1987 s. 399.

153.90 Penalties. **(1)** Whoever intentionally violates s. 153.50 or rules promulgated under s. 153.75 (1) (a) may be fined not more than $10,000 or imprisoned for not more than 9 months or both.

(2) Any person who violates this chapter or any rule promulgated under the authority of this chapter, except ss. 153.50 and 153.75 (1) (a), as provided in s. 153.85 and sub. (1), shall forfeit not more than $100 for each violation. Each day of violation constitutes a separate offense, except that no day in the period between the date on which a request for a hearing is filed under s. 227.44 and the date of the conclusion of all administrative and judicial proceedings arising out of a decision under this section constitutes a violation.

(3) The commissioner may directly assess forfeitures under sub. (2). If the commissioner determines that a forfeiture should be assessed for a particular violation or for failure to correct the violation, the commissioner shall send a notice of assessment to the alleged violator. The notice shall specify the alleged violation of the statute or rule and the amount of the forfeiture assessed and shall inform the alleged violator of the right to contest the assessment under s. 227.44.

History: 1987 a. 399; 1989 a. 18; 1993 a. 16.