

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 deductible 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 additional 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 specific services (“CPT codes”) are available from this practice on request, if it is a service provided by this practice. There are important notes and definitions following the table.



25 Most Common Health Conditions as Identified by the Wisconsin Health Care Transparency Law (Act 146)

Common Medical Conditions Seen by this Practice			Current Billed Charge	Current Billed Charge if seen in Emergency Room	Median Billed Charge (2025)	Medicare pays this practice	Average Payment from 3rd Party Payor
Routine Exam	99396	PREVENTIVE VISIT, EST, 40-64	N/A				
	99392	PREVENTIVE VISIT, EST, AGE 1-4	N/A				
	99395	PREVENTIVE VISIT, EST, 18-39	N/A				
	77057	SCREENING MAMMOGRAPHY BILATERAL	N/A				
	99393	PREVENTIVE VISIT, EST, AGE5-11	N/A				
Hyperlipidemia, other	80061	LIPID PANEL	N/A				
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	99396	PREVENTIVE VISIT, EST, 40-64	N/A				
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	80053	COMPREHEN METABOLIC PANEL	N/A				
Hypertension	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	99396	PREVENTIVE VISIT, EST, 40-64	N/A				
	93306	ECHOCARDIOGRAPHY TRANSTHORACIC WITH DOPPLER AND CO	N/A				
	80053	COMPREHEN METABOLIC PANEL	N/A				
Other minor orthopedic disorders - back	98941	CHIROPRACTIC MANIPULATION	\$181		\$181	\$38	\$62
	98940	CHIROPRACTIC MANIPULATION	\$125		\$125	\$26	\$43
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	97110	THERAPEUTIC EXERCISES	\$102		\$102	\$28	\$69
	72148-26*	MAGNETIC IMAGE, LUMBAR SPINE	\$617		\$617	\$66	\$278
Joint degeneration, localized back, w/o surgery	72148-26*	MAGNETIC IMAGE, LUMBAR SPINE	\$617		\$617	\$66	\$278
	98941	CHIROPRACTIC MANIPULATION	\$181		\$181	\$38	\$62
	98940	CHIROPRACTIC MANIPULATION	\$125		\$125	\$26	\$43
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	97110	THERAPEUTIC EXERCISES	\$102		\$102	\$28	\$69
Isolated signs, symptoms, & non-specific	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	70553-26*	MAGNETIC IMAGE, BRAIN	\$1,767		\$1,767	\$102	\$429
	77057-26*	SCREENING MAMMOGRAPHY BILATERAL	N/A				
	71020 (Global)	CHEST X-RAY	N/A				
	71020-26*	CHEST X-RAY	N/A				
	71020-TC**	CHEST X-RAY	N/A				



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Diabetes, w/o surgery	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	83036	GLYCATED HEMOGLOBIN TEST	N/A				
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	82043	MICROALBUMIN, QUANTITATIVE	N/A				
	80061	LIPID PANEL	N/A				
Obesity, w/o surgery	80061	LIPID PANEL	N/A				
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	95811-26*	POLYSOMNOGRAPHY W/CPAP	\$1,752		\$1,752	\$120	\$392
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	99396	PREVENTIVE VISIT, EST, 40-64	N/A				
Hypo-functioning thyroid gland, w/o surgery	84443	ASSAY THYROID STIM HORMONE	N/A				
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	80061	LIPID PANEL	N/A				
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	99396	PREVENTIVE VISIT, EST, 40-64	N/A				
Acne	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	99202	OFFICE/OUTPATIENT VISIT, NEW	\$310		\$310	\$72	\$210
	99212	OFFICE OUTPATIENT VISIT EST	\$191		\$191	\$57	\$137
	99203	OFFICE/OUTPATIENT VISIT, NEW	\$441		\$441	\$111	\$307
Acute bronchitis	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	71020 (Global)	CHEST X-RAY	N/A				
	71020-26*	CHEST X-RAY	N/A				
	71020-TC**	CHEST X-RAY	N/A				
	99284	URGENT CARE/EMERGENCY	\$576		\$576	\$110	\$416
	94640	PRESSURIZED OR NONPRESSURIZED INHALATION TREATMENT	N/A				
Acute sinusitis, w/o surgery	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	70486-26*	COMPUTED TOMOGRAPHY MAXILLOFACIAL AREA W/O CONTRAS	\$427		\$427	\$39	\$161
	99203	OFFICE/OUTPATIENT VISIT, NEW	\$441		\$441	\$111	\$307



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	95165	ANTIGEN THERAPY SERVICES	N/A				
Chronic sinusitis, w/o surgery	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	70486-26*	COMPUTED TOMOGRAPHY MAXILLOFACIAL AREA W/O CONTRAS	\$427		\$427	\$39	\$161
	95004	ALLERGY SKIN TESTS	N/A				
	31231	NASAL ENDOSCOPY, DX	\$1,041		\$1,041	\$183	\$845
Tonsillitis, adenoiditis or pharyngitis, w/o surgery	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	87880	STREP A ASSAY W/OPTIC	N/A				
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	87081	BACTERIA CULTURE SCREEN	N/A				
	99284	URGENT CARE/EMERGENCY	\$576		\$576	\$110	\$416
Otitis Media, w/o surgery	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	99283	URGENT CARE/EMERGENCY	\$372		\$372	\$64	\$232
	99212	OFFICE OUTPATIENT VISIT EST	\$191		\$191	\$57	\$137
	69436	CREATE EARDRUM OPENING	\$962		\$962	\$135	\$702
Otolaryngology diseases signs & symptoms	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	30901	CONTROL OF NOSEBLEED	\$740		\$740	\$156	\$621
	31238	NASAL/SINUS ENDOSCOPY, SURG	\$2,263		\$2,263	\$245	\$1,077
	99283	URGENT CARE/EMERGENCY	\$372		\$372	\$64	\$232
Routine Inoculation	99396	PREVENTIVE VISIT, EST, 40-64	N/A				
	90715	TETANUS, DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS	N/A				
	99395	PREVENTIVE VISIT, EST, 18-39	N/A				
	90471	IMMUNIZATION ADMINISTRATION	N/A				
	90649	HUMAN PAPILLOMA VIRUS VACCINE TYPES 6 11 16 18 THR	N/A				
Contraceptive management	99395	PREVENTIVE VISIT, EST, 18-39	N/A				
	58300	INSERT INTRAUTERINE DEVICE	N/A				
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224



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	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	76830-26*	ECHO EXAM, TRANSVAGINAL	\$263		\$263	\$32	\$130
Gastroenterology diseases signs & symptoms	45378	DIAGNOSTIC COLONOSCOPY	N/A				
	72193-26*	CONTRAST CAT SCAN OF PELVIS	\$477		\$477	\$52	\$218
	74160-26*	CONTRAST CAT SCAN OF ABDOMEN	\$565		\$565	\$57	\$239
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
Fungal skin infection	11721	DEBRIDE NAIL, 6 OR MORE	\$125		\$125	\$43	\$198
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	11750	REMOVAL OF NAIL BED	\$893		\$893	\$150	\$689
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	99212	OFFICE OUTPATIENT VISIT EST	\$191		\$191	\$57	\$137
Mood disorder, depressed	90806	PSYTX, OFFICE (45-50)	N/A				
	90801	PSY DX INTERVIEW	N/A				
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	90862	MEDICATION MANAGEMENT	N/A				
	90805	PSYTX, OFFICE (20-30) W/E&M	N/A				
Other neuropsychological or behavioral disorders	90806	PSYTX, OFFICE (45-50)	N/A				
	90801	PSY DX INTERVIEW	N/A				
	90847	FAMILY PSYTX W/PATIENT	N/A				
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
Visual disturbances, w/o surgery	92014	EYE EXAM & TREATMENT	\$324		\$324	\$123	\$460
	92004	EYE EXAM, NEW PATIENT	\$395		\$395	\$145	\$548
	92015	REFRACTION	\$55		\$55	\$18	\$66
	92012	EYE EXAM ESTABLISHED PT	\$231		\$231	\$87	\$323
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
Cataract, w/o surgery	92014	EYE EXAM & TREATMENT	\$324		\$324	\$123	\$460
	92015	REFRACTION	\$55		\$55	\$18	\$66
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	92004	EYE EXAM, NEW PATIENT	\$395		\$395	\$145	\$548
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224



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Inflammatory eye disease, w/o surgery	92014	EYE EXAM & TREATMENT	\$324		\$324	\$123	\$460
	99213	OFFICE/OUTPATIENT VISIT, EST	\$307		\$307	\$91	\$224
	92015	REFRACTION	\$55		\$55	\$18	\$66
	99214	OFFICE/OUTPATIENT VISIT, EST	\$446		\$446	\$130	\$324
	92004	EYE EXAM, NEW PATIENT	\$395		\$395	\$145	\$548



## 25 Most Common Health Conditions as Identified by the Wisconsin Health Care Transparency Law (Act 146)

Common Medical Conditions Seen by this Practice		Current Billed Charge	Current Billed Charge if seen in Emergency Room	Median Billed Charge (2025)	Medicare pays this practice	Average Payment from 3rd Party Payor
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### Important Notes:

- Information on quality can be found at [www.baycare.net](http://www.baycare.net)
- 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 other providers and your insurer if you want an estimate of the probable 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.
- 'N/A' - 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 2021. 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.
- Reports on quality are publicly available at [www.baycare.net](http://www.baycare.net)
- 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>.
- "Global" - When this term is noted on this schedule, it indicates that the code can be billed with a physician service or facility component. When the code is billed 'globally', it represents both components.
- \* The fee noted on this schedule, and denoted with - 26, is only for the physician service portion of the fee which would be billed by BayCare Clinic. Patients should expect to also be billed by the facility for the technical portion of this procedure.
- \*\* The fee noted on this schedule, and denoted with - TC, is only for the technical or facility portion of the fee. Patients should expect to also be billed for the physician portion of this service.