Employer Group Reporting Package

State of Wisconsin

2003 Utilization Summary

Prepared by
Reporting and Data Management
October 2004

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PURPOSE

The purpose of this report is:

- To summarize the healthcare utilization of the State of Wisconsin Employees and Wisconsin Public Employees members.
- To compare your statistics to normative data.
- To assist you in monitoring utilization patterns.
- To identify ways to optimize the use of health care benefits.

REPORT STRUCTURE

The data presented in the following graphs and tables represent the health care utilization for the State of Wisconsin Employees and Wisconsin Public Employees.

The content of the report represents incurred claims experience from January 1, 2003 through December 31, 2003 and paid through March 31, 2004. Claims are considered incurred on the date that the health care services are rendered.

Many of your health care utilization statistics have been compared to normative data from Blue Cross & Blue Shield of Wisconsin (BCBSWI). The normative values used throughout this report represent the cumulative 2002 healthcare utilization data of BCBSWI business.


STATE OF WISCONSIN
EMPLOYEES

STATE OF WISCONSIN EMPLOYEES

This segment of the report provides a compilation of data for the State of Wisconsin Employees consisting of all non-Medicare Employees, their spouses and dependents.

There was an average of 5,272 non-Medicare members. The average age of the population was 45.4 years.

State of Wisconsin Employee members received inpatient, outpatient, and professional services totaling $24,810,863 in total payments. The average payment per member per month was $392. Skin/Musculoskeletal disorders accounted for 16% of the total payments.

During the period, members experienced 446 admissions. This equated to 84.6 admissions per 1,000 members. The average length of stay was 4.7 days. Fifty-one percent of the admissions were Surgical related. These admissions generated 76% of the inpatient payments. Skin/Musculoskeletal disorders accounted for 17% of the 446 admissions and 22% of the payments. Twenty-nine percent of the admissions in this category were for major joint reconstruction procedures.

Outpatient payments totaled $6,667,130.85. Outpatient Routine Care visits accounted for 18% of the payments. Included in this category were visits for physical and occupational therapy, mammograms, routine medical exams, and immunizations.

Members of the State of Wisconsin Employees incurred a rate of 148.58 emergency room visits per 1,000. Ill-defined conditions, including abdominal pain and nausea accounted for 8% of the emergency room visits.

State of Wisconsin Employees experienced 58,007 professional visits during the period. The payments for these visits totaled $11,274,913. Eighteen percent of the professional payments were the result of Skin/Musculoskeletal disorders. Psychiatry/Psychology providers received 11% of the total professional visits. These visits accumulated 10% of the professional payments.

PAYMENT SUMMARY AND MEMBERSHIP DISTRIBUTION

The Payment Summary provides general payment information pertaining to Medicare and non-Medicare State of Wisconsin Employees and offers a visual comparison of the membership distribution by gender and relationship.

Specifically, this table reflects total facility and professional payments incurred in inpatient, outpatient, and professional settings. A more detailed analysis of inpatient, outpatient, and professional utilization is provided in the sections of this report dedicated exclusively to those areas.

During the 12-month report period outlined:

- Charges for inpatient, outpatient, professional and other services rendered totaled $205,813,131. The average charge per member per month was $1,136.
- Payments totaled $65,777,507 – 32% of the total charges. The overall average payment per member per month was $363. Fifty-three percent of the total payments were incurred by State of Wisconsin Employee Medicare members.
- One-quarter of the total charges and 14% of the payments were the result of inpatient facility services. Outpatient facility payments represented 15% of the total payments.
- Professional services resulted in 34% of the charges and 26% of the payments.
- Services related to Skilled Nursing Facilities, Rehabilitation facilities, and pharmacy accumulated 45% of the total payments.

The membership distribution revealed:

- There was an average of 15,094 State of Wisconsin Employees – Medicare and non-Medicare members during the 12-month period. Sixty-five percent of the population was represented by Medicare members.
- The overall age of the combined population was 66.8 years.
- Sixty-nine percent of the members were employees.
- Females (employees, spouses and dependents) accounted for the majority (59%) of the State of Wisconsin Employees members.

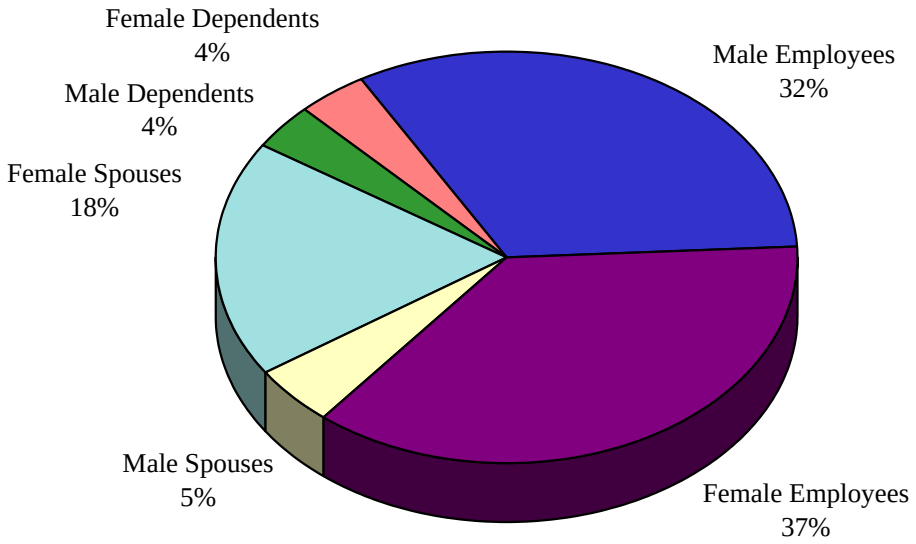
The remaining tables in this report reflect only non-Medicare costs and utilization.

State of Wisconsin - Employees
Medicare & Non-Medicare
PAYMENT SUMMARY

Incurred: January 1, 2003 - December 31, 2003
Paid: January 1, 2003 - March 31, 2004

	Total Charges	Total Payments
Inpatient:	$52,006,898	$9,019,734
Outpatient:	$37,164,556	$9,889,613
Professional:	$70,062,098	$17,282,311
Other:	$46,579,579	$29,585,849
Total:	**$205,813,131**	**$65,777,507**
Average PMPM:	$1,136	$363

Membership Distribution



Total Membership: 15,094
Average Age of Membership: 66.8

MEMBERSHIP SUMMARY AND PAYMENT DISTRIBUTION

Membership Summary

The Membership Summary provides general membership information pertaining to State of Wisconsin Employees membership.

The membership distribution for State of Wisconsin Employees revealed:

- During the 2003 calendar year there was an average of 5,272 members.
- Fifty-five percent of the members were employees.
- The average age of the population was 45.4 years. This is 13 years older than the BCBSWI normative average age.

Payment Distribution by Gender/Relationship

The Payment Distribution by Gender/Relationship graph provides a visual comparison of payment distribution by gender and relationship classification for State of Wisconsin Employees membership. This allows you to determine how much of your total payments were allocated to each of the six gender/relationship categories.

- Sixty-two percent of the payments were incurred by employees. Male employees accounted for 29% of the payments and female employees accumulated 33%.
- Spouses accounted for 30% of the total payments.
- The remaining 8% of the payments were the result of services incurred by dependents – equally divided among male and female dependents.
- The majority (59%) of the payments were for services experienced by female members of the State of Wisconsin Employees.

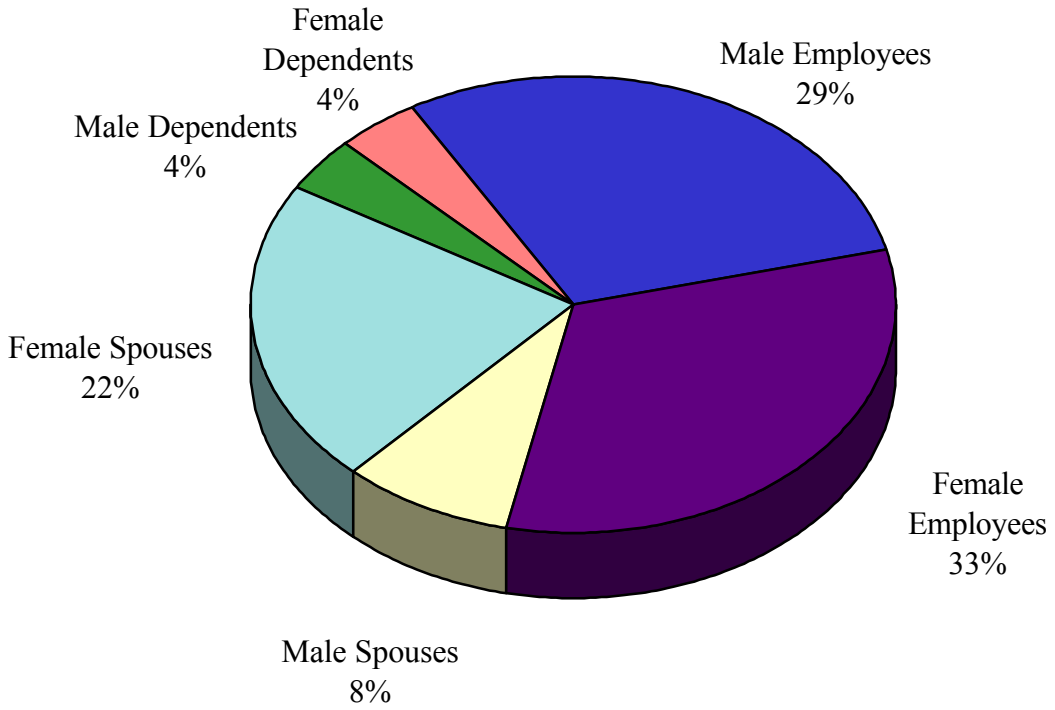
State of Wisconsin - Employees
MEMBERSHIP & PAYMENT DISTRIBUTION
By Gender/Relationship

Total Membership

Employees:	2,916
Spouses:	1,212
Dependents:	1,144
Total:	**5,272**

Average Age of Membership: 45.4

Payment Distribution



TOTAL PAYMENTS BY DISEASE CATEGORY

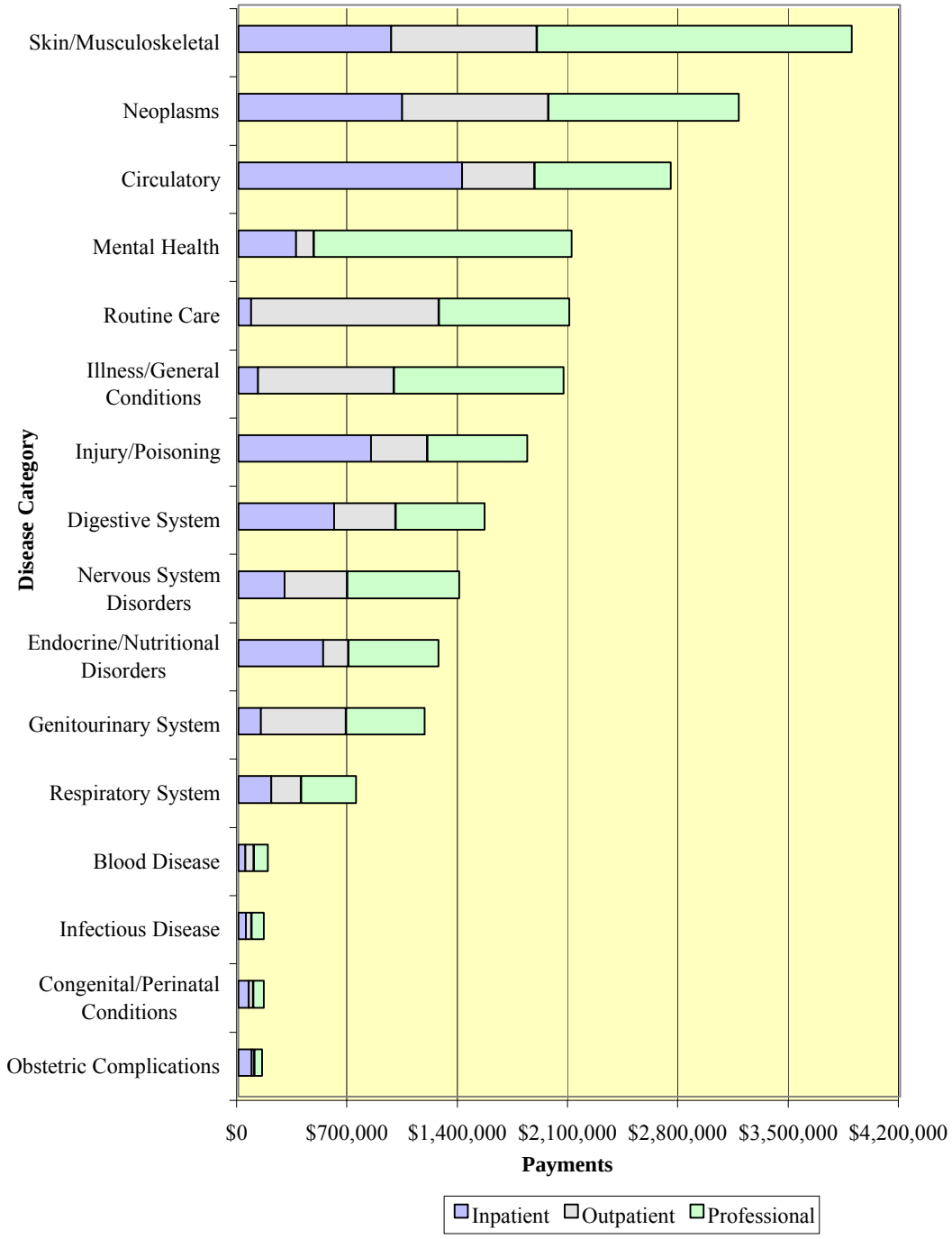
The Total Payments by Disease Category graph offers a visual account of total payment distribution by a variety of disease categories. This table reflects total facility and professional payments incurred in the inpatient, outpatient, and professional settings.

Review of the payment distribution graph indicates:

- Inpatient, outpatient, and professional services totaled $24,810,863 in payments.
- Skin/Musculoskeletal disorders accounted for 16% of the total payments incurred during the period. Professional payments represented 51% of those payments. Included in this category is treatment for osteoarthrosis and disc disorders.
- Thirteen percent of the total payments were for Neoplasm diagnoses. Some of the more commonly treated diagnoses in this category included breast cancer, colon cancer, lymphoma, and lung cancer.
- Circulatory diagnoses accounted for 11% of the total payments. Inpatient care represented 52% of the payments in this category.

State of Wisconsin - Employees
TOTAL PAYMENTS BY DISEASE CATEGORY

Payment Distribution



Total Payments = $24,810,863


INPATIENT

INPATIENT ADMISSION SUMMARY

The Inpatient Admission Summary table outlines facility charges and payments by type of admission. Inpatient charges include hospital services such as room accommodations, equipment, medication, and supplies (except take-home) that are rendered to a patient during a hospital stay.

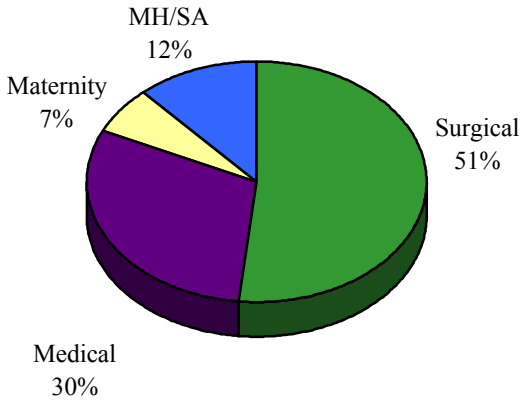
According to the inpatient experience:

- There were a total of 446 admissions experienced during the period. These admissions generated 2,085 days and resulted in an average length of stay of 4.7 days.
- Fifty-one percent of the admissions and 76% of the payments were related to Surgical care. The average length of stay for these admissions was 4.9 days. Major joint replacement/reconstruction procedures accounted for 22 of the Surgical admissions and 10% of the payments. Procedures for obesity accounted for an additional 9% of the admissions and 8% of the Surgical payments. Ten of the Surgical procedures were hysterectomies.
- There were a total of 134 Medical admissions during the period. These admissions accounted for 18% of the total inpatient payments. Admissions for treatment of simple pneumonia accounted for seven admissions and $79,934 in payments. Another seven admissions were for treatment of chest pain. One admission for digestive malignancy resulted in 14 days and $85,544 in payments.
- The average length of stay for the 52 Mental Health/Substance Abuse admissions was 7.9 days. Payments for these admissions represented 5% of the total. Psychosis admissions accounted for 62% of the admissions in this category.
- Only 7% of the admissions and 1% of the payments were the result of Maternity care.

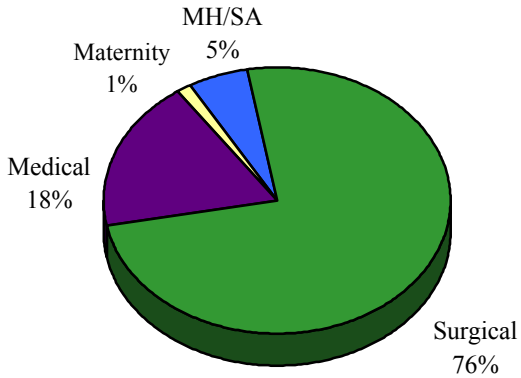
State of Wisconsin - Employees
INPATIENT ADMISSION SUMMARY

Type of Admission	Total Admits	Total Days	Length of Stay	Charges	Payments
Surgical	231	1,121	4.9	$6,398,130	$5,127,602
Medical	134	481	3.6	$1,692,798	$1,264,814
Mental Health/Substance Abuse	52	412	7.9	$505,819	$373,494
Maternity	29	71	2.4	$143,414	$102,909
Total	**446**	**2,085**	**4.7**	**$8,740,160**	**$6,868,820**

Admission Summary
By Number of Admissions



Admission Summary
By Payments



ADMISSION DISTRIBUTION

Admissions by Gender/Relationship

The Admissions by Gender/Relationship graph offers a visual comparison of admissions by gender/relationship within your total membership.

According to data reported during the incurred period:

- Fifty-eight percent of the admissions were experienced by employees.
- Spouses experienced 31% of the admissions during the period. Seventy-one percent of the spouse's admissions were incurred by females.
- Dependents were responsible for 11% of the 446 admissions.

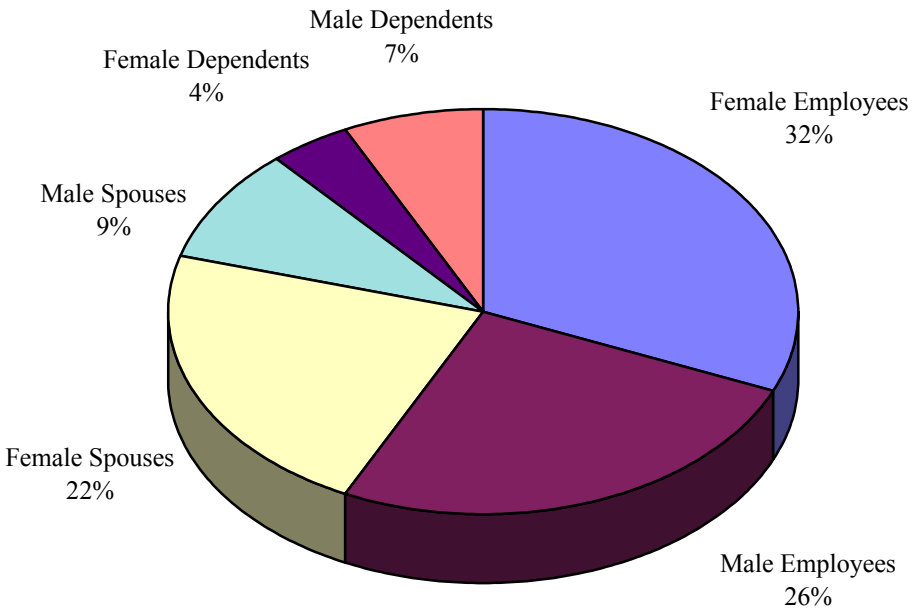
Admission Rate Per 1,000 by Age Category

The Admissions Rate per 1,000 by Age Category graph represents admissions occurring per age group. The admission information reported in this table has been converted to per 1,000 rates in order to allow accurate comparisons to normative data. A "per 1,000" rate measures how often a particular event is likely to occur within any given population of 1,000 people.

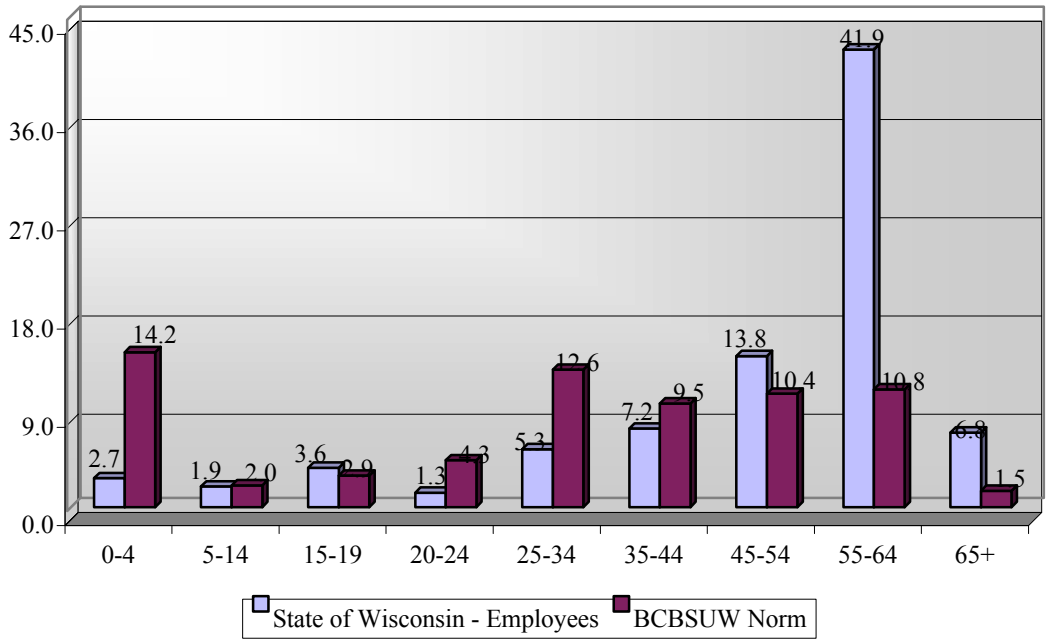
- Members between the ages of 45 and 54 years incurred a rate of 13.8 admissions per 1,000. Some of the more common diagnoses in this age category included major joint reconstruction, procedures for obesity, and psychosis.
- Half of all the admissions were experienced by members between the ages of 55 and 64. This equated to 41.9 admissions per 1,000 members. Male employees accounted for 37% of the admissions in this age category. Admissions by these members included major joint reconstruction procedures, simple pneumonia, and psychosis.
- State of Wisconsin Employee members over the age of 65 experienced a rate of 6.8 admissions per 1,000.

State of Wisconsin - Employees
ADMISSION DISTRIBUTION
By Gender/Relationship and Age Category

Admissions by Gender/Relationship



Admission Rate per 1,000 by Age Category



COMPARISON WITH BCBSWI

The Comparison with BCBSWI table allows a comparative analysis of your specific group data to the BCBSWI normative data.

Comparisons between State of Wisconsin Employees and BCBSWI reveal:

- The overall average charge per admission was $19,597. This is 78% higher than the BCBSWI normative average charge.
- Based on the 446 admission and $6,868,820 in payments the average payment per admission was $15,401. The BCBSWI normative average payment per admission was $8,091.
- The average charge per Surgical admission was $27,698. The average payment per admission was $22,197. The first three high cost admissions (payments over $20,000 each) were Surgical procedures. These three procedures accumulated $470,057 in payments.
- The average Mental Health/Substance Abuse payment per admission was $7,183. This exceeded the BCBSWI normative average by 99%. Nineteen percent of the admissions in this category resulted in payments of $10,000 or more.

State of Wisconsin - Employees
COMPARISON WITH BC&BSUW

Charge Per Admission

	State of Wisconsin Employees	BC&BSUW Normative
Surgical	$27,698	$21,911
Medical	$12,633	$8,198
Mental Health/Substance Abuse	$9,727	$4,095
Maternity	$4,945	$4,785
Average Charge Per Admission	$19,597	$11,000
Average Charge Per Day	$4,192	$3,171

Payment Per Admission

	State of Wisconsin Employees	BC&BSUW Normative
Surgical	$22,197	$16,312
Medical	$9,439	$6,094
Mental Health/Substance Abuse	$7,183	$3,603
Maternity	$3,549	$3,419
Average Payment Per Admission	$15,401	$8,091
Average Payment Per Day	$3,294	$2,333

INPATIENT UTILIZATION COMPARISON

The Inpatient Utilization Comparison graphs provide a visual comparison of State of Wisconsin Employees' admissions per 1,000 members, inpatient days per 1,000, and average length of stay to normative data for BCBSWI.

Admissions per 1,000 Members

- Members of the State of Wisconsin Employees experienced a rate of 84.6 admissions per 1,000. This rate exceeded the normative rate by 24%.
- The rate of Surgical admissions per 1,000 was 43.8.
- The Medical rate of admissions per 1,000 experienced by the State of Wisconsin Employees exceeded the normative rate by 40%.
- The 52 Mental Health/Substance Abuse admissions resulted in a rate of 9.9 admissions per 1,000 members. This rate is 130% higher than the normative rate.
- Maternity admissions were the only type to result in a lower rate of admissions per 1,000 member than the BCBSWI norm.

Days per 1,000 Members

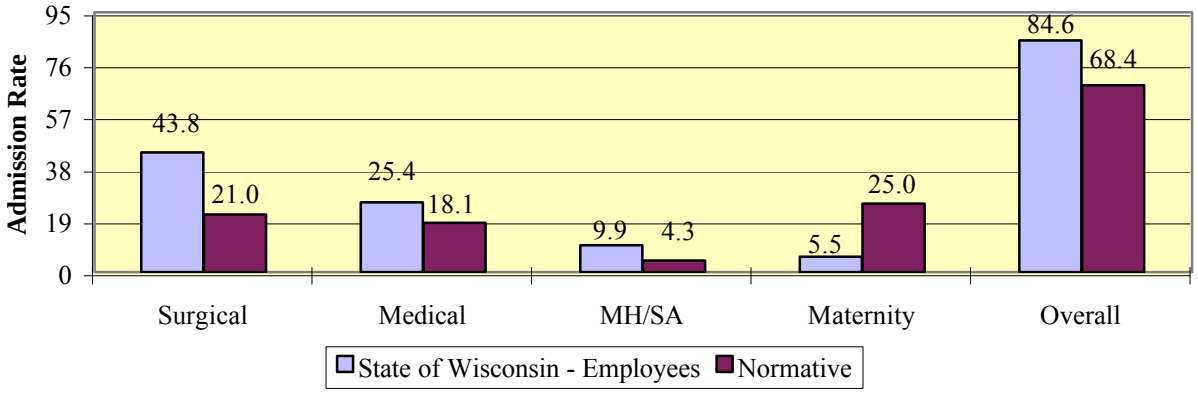
- The 2,085 inpatient days resulted in 395.5 days per 1,000 members. This was 67% higher than the BCBSWI normative rate.
- The Surgical rate of days per 1,000 was 212.6. This is reflective of the higher number of Surgical admissions experienced during the period.
- The rate of Mental Health/Substance Abuse days per 1,000 was 78.1. A single visit for treatment of anorexia nervosa lasted 52 days.

Average Length of Stay

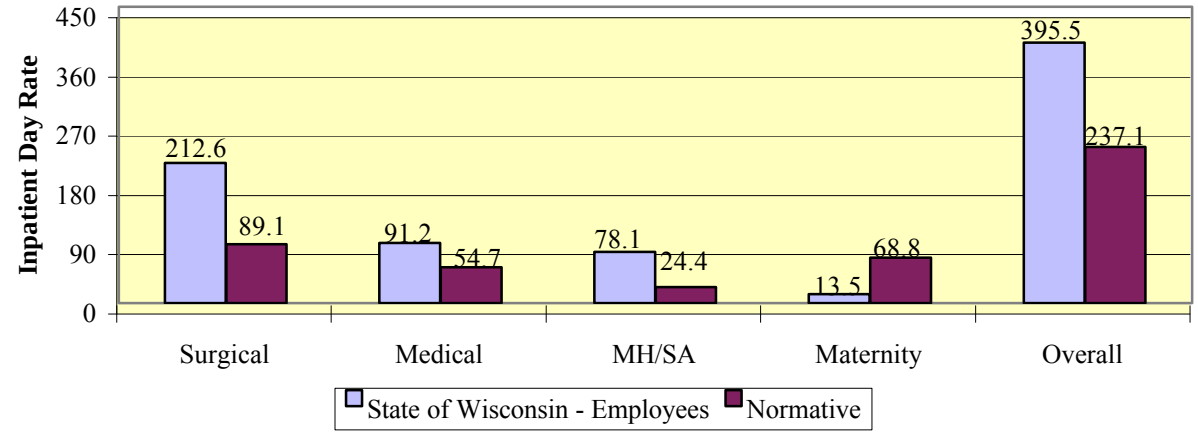
- The overall average length of stay for the 446 admissions was 4.7 days. The BCBSWI average length of stay was 3.5 days.
- The 231 Surgical admissions resulted in an average length of stay of 4.9 days.
- The longest average length of stay was for the Mental Health/Substance Abuse admissions at 7.9 days. Four of the admissions lasted over 20 days each. These admissions significantly impacted the average. By removing these admissions from the experience, the average Mental Health/Substance Abuse length of stay falls to 6.0 days.

State of Wisconsin - Employees
INPATIENT UTILIZATION COMPARISON

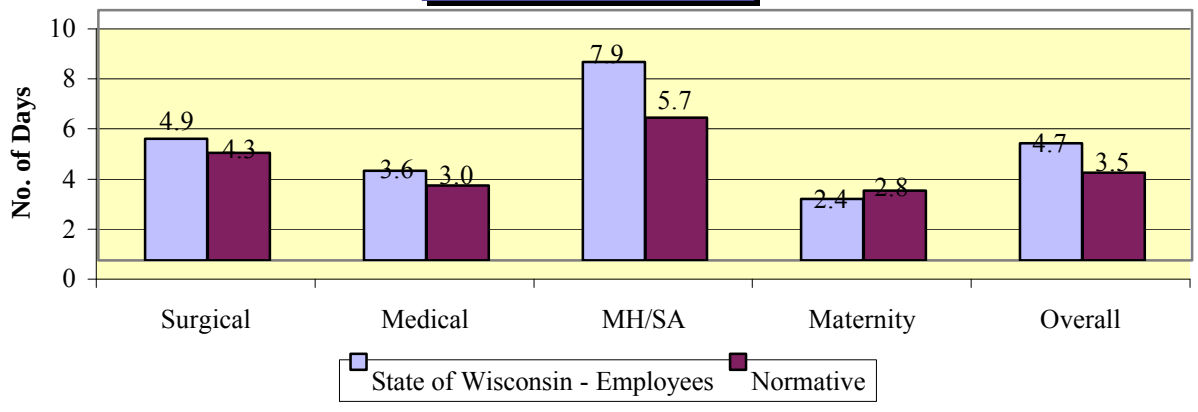
Admissions per 1,000 Members



Inpatient Days per 1,000 Members



Average Length of Stay



ADMISSIONS AND INPATIENT PAYMENTS BY MAJOR DIAGNOSTIC CATEGORY

The Distribution of Admissions and Inpatient Payments by Major Diagnostic Category graph offers a visual account of admission and payment distribution by specific diagnostic categories.

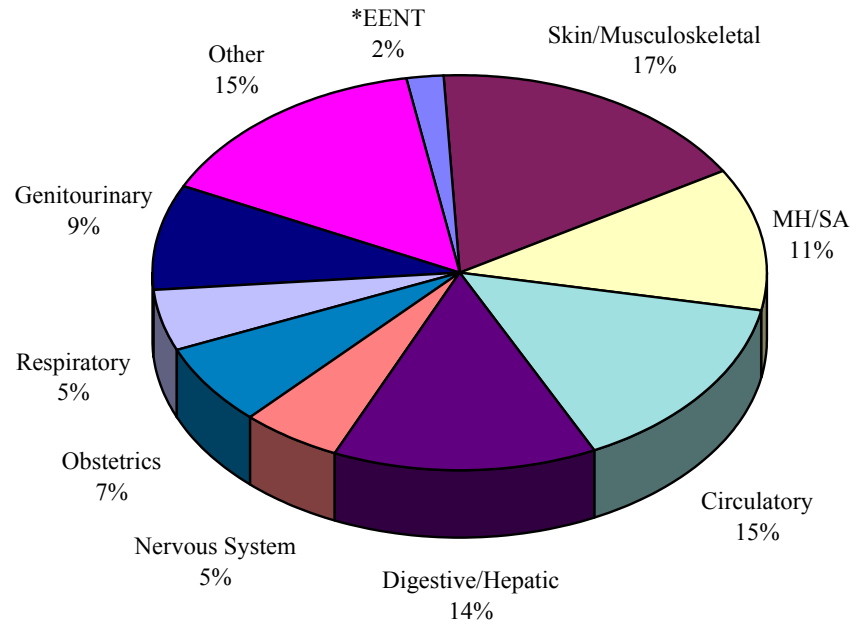
During the incurred period:

- Skin/Musculoskeletal disorders accounted for 17% of the admissions and generated 23% of the payments. Twenty-nine percent of the admissions in this category were for major joint reconstruction procedures. Also included in this category were admissions for spinal fusion procedures, back problems, and cellulitis.

- The Other category included admissions for Endocrine, Blood Disease, Myeloproliferative Disease, Infectious Disease, Injury, Burns, and Multiple Trauma diagnoses. Procedures for obesity represented 31% of the admissions in this category and 35% of the payments. Also included were admissions for post-traumatic infections, red blood cell disorders, and fevers.

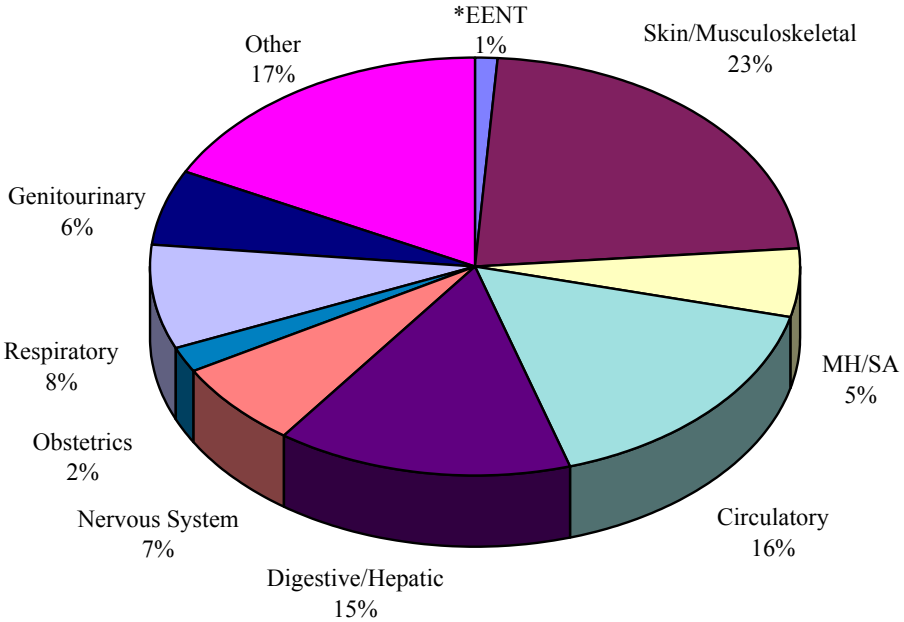
- Circulatory related diagnoses accounted for 15% of the admissions experienced during the period. These admissions accumulated 16% of the total payments. Admissions in this category included cardiac valve procedures, peripheral vascular disorders, chest pain, and coronary artery stent.

State of Wisconsin - Employees
ADMISSION DISTRIBUTION
By Major Diagnostic Category



Total Admissions = 446

PAYMENT DISTRIBUTION
By Major Diagnostic Category



Total Payments = $6,868,820

*EENT includes eye, ear, nose and throat

SUMMARY OF MOST FREQUENTLY UTILIZED INPATIENT FACILITIES

The Utilization of Inpatient Facilities table provides an overview of your most frequently utilized inpatient facilities.

During the report period:

- Thirty-eight percent of the admissions were incurred at the ten facilities listed on the table. These admissions generated 48% of the payments.
- University Hospitals incurred 10% of the admissions. These admissions accounted for 13% of the payments and 12% of the days.
- The average payment per day at St. Luke's Medical Center was $6,170 - 87% higher than the overall average payment per day. One admission for treatment of coronary atherosclerosis resulted in a two-day stay totaling $35,296 in payments or $17,648 per day. Another admission for the same diagnosis resulted in a one-day stay and $32,594 in payments.
- The nine admissions at Luther Hospital resulted in an average payment per admission of $38,741. The most costly admission experienced during the period was at this facility resulting in 63% of the facility's payments.

State of Wisconsin - Employees
SUMMARY OF MOST FREQUENTLY UTILIZED INPATIENT FACILITIES

Facility	Total Payments	Total Admits	Total Days	Avg. Paid Per Day
University Hospitals	$924,376	46	240	$3,852
Meriter Hospital, Inc.	$530,850	37	165	$3,217
Columbia Hospital	$203,448	17	44	$4,624
St. Luke's Medical Center	$351,683	16	57	$6,170
All Saints-St. Mary's Medical Center	$205,549	14	77	$2,669
Froedtert Memorial Lutheran Hospital	$289,311	11	56	$5,166
Luther Hospital	$348,666	9	76	$4,588
St. Mary's Hospital Medical Center	$209,026	8	46	$4,544
Aurora Sinai Medical Center	$105,508	7	21	$5,024
Waukesha Memorial Hospital	$129,859	6	77	$1,686
Subtotal	$3,298,277	171	859	$3,840
Other Facilities	$3,570,542	275	1,226	$2,912
TOTAL	**$6,868,820**	**446**	**2,085**	**$3,294**

HIGH COST ADMISSIONS

The High Cost Admissions table outlines single admissions within Major Diagnostic Categories with total payments of $20,000 or more. A complete listing of all high cost admissions is provided in the Appendix.

State of Wisconsin Employees members experienced a total of 109 high cost admissions during the report period. These high cost admissions had the following impact on your experience:

- Twenty-four percent of the total admissions were responsible for 60% of the total inpatient payments. The average length of stay for the admissions was 9.0 days.
- Thirty percent of the high cost admissions were for Skin/Musculoskeletal disorders. Major joint reconstruction procedures accounted for 16 of the admissions in this category and 43% of the payments.
- Circulatory disorders accounted for 20 high cost admissions. Included in this category were admissions for major cardiovascular procedures, cardiac valve procedures, and percutaneous cardiovascular procedure.
- There were seven high cost admissions associated with Respiratory disorders. The most costly admission experienced during the period was for a tracheostomy procedure totaling $220,549 in payments.

State of Wisconsin - Employees
HIGH COST ADMISSIONS

Diagnosis	Admits	Days	Total Charges	Total Payments
Skin/Musculoskeletal	33	229	$1,260,068	$1,010,732
Circulatory	20	108	$888,946	$798,155
Other	22	186	$938,384	$750,841
Digestive/Hepatic	12	126	$678,261	$550,068
Nervous System	6	76	$301,458	$286,024
Genitourinary	4	32	$221,788	$158,541
Respiratory	7	115	$485,183	$416,459
Mental Health	4	103	$125,360	$105,798
Obstetrics	1	8	$38,246	$32,409
	109	**983**	**$4,937,693**	**$4,109,027**


OUTPATIENT

OUTPATIENT PAYMENTS BY DISEASE CATEGORY

The Outpatient Payments by Disease Category graph provides a visual display of the distribution of outpatient payments by a variety of disease categories. Disease categories are determined based on the ICD-9 code associated with the claim.

Outpatient care includes payments for hospital services, room accommodations, equipment, medication, and supplies (except take-home) that are rendered to a patient in an outpatient setting. Outpatient settings include the outpatient department in a hospital, ambulatory surgery centers, and therapy centers. This includes diagnostic X-ray and lab services rendered by a radiologist or pathologist on an outpatient basis.

The graph reveals the following:

- The largest portion (18%) of the State of Wisconsin Employees outpatient payments was associated with Routine Care visits. Twenty-one percent of the payments were for physical therapy visits. Mammograms accounted for an 4% of the payments and 14% of the Routine Care visits. Also included in this category were visits for colon screenings, chemotherapy, and radiotherapy.

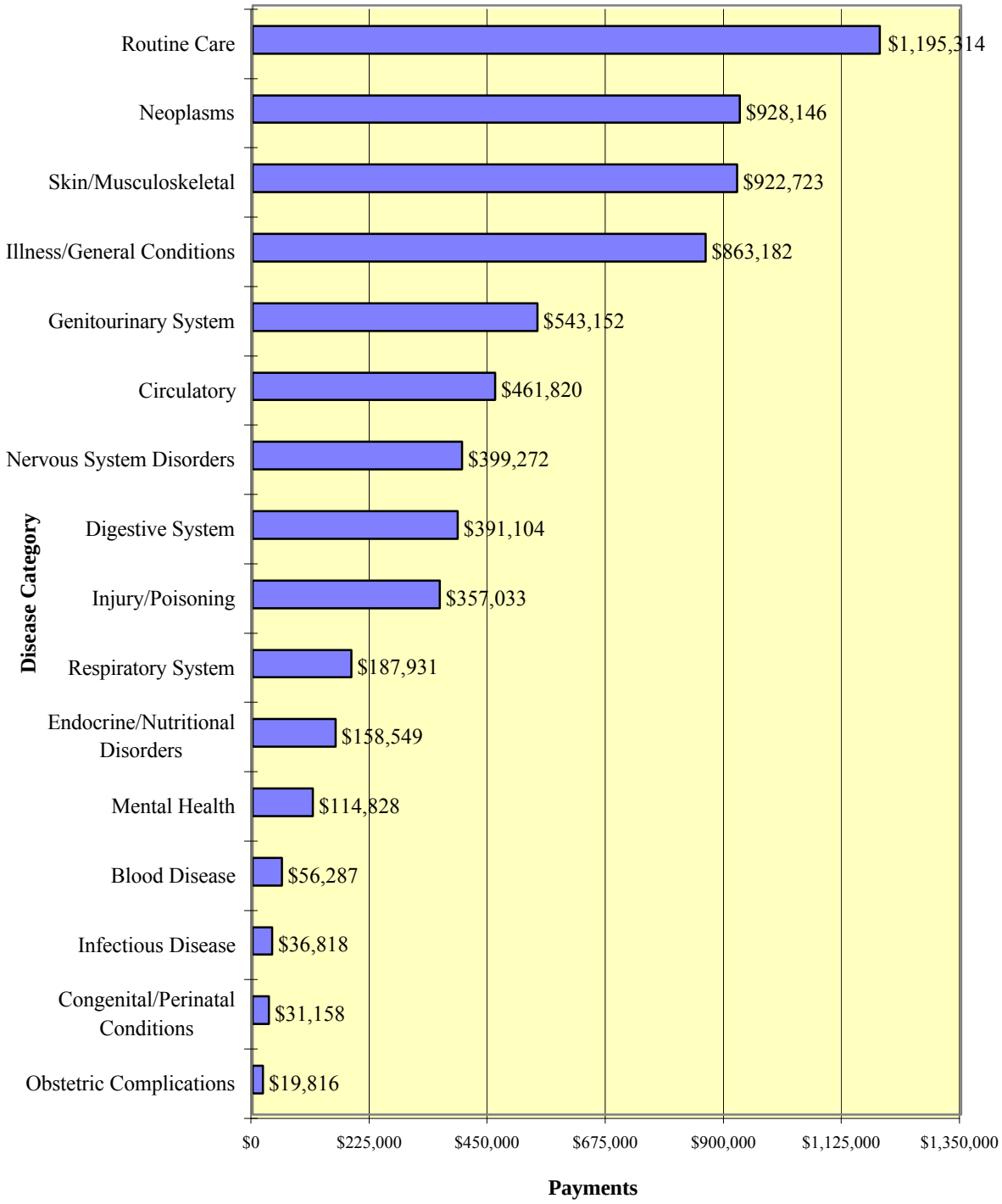
- Fourteen percent of the payments were the result of Neoplasm diagnoses. Included in this category were visits associated with breast cancer, colon cancer, lymphoma, and lung cancer.

- An additional 14% of the outpatient payments were associated with Skin/Musculoskeletal disorders.

State of Wisconsin - Employees

OUTPATIENT PAYMENTS BY DISEASE CATEGORY

Payment Distribution



Total Payments = $6,667,130.85

OUTPATIENT VISITS BY FACILITY

The Outpatient Visits By Facility table lists the most frequently utilized outpatient facilities.

The table shows:

- Members of the State of Wisconsin Employees experienced 11,551 outpatient visits during 2003. This equates to 2,191.0 visits per 1,000. The BCBSWI normative average was 910.2 visits per 1,000 members.
- The overall average payment per outpatient visit was $577.
- Thirty-two percent of the total visits were experienced at University Hospitals. These visits accumulated 19% of the outpatient visits.

State of Wisconsin - Employees
OUTPATIENT VISITS BY FACILITY

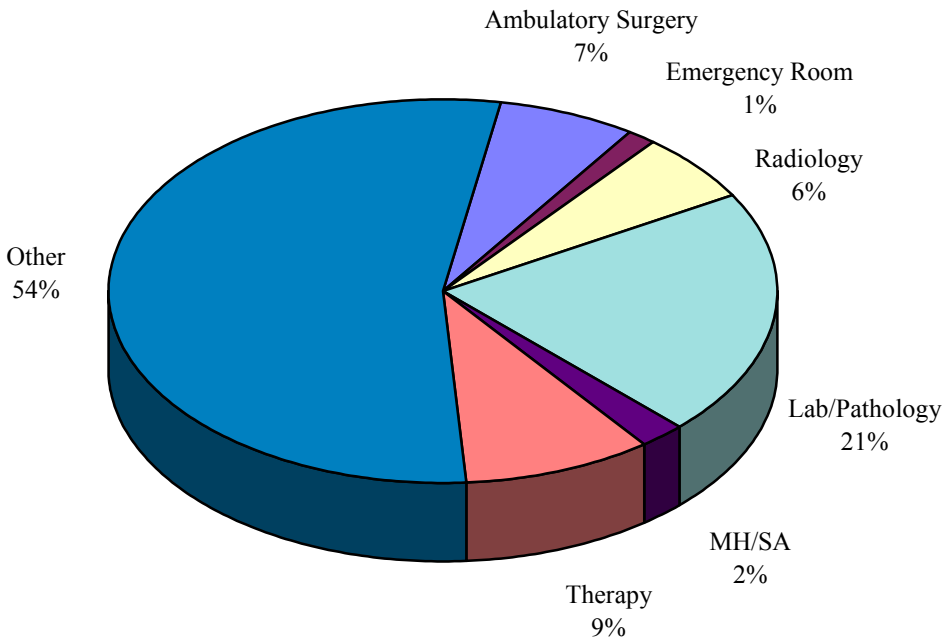
Facility	Total Visits	Total Charges	Total Payments
University Hospitals	3,739	$1,510,383	$1,256,396
Columbia Hospital	496	$503,347	$358,742
All Saints - St. Mary's Medical Center	476	$306,137	$223,834
St. Lukes Medical Center	364	$452,179	$336,234
Froedtert Memorial Lutheran Hospital	341	$322,803	$226,748
Meriter Hospital, Inc.	297	$241,887	$192,973
St. Marys Hospital	283	$179,355	$116,847
Children's Hospital of Wisconsin	213	$94,294	$73,793
Aurora Sinai Medical Center	176	$148,440	$99,529
Waukesha Memorial Hospital	175	$132,226	$94,666
Subtotal	6,560	$3,891,051	$2,979,763
Other	4,991	$4,963,290	$3,687,368
TOTAL	**11,551**	**$8,854,341**	**$6,667,131**

OUTPATIENT SERVICES AND PAYMENTS BY SERVICE CATEGORY

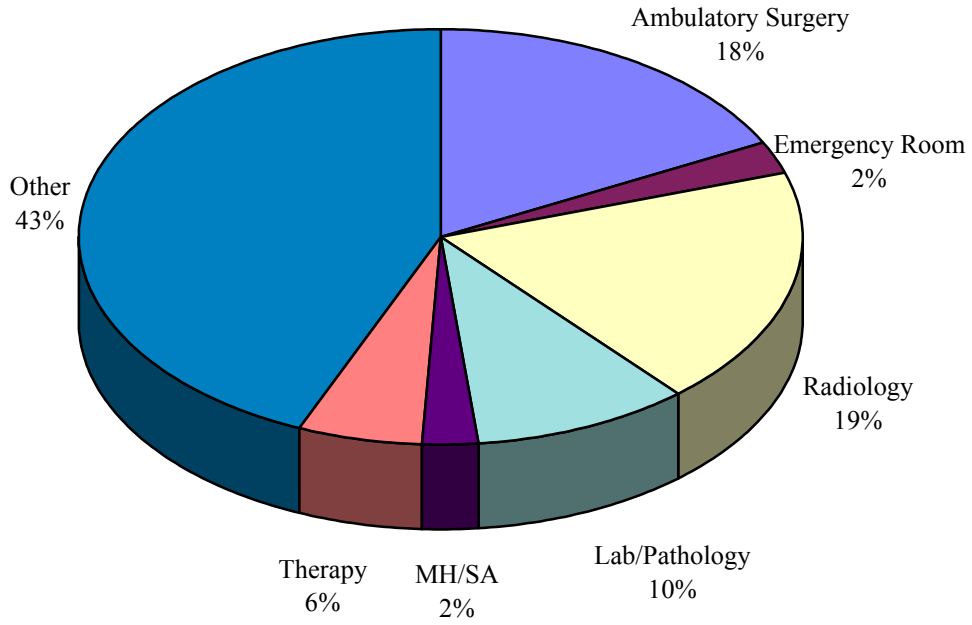
The Outpatient Services and Payments by Service Category graphs show the distribution of payments and services by Service Category. A breakdown of the top service categories are described in more detail on the following pages.

- The majority (54%) of the outpatient services were included in the Other category. These services accumulated 43% of the payments. This category included services such as screenings, routine medical exams, rehabilitation and immunizations.
- While representing only 7% of the outpatient services, Ambulatory Surgery accounted for 18% of the outpatient payments.
- Six percent of the services were associated with Radiology. These services generated 19% of the outpatient payments.
- Lab/Pathology services accounted for 21% of the total services provided. These services generated 10% of the payments.

State of Wisconsin - Employees
OUTPATIENT SERVICE DISTRIBUTION
By Service Category



OUTPATIENT PAYMENT DISTRIBUTION
By Service Category



OUTPATIENT OTHER CATEGORY DIAGNOSES BY PAYMENTS

The Outpatient Other Category Diagnoses by payments table lists the top ten diagnoses found in the Other service category. The Other category includes services for observation and treatment rooms for exams, nursing staff services, consultations, second and third opinions, and screenings.

- The average payment per service in the Other category was $50.
- Eight percent of the services and payments in the Other category were for treatment of chronic renal failure.
- Chemotherapy encounters accounted for 4% of the services in the Other category and 6% of the payments. The average payment per service was $69.
- The average payment per service for treatment of rheumatoid arthritis was $91.

State of Wisconsin - Employees
OUTPATIENT OTHER CATEGORY DIAGNOSES
By Payments

Diagnosis	Charges	Payments	Services	Avg. Paid Per Service
Chronic Renal Failure	$203,673	$178,740	3,841	$47
Chemotherapy	$144,631	$133,019	1,916	$69
Rheumatoid Arthritis	$78,342	$72,089	794	$91
Malignant Neoplasm of Breast	$53,592	$44,156	455	$97
Multiple Sclerosis	$39,684	$36,204	1,408	$26
Colon Cancer Screening	$44,721	$31,692	480	$66
Dislocation of the Knee	$32,810	$27,359	450	$61
Malignant Neoplasm of Lung	$21,326	$19,850	491	$40
Breast Carcinoma	$15,072	$13,650	531	$26
Renal Dialysis	$14,796	$6,381	3,046	$2
Subtotal	$648,647	$563,141	13,412	$42
Other	$2,247,131	$1,728,885	32,260	$54
TOTAL	**$2,895,778**	**$2,292,026**	**45,672**	**$50**

OUTPATIENT AMBULATORY SURGERY DIAGNOSES BY PAYMENTS

The Outpatient Ambulatory Surgery Category Diagnoses by payments table lists the top ten diagnoses found in the Ambulatory Surgery service category. This includes services associated with outpatient operations, topical anesthesia, and uncomplicated follow up care.

- The overall average payment per Ambulatory Surgery service was $227.
- Ambulatory surgery services associated with colon cancer screening diagnoses accumulated 6% of the services and payments. The average payment per service was $251.
- Breast carcinoma diagnoses represented 4% of the services in the Ambulatory Surgery category.

State of Wisconsin - Employees
OUTPATIENT AMBULATORY SURGERY DIAGNOSES
By Payments

Diagnosis	Charges	Payments	Services	Avg. Paid Per Service
Colon Cancer Screening	$116,944	$93,137	323	$288
Dislocation of the Knee	$26,413	$85,920	164	$524
Fracture of the Lower Ulna	$7,502	$57,395	173	$332
Breast Carcinoma	$23,168	$45,547	220	$207
Displacement of Lumbar Intervertebral Disc	$11,260	$43,137	118	$366
Mitral Valve Disorders	$11,233	$41,023	127	$323
Malignant Neoplasm Of Breast	$9,465	$36,417	171	$213
Internal Derangement of the Knee	$5,780	$26,995	118	$229
Skin Lipoma	$4,107	$20,561	123	$167
Anal Fistula	$3,818	$20,113	122	$165
Subtotal	$219,689	$470,245	1,659	$283
Other	$1,602,908	$837,885	11,880	$71
TOTAL	**$1,822,597**	**$1,308,130**	**13,539**	**$97**

OUTPATIENT RADIOLOGY CATEGORY DIAGNOSES BY PAYMENTS

The Outpatient Radiology Category Diagnoses by payments table lists the top ten diagnoses found in the Radiology service category. This includes services associated with X-rays, ultrasounds, and Magnetic Resonance Imaging (MRI).

- The average payment per Radiology service was $341.
- The general diagnosis of radiology encounters accounted for 5% of the services in this category and 7% of the payments. These services resulted in an average payment per service of $453.
- Malignant neoplasm of the breast accounted or 138 services in this category and $64,962 in payments.
- Mammograms accounted for the largest percentage (14%) of services in the Radiology outpatient category. The average payment per service was $66.

State of Wisconsin - Employees
OUTPATIENT RADIOLOGY CATEGORY DIAGNOSES
By Payments

Diagnosis	Charges	Payments	Services	Avg. Paid Per Service
Radiology Encounter	$117,443	$113,593	251	$453
Malignant Neoplasm of Breast	$79,139	$64,962	138	$471
Mammogram	$74,646	$45,890	692	$66
Malignant Neoplasm of Lung	$54,954	$32,245	78	$413
Follow Up Exam	$37,839	$31,984	100	$320
Abdominal Pain	$38,268	$28,626	52	$551
Chest Pain	$36,647	$28,147	84	$335
Malignant Neoplasm of Respiratory Organ	$32,375	$26,256	50	$525
Joint Pain	$21,698	$15,966	58	$275
Malignant Neoplasm of Prostate	$26,702	$3,524	76	$46
Subtotal	$519,710	$391,192	1,579	$248
Other	$1,672,405	$1,263,362	3,270	$386
TOTAL	**$2,192,115**	**$1,654,554**	**4,849**	**$341**

EMERGENCY ROOM UTILIZATION SUMMARY

The Emergency Room Utilization Summary table lists visits, charges, and payments by each emergency provider.

Review of the emergency room utilization reveals:

- State of Wisconsin Employees members experienced 783 emergency room visits during the period. This equates to a rate of 148.5 visits per 1,000. This rate is almost equal to the BCBSWI normative rate of 149.7.
- Thirty-nine percent of the emergency room visits and 43% of the payments were experienced at the ten facilities listed on the table.
- The average payment per visit at University Hospitals was $1,041. A member with a diagnosis of respiratory neoplasm incurred a visit to this facility totaling $17,380.
- Columbia Hospital received 7% of the emergency room visits and 6% of the payments.

State of Wisconsin - Employees
EMERGENCY ROOM UTILIZATION SUMMARY

Facility	Total Visits	Total Charges	Total Payments	Avg. Paid Per Visit
University Hospitals	59	$75,609	$61,431	$1,041
Columbia Hospital	56	$43,117	$30,486	$544
Meriter Hospital	45	$37,086	$29,473	$655
All Saints - St. Mary's Medical Center	27	$22,677	$15,448	$572
St. Mary's Hospital - Ozaukee	23	$24,501	$15,394	$669
Kenosha Hospital	21	$19,438	$12,338	$588
St. Mary's Hospital	21	$23,544	$15,037	$716
Bay Area Medical Center	20	$16,350	$15,627	$781
Mercy Medical Center	17	$10,811	$9,028	$531
St. Mary's Hospital Medical Center	15	$8,312	$6,749	$450
Subtotal	304	$281,445	$211,012	$694
Other Facilities	479	$406,221	$283,618	$592
TOTAL	**783**	**$687,666**	**$494,630**	**$632**

EMERGENCY ROOM VISITS BY DIAGNOSIS

The Emergency Room Visits by Diagnosis table provides a visual display of the distribution of visits by a variety of diagnoses. Many of the diagnoses listed in this table may have been more appropriately treated at an office/clinic setting or at home with self-care.

Review of the data indicates:

- Seven percent of the total outpatient payments were for emergency room visits. The average payment per visit was $632. The average BCBSWI normative payment per visit was $368.

- There were 66 visits that were classified as ill-defined conditions. Abdominal pain accounted for 17% of the visits in this category and 22% of the payments. Also included were visits for fever, blackouts, and nausea.

- The average payment per visit for diseases of the heart diagnoses was $1,572. Chest pain accounted for 64% of the visits in this category and 78% of the payments.

State of Wisconsin - Employees
EMERGENCY ROOM VISITS BY DIAGNOSIS

Diagnosis Category	Total Visits	Total Charges	Total Payments	Avg. Paid Per Visit
Ill-defined conditions	66	$86,280	$58,660	$889
Contusions	63	$33,006	$22,948	$364
Open Wounds	54	$25,832	$14,246	$264
Sprains & strains	52	$30,430	$20,668	$397
Respiratory Infections	50	$17,397	$12,220	$244
Diseases of the Heart	39	$80,311	$61,313	$1,572
Headaches	36	$38,099	$27,053	$751
Diseases of the Urniary System	33	$34,350	$26,925	$816
Back Disorders	29	$23,710	$15,556	$536
Fractures	26	$25,519	$19,735	$759
Subtotal	448	$394,933	$279,324	$623
Other	335	$292,734	$215,306	$643
TOTAL	**783**	**$687,666**	**$494,630**	**$632**

ER Payments as a Percentage of the Total Outpatient Payments = 7%


PROFESSIONAL

PROFESSIONAL PAYMENTS BY DISEASE CATEGORY

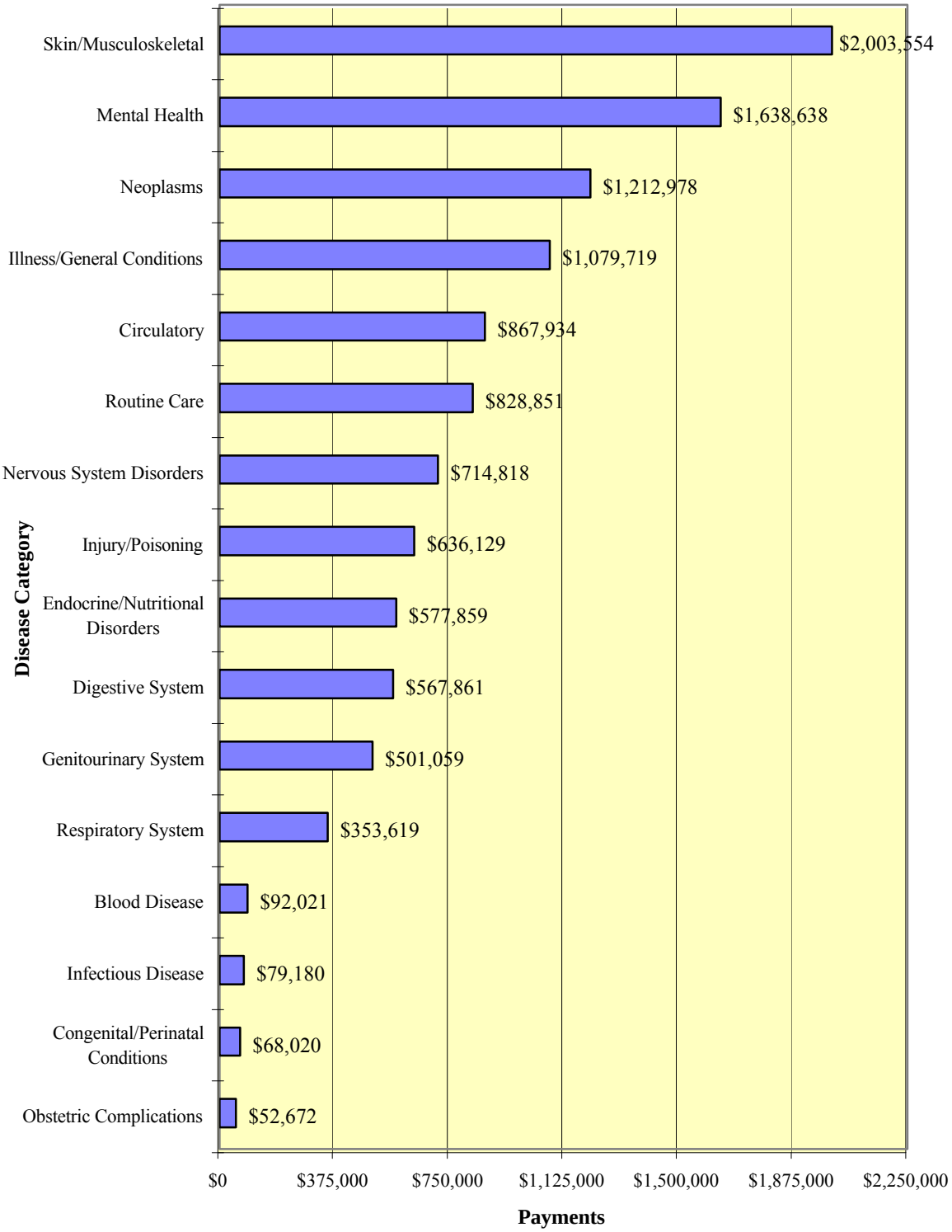
The Professional Payments By Disease Category graph provides a visual display of the type of professional treatment by disease category sorted by payments. Disease categories are determined based on the ICD-9 code associated with the claim.

Professional payments include payments for services performed and billed by licensed practitioners such as: surgeons, podiatrists, dentists, optometrists, or chiropractors. Professional services include services prescribed by a physician for drugs, durable medical equipment, lab, X-ray, therapy, etc.

Review of the data indicated:

- Skin/Musculoskeletal disorders were responsible for 18% of the professional payments.
- Fifteen percent of the payments were the result of Mental Health/Substance Abuse visits. The BCBSWI normative population experienced 5% of their professional payments on Mental Health/Substance Abuse visits.
- Neoplasm diagnoses accounted for 11% of the payments. Some of the more commonly treated diagnoses in this category included breast cancer, colon cancer, lymphoma, and lung cancer.

State of Wisconsin - Employees
PROFESSIONAL PAYMENTS BY DISEASE CATEGORY
Payment Distribution



Total Payments = $11,274,913

PROFESSIONAL SPECIALTIES BY VISITS

The Professional Specialties By Visits table summarizes professional services by frequently utilized providers. This table provides you with an insight into the types of professional services being used by your members.

Data reported by professional specialty during the reporting period revealed:

- State of Wisconsin Employees experienced 58,007 professional visits. This equated to a rate of 11,002.8 visits per 1,000 members. The BCBSWI normative population incurred a rate of 7,631.7 visits per 1,000.
- The average payment per visit was $194.
- The ten provider types listed on the table accounted for 53% of the visits provided and 42% of the professional payments.
- Twelve percent of the visits and 8% of the payments were for services provided by Internal Medicine specialists.
- Psychiatry/Psychology providers received 11% of the visits. These visits accumulated 10% of the professional payments.
- The average payment per visits at Cardiology specialists was $460.
- Forty-seven percent of the professional visits were experienced at providers in the Other category. Some of the providers in that category included: Radiologists, Ophthalmologists, Anesthesiologists and General Surgeons.

State of Wisconsin - Employees
PROFESSIONAL SPECIALTIES BY VISITS

Specialty	Total Visits	Total Charges	Total Payments	% of Professional Payments
Internal Medicine	7,087	$1,487,343	$933,749	8%
Psychiatry/Psychology	6,279	$1,498,826	$1,159,290	10%
Chiropractor	4,640	$470,260	$308,162	3%
Family Practice	4,638	$725,072	$422,614	4%
Dermatology	1,547	$340,735	$210,735	2%
Peidatric	1,546	$230,812	$131,517	1%
Orthopedic Surgery	1,435	$925,036	$611,011	5%
Obstetrics/Gynecology	1,373	$422,393	$254,846	2%
Cardiology	1,203	$838,655	$552,901	5%
General Practice	1,067	$210,626	$144,937	1%
Subtotal	30,815	$7,149,758	$4,729,762	42%
Other	27,192	$9,918,587	$6,545,151	58%
TOTAL	**58,007**	**$17,068,345**	**$11,274,913**	**100%**


WISCONSIN PUBLIC
EMPLOYEES

WISCONSIN PUBLIC EMPLOYEES OVERVIEW

This segment of the report provides a compilation of data for the Wisconsin Public Employees (WPE) consisting of all non-Medicare Employees, their spouses and dependents.

There was an average of 688 non-Medicare members in the WPE segment. The average age of the population was 42.8 years old. Employees represented 51% of the total population.

Total payments for inpatient, outpatient and professional services were $3,810,802. The average payment per member per month was $461. Twenty-four percent of the total payments were the result of Circulatory diagnoses.

Members of WPE experienced 67 admissions during the 12-month period. The average payment per admission was $28,203. Circulatory disorders accounted for 17 admissions and 41% of the inpatient payments. Twenty-one of the total admissions were the result of high cost admissions (payments of $20,000 or more). These admissions represented 77% of the payments.

Outpatient payments totaled $1,051,849. Twenty-one percent of the payments were the result of Genitourinary System diagnoses. Sixty-one percent of the payments were for treatment of chronic renal failure.

Members of WPE experienced a rate of 210.8 emergency room visits per 1,000. These visits represented 12% of the total outpatient visits.

During the period, members experienced 7,383 professional visits. These visits accumulated $1,657,276 in payments. Skin/Musculoskeletal disorders accumulated 20% of the total payments. Cardiologists generated 6% of the total professional payments.

PAYMENT SUMMARY AND MEMBERSHIP DISTRIBUTION

The Payment Summary table provides general information pertaining to Medicare and non-Medicare members of the Wisconsin Public Employees (WPE).

Specifically, this table reflects total facility and professional charges and payments incurred in inpatient, outpatient and professional settings. A more detailed analysis of non-Medicare inpatient, outpatient, and professional utilization is provided in the sections of this report dedicated exclusively to those areas.

During the 12-month report period outlined:

- Members of WPE incurred services totaling $13,374,684 in charges. Payments for the services represented 48% of the total charges.
- Inpatient and outpatient facility payments, combined, accounted for 49% of the total.
- Professional care generated 29% of the total payments.
- Pharmacy, Skilled Nursing Facilities and Rehabilitation Centers received 22% of the WPE total payments during the report period.

The membership distribution revealed:

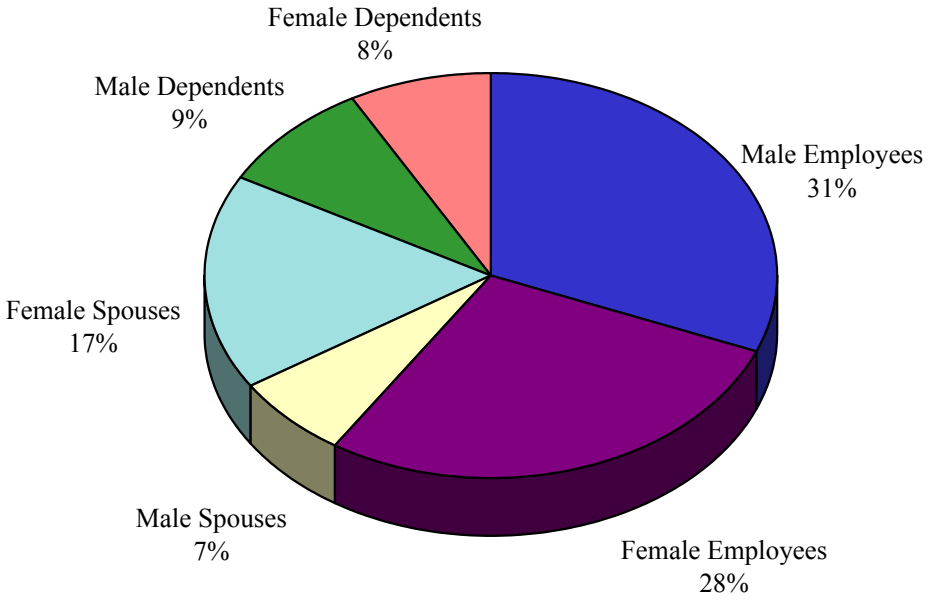
- There were a total of 1,001 members. Non-Medicare members accounted for 69% of the members.
- The average age of the Medicare and non-Medicare members was 52.6 years.
- Employees represented 59% of the total population – 31% males and 28% females.
- Twenty-four percent of the members were spouses.
- The remaining 17% of the members were dependents.

The remaining tables in this report reflect only non-Medicare costs and utilization.

State of Wisconsin - Public Employees
Medicare & Non-Medicare
PAYMENT SUMMARY
Incurred: January 1, 2003 - December 31, 2003
Paid: January 1, 2003 - March 31, 2004

	Total Charges	Total Payments
Inpatient:	$4,022,838	$1,977,248
Outpatient:	$2,544,861	$1,173,593
Professional:	$4,482,043	$1,861,839
Other:	$2,324,941	$1,446,960
Total:	**$13,374,684**	**$6,459,640**
Average PMPM:	$1,113	$538

Membership Distribution



Total Membership:	1,001
Average Age of Membership:	52.6

MEMBERSHIP AND PAYMENT DISTRIBUTION BY GENDER/RELATIONSHIP

Membership Distribution

The Membership Distribution provides a breakout of the membership distribution by relationship classification for WPE.

The membership distribution for WPE revealed:

- There was an average of 688 members during 2003. The average age of the population was 42.8 years.
- Employees represented 51% of the total membership.
- Twenty-four percent of the members were spouses.
- The remaining 25% of the population were dependents.

Payment Distribution by Gender/Relationship

The Payment Distribution by Gender/Relationship graph provides a visual comparison of payment distribution by gender and relationship classification for WPE membership. This allows you to determine how much of your total payments were allocated to each of the six gender/relationship categories.

- The largest portion (48%) of the payments was experienced by employees – 30% by males and 18% by females.
- Spouses generated 42% of the total payments.
- The smallest portion of payments was incurred by dependents at 10% of the total.

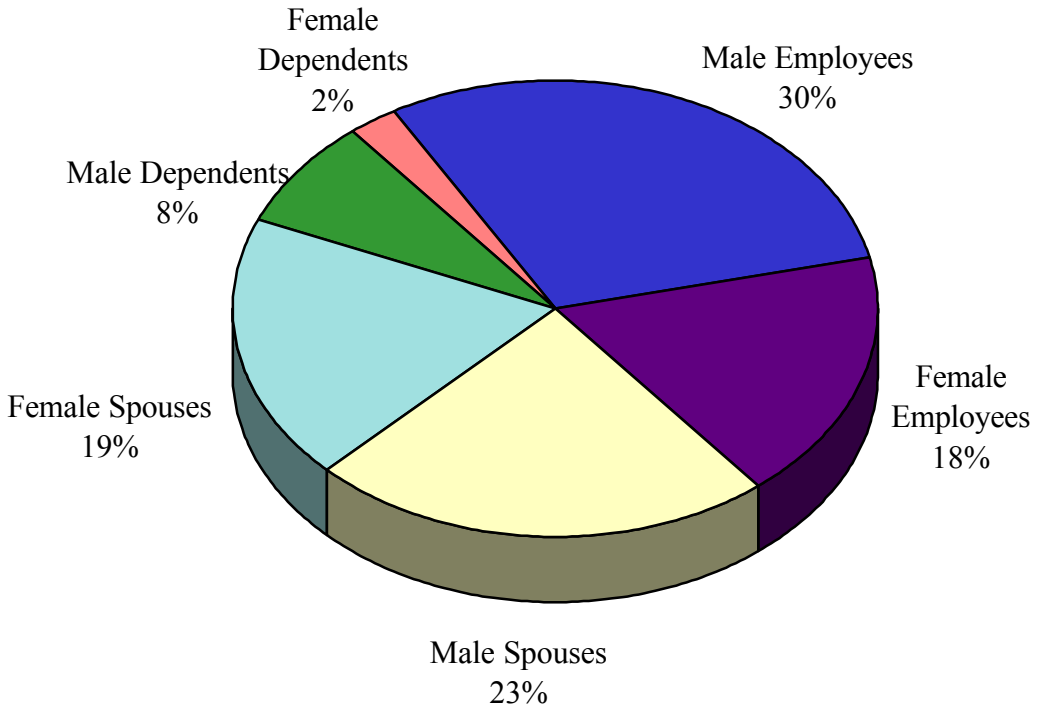
State of Wisconsin - Public Employees
MEMBERSHIP & PAYMENT DISTRIBUTION
By Gender/Relationship

Total Membership

Employees:	352
Spouses:	165
Dependents:	171
Total:	**688**

Average Age of Membership: 42.8

Payment Distribution



TOTAL PAYMENTS BY DISEASE CATEGORY

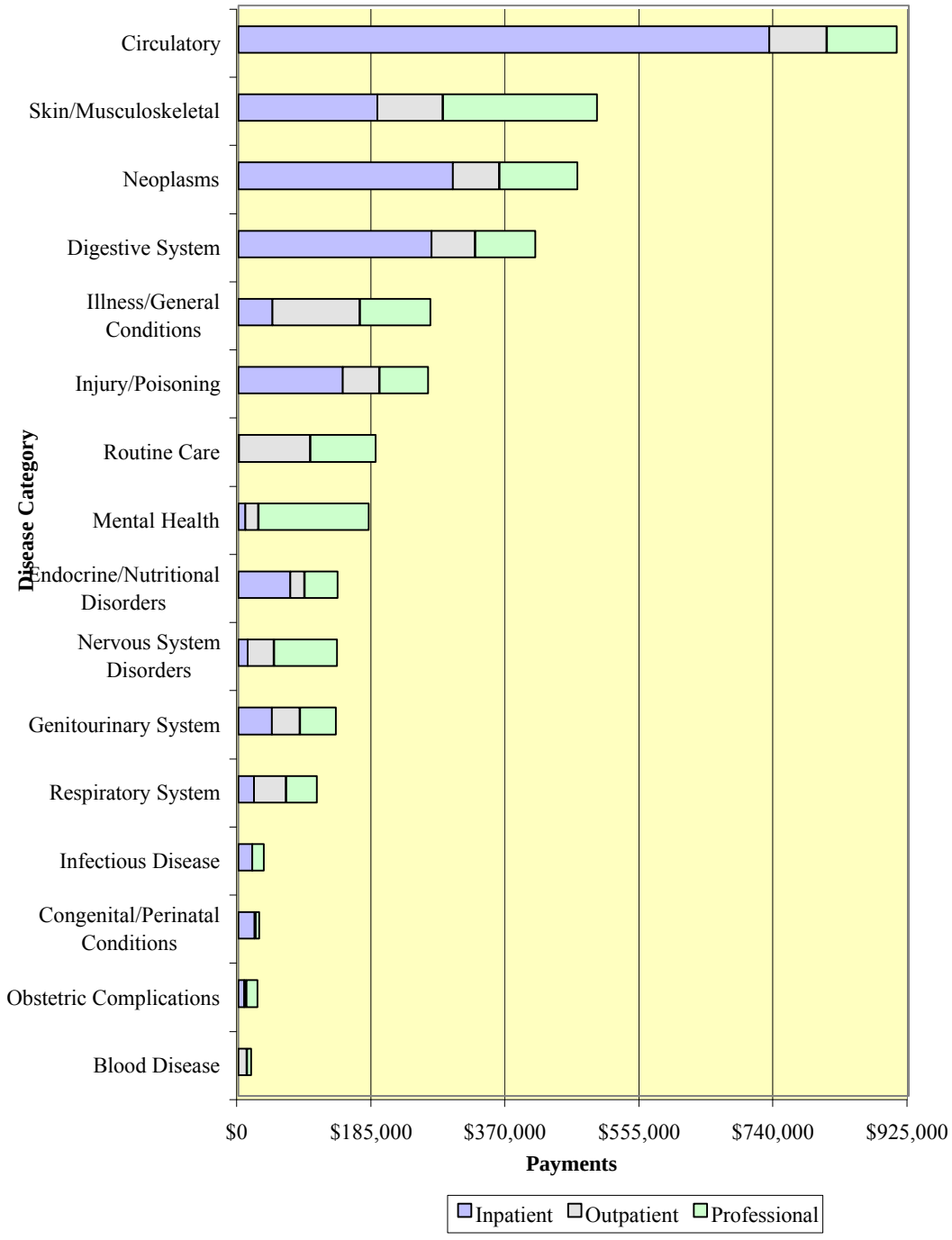
The Total Payments by Disease Category graph offers a visual account of total payment distribution by a variety of disease categories. This table reflects total facility and professional payments incurred in the inpatient, outpatient, and professional settings.

Review of the payment distribution graph indicates:

- Twenty-four percent of the total payments were the result of Circulatory diagnoses. Inpatient payments were responsible for 81% of the payments in this disease category.
- Skin/Musculoskeletal disorders accumulated 13% of the total WPE payments. Professional services generated 43% of the payments in this category.
- Diagnoses associated with Neoplasm accounted for 12% of the $3,810,802 in payments.

State of Wisconsin - Public Employees
TOTAL PAYMENTS BY DISEASE CATEGORY

Payment Distribution



Total Payments = $3,810,802


INPATIENT

INPATIENT ADMISSION SUMMARY

The Inpatient Admission Summary table outlines facility charges and payments by type of admission. Inpatient charges include hospital services such as room accommodations, equipment, medication, and supplies (except take-home) that are rendered to a patient during a hospital stay.

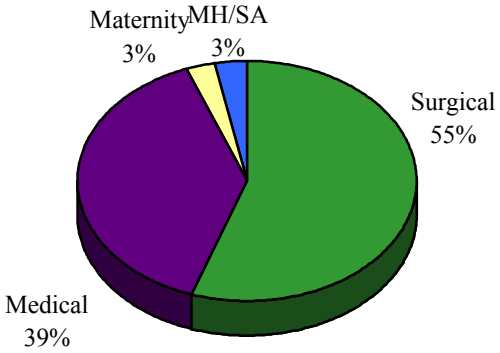
According to the inpatient experience:

- The 37 Surgical admissions accumulated 83% of the total payments. The three most costly admissions experienced during the period were Surgical admissions, accumulating 48% of the Surgical payments. Four of the Surgical admissions were craniotomy procedures totaling $113,958 in payments.
- There were 26 Medical admissions experienced. Payments for these admissions totaled $295,731. Three of the admissions were for treatment of cardiac arrhythmia totaling $29,101 in payments. There was one Medical admission for treatment of heart failure resulting in eight inpatient days and $33,855 in payments.
- There were two Mental Health/Substance Abuse admissions resulting in a five-day average length of stay.

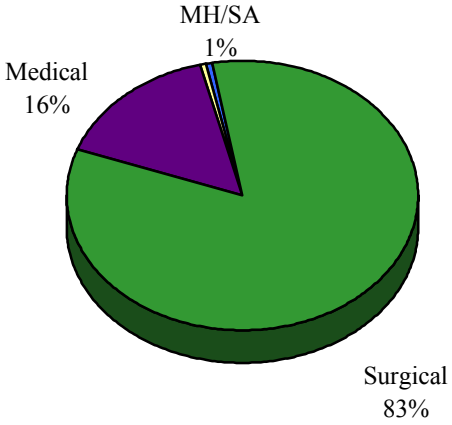
State of Wisconsin - Public Employees
INPATIENT ADMISSION SUMMARY

Type of Admission	Total Admits	Total Days	Length of Stay	Charges	Payments
Surgical	37	321	8.7	$1,843,165	$1,575,389
Medical	26	93	3.6	$332,300	$295,731
Mental Health/Substance Abuse	2	10	5.0	$15,985	$9,833
Maternity	2	8	4.0	$10,638	$8,649
Total	**67**	**432**	**6.4**	**$2,202,088**	**$1,889,602**

Admission Summary
By Number of Admissions



Admission Summary
By Payments



ADMISSION DISTRIBUTION

Admissions by Gender/Relationship

The Admissions by Gender/Relationship graph offers a visual comparison of admissions by gender/relationship within your total membership.

According to data reported during the incurred period:

- Thirty of the 67 admissions were experienced by employees. Male employees incurred 70% of the employee admissions.
- Spouses accounted for 39% of the total admissions.
- Dependents accounted for 16% of the admissions. Seven of the 11 dependent admissions were experienced by male members between the ages of 15 and 19.

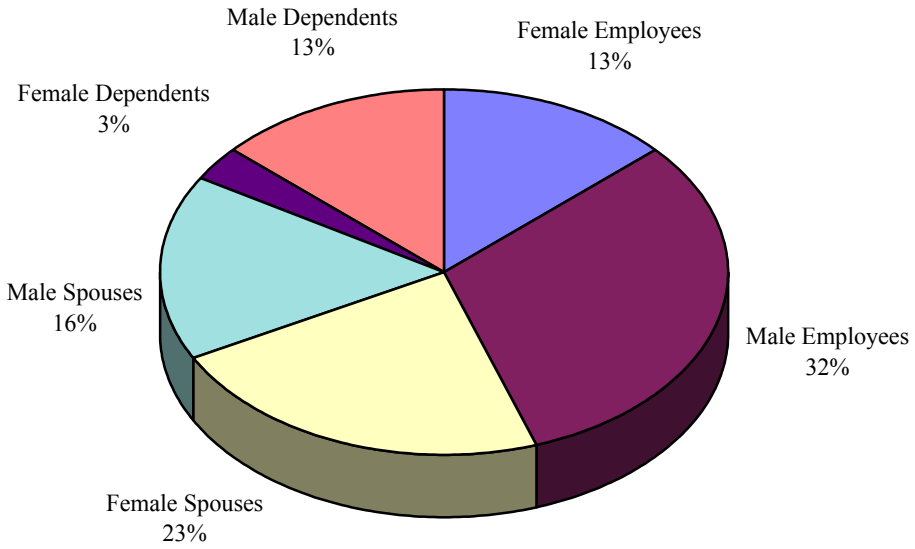
Admission Rate Per 1,000 by Age Category

The Admission Rate per 1,000 by Age Category graph represents admissions occurring per age group. The admission information reported in this table has been converted to per 1,000 rates in order to allow accurate comparisons to normative data. A "per 1,000" rate measures how often a particular event is likely to occur within any given population of 1,000 people.

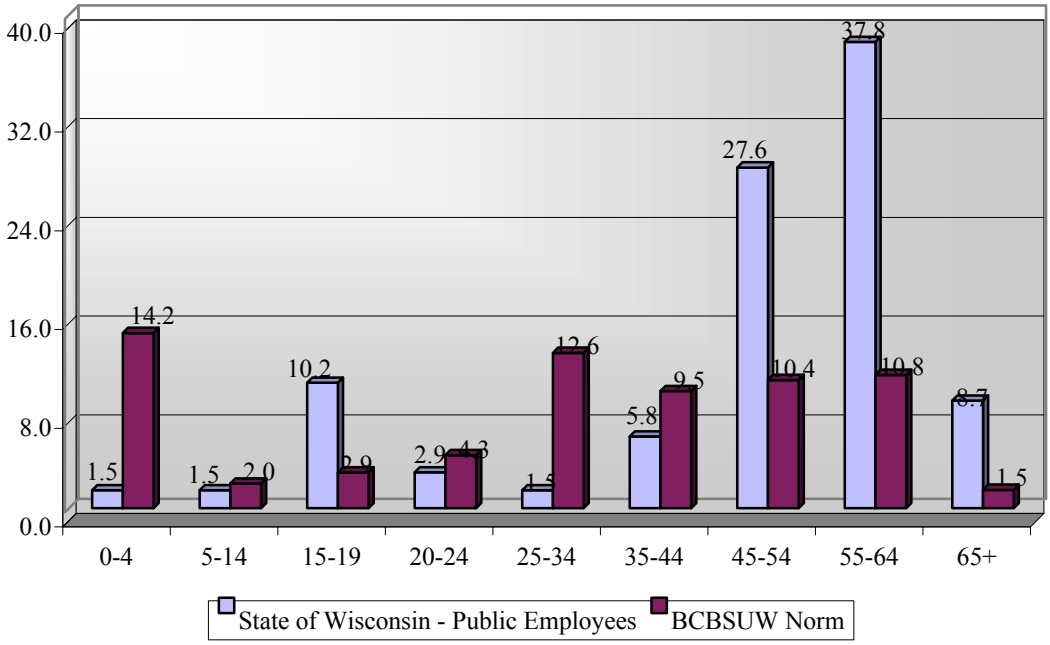
- Dependents between the ages of 15 and 19 experienced seven admissions during the period resulting in a rate of 10.2 admissions per 1,000 members. Three of the admissions were experienced by the same member for treatment of seizures and headaches.
- WPE members between the ages of 45 and 54 incurred a rate of 27.6 admissions per 1,000 members. Sixty-eight percent of the admissions were by employees.
- The largest portion (39%) of the admissions was experienced by members between the ages of 55 and 64. Seventy-three percent of the admissions in this age category were incurred by males.

State of Wisconsin - Public Employees
ADMISSION DISTRIBUTION
By Gender/Relationship and Age Category

Admissions by Gender/Relationship



Admission Rate per 1,000 by Age Category



COMPARISON WITH BCBSWI

The Comparison with BCBSWI table allows a comparative analysis of your specific group data to the BCBSWI normative data.

Comparisons between WPE and BCBSWI reveal:

- The overall average charge per admission for the 64 admissions was $32,867. The average charge per day was $5,097.
- The average payment per admission was $28,203. This average was negatively influenced by two admissions accumulating over $200,000 each. Combined the two admissions totaled $597,312 in payments.
- Surgical admissions resulted in the highest average charge per admission at $49,815. The average payment per admission was $42,578. The most costly admission experienced during the period was a Surgical procedure totaling $393,501 in payments.
- The Medical average payment per admission was $11,374 – 87% higher than the BCBSWI normative average.

State of Wisconsin - Public Employees
COMPARISON WITH BC&BSUW

Charge Per Admission

	Wisconsin Public Employees	BC&BSUW Normative
Surgical	$49,815	$21,911
Medical	$12,781	$8,198
Mental Health/Substance Abuse	$7,992	$4,095
Maternity	$5,319	$4,785
Average Charge Per Admission	$32,867	$11,000
Average Charge Per Day	$5,097	$3,171

Payment Per Admission

	Wisconsin Public Employees	BC&BSUW Normative
Surgical	$42,578	$16,312
Medical	$11,374	$6,094
Mental Health/Substance Abuse	$4,917	$3,603
Maternity	$4,324	$3,419
Average Payment Per Admission	$28,203	$8,091
Average Payment Per Day	$4,374	$2,333

INPATIENT UTILIZATION COMPARISON

The Inpatient Utilization Comparison graphs provide a visual comparison of WPE admissions per 1,000 members, inpatient days per 1,000, and average length of stay to normative data for BCBSWI.

Admissions per 1,000 Members

- The 67 admissions resulted in a rate of 97.4 admissions per 1,000. This rate exceeded the BCBSWI normative rate by 42%.
- Members of WPE incurred a rate of 53.8 Surgical admissions per 1,000. This is 156% higher than the BCBSWI normative rate.
- The rate of Medical admissions per 1,000 of 37.8 was 109% higher than the normative rate.

Days per 1,000 Members

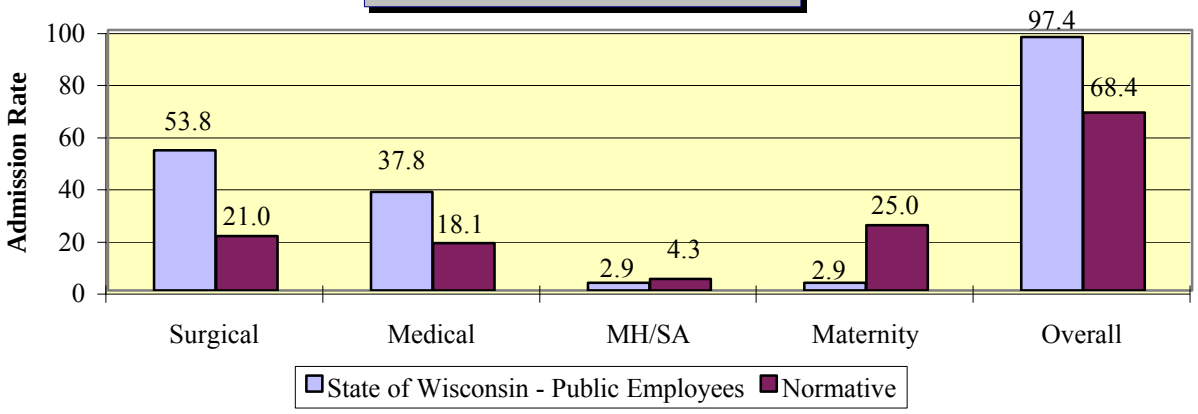
- Members of WPE experienced a rate of 627.9 inpatient days per 1,000. This was strongly influenced by the three most costly admissions totaling 198 inpatient days.
- Seventy-four percent of the total days were for Surgical admissions. The 37 Surgical admissions resulted in 466.6 days per 1,000. Removing the three most costly admissions from the Surgical admissions would reduce the Surgical rate to 178.8 days and the overall average days per 1,000 to 340.1.

Average Length of Stay

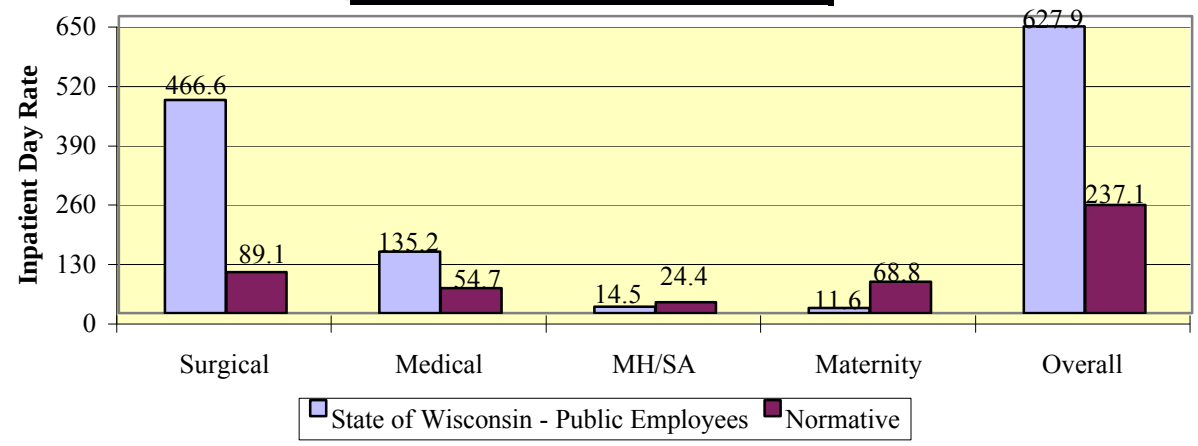
- The overall average length of stay for the 67 admissions was 6.4 days.
- The lengthiest admission type was Surgical at 8.7 days. By removing the three lengthy Surgical admissions mentioned above, the Surgical and overall average length of stay falls to 3.6 days.

State of Wisconsin - Public Employees
INPATIENT UTILIZATION COMPARISON

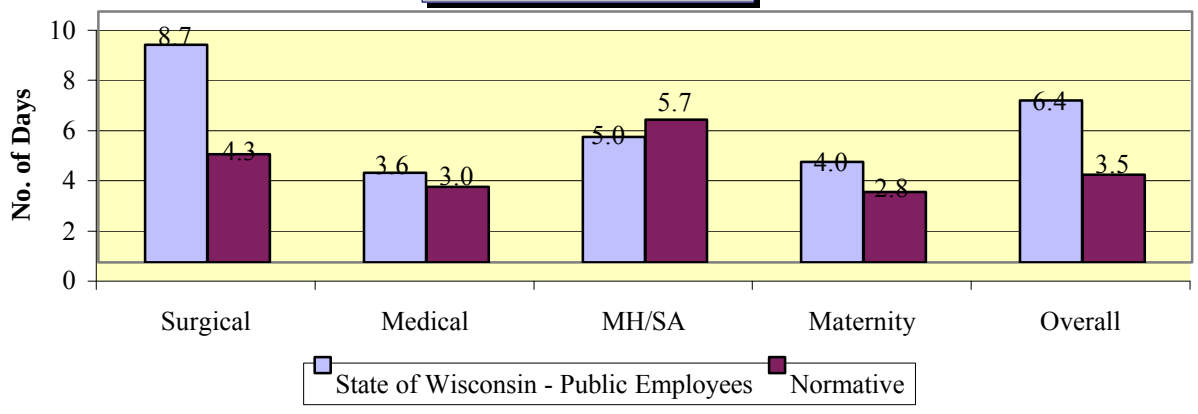
Admissions per 1,000 Members



Inpatient Days per 1,000 Members



Average Length of Stay



ADMISSIONS AND INPATIENT PAYMENTS BY MAJOR DIAGNOSTIC CATEGORY

The Distribution of Admissions and Inpatient Payments by Major Diagnostic Category graph offers a visual account of admission and payment distribution by specific diagnostic categories.

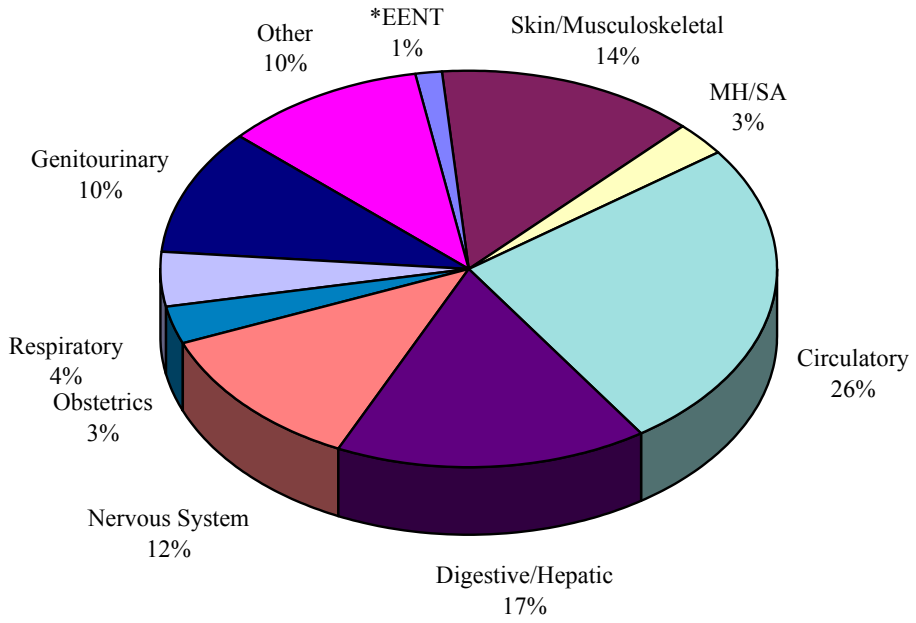
During the incurred period:

- Circulatory disorders accounted for 17 of 67 admissions. Payments for these admissions represented 41% of the total. The most costly admission experienced during the period was a coronary bypass procedure totaling $393,501 in payments – 51% of the major diagnostic category's payments.

- Seventeen percent of the admission and 24% of the payments were the result of Digestive/Hepatic disorders. The second most costly admission incurred was an admission for treatment of a digestive system diagnosis. This admission represented 44% of the category's payments. Two of the admissions were for stomach procedures totaling $167,003 in payments.

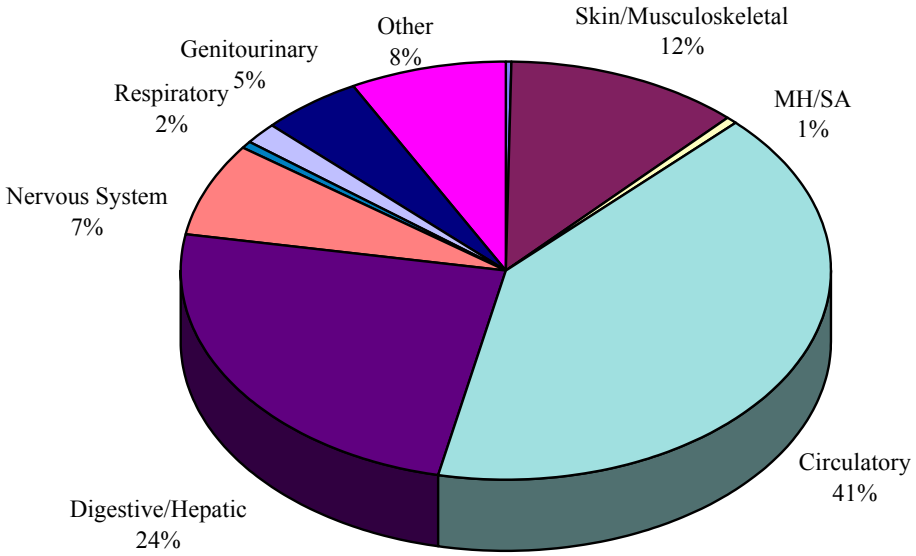
- Skin/Musculoskeletal disorders were responsible for 14% of the admissions and 12% of the payments. Major joint reconstruction procedures accounted for two of the 9 admissions in this category. An additional two admissions were for spinal fusion procedures.

State of Wisconsin - Public Employees
ADMISSION DISTRIBUTION
By Major Diagnostic Category



Total Admissions = 67

PAYMENT DISTRIBUTION
By Major Diagnostic Category



Total Payments = $1,889,602

*EENT includes eye, ear, nose and throat

SUMMARY OF MOST FREQUENTLY UTILIZED INPATIENT FACILITIES

The Utilization of Inpatient Facilities table provides an overview of your most frequently utilized inpatient facilities.

During the report period:

- The ten facilities listed on the table received 63% of the admissions and 77% of the payments.
- St. Luke's Medical Center, Inc. received 11 of the 67 admissions. These admissions generated 12% of the payments.
- Five admissions and 21% of the payments were experienced at St. Mary's Hospital in Rochester, Minnesota. The second and third most costly admissions were experienced at this facility. These two admissions accumulated 89% of the facility's payments.
- The most costly admission was experienced at St. Mary's Hospital Medical Center. This single admission generated 88% of the payments at this facility.

State of Wisconsin - Public Employees
SUMMARY OF MOST FREQUENTLY UTILIZED INPATIENT FACILITIES

Facility	Total Payments	Total Admits	Total Days	Avg. Paid Per Day
St. Lukes Medical Center	$227,894	11	22	$10,359
St. Marys Hospital - Rochester, MN	$401,397	5	134	$2,996
Howard Young Medical Center	$72,103	5	21	$3,433
Meriter Hospital	$73,655	4	18	$4,092
Children's HealthCare, MN	$46,616	4	8	$5,827
Sacred Heart Hospital	$47,517	3	10	$4,752
Columbia Hospital	$45,080	3	8	$5,635
Kenosha Hospital & Medical Center	$18,017	3	10	$1,802
St. Marys Hospital Medical Center	$447,253	2	105	$4,260
Catholic Healthcare	$67,815	2	8	$8,477
Subtotal	$1,447,349	42	344	$4,207
Other Facilities	$442,253	25	88	$5,026
TOTAL	**$1,889,602**	**67**	**432**	**$4,374**

HIGH COST ADMISSIONS

The High Cost Admissions table outlines single admissions with total payments of $20,000 or more.

WPE members experienced ten high cost admissions during the report period. These high cost admissions had the following impact on your experience:

- Seventy-seven percent of the total inpatient payments were the result of the 21 high cost admissions. These admissions represented 31% of the admissions experienced.
- These admissions accounted for 69% of the days. The average length of stay for the high cost admissions was 14.2 days.
- The most costly admission experienced during the period was a coronary bypass procedure that totaled $393,501 in payments – 27% of the high cost payments. The admission lasted 83 days.
- Circulatory disorders accounted for eight of the high cost admissions, generated 47% of the payments, and resulted in 37% of the days.

State of Wisconsin - Public Employees
HIGH COST ADMISSIONS

Diagnosis	Length of Stay	Payments	Average Payment Per Day	Facility
Coronary Bypass w/Cardiac Cath.	83	$393,501	$4,741	St. Mary's Hosp Med Ctr
Digestive System Diagnoses	69	$203,811	$2,954	St. Mary's Hosp - Rochester
Stomach, Esoph. & Duoden. Proc.	46	$154,117	$3,350	St. Mary's Hosp - Rochester
Spinal Fusion	4	$74,729	$18,682	St. Luke's Medical Center, Inc.
Cardiac Valve Proc. W/O Cardiac Cath.	8	$69,485	$8,686	Luther Hospital
Coronary Bypass w/ Ptca	5	$66,992	$13,398	Aurora Sinai Med Ctr
Wound Debridements	22	$53,752	$2,443	St. Mary's Hosp Med Ctr
Nutritional & Metabolic Disorder	12	$46,163	$3,847	Childrens Hospital of WI
Craniotomy	6	$45,306	$7,551	Catholic Healthcare
Coronary Atherosclerosis	1	$36,833	$36,833	St. Luke's Medical Center, Inc.
Knee Procedure	1	$35,966	$35,966	Rush Presbyterian
Cardiac Defibrillator Implant	2	$33,892	$16,946	Children's HealthCare, MN
Heart Failure	8	$33,855	$4,232	Meriter Hosptial
Digestive System Diagnoses	1	$30,172	$30,172	Meriter Hosptial
Craniotomy	2	$28,103	$14,052	Sacred Heart Hospital
Kidney Procedure	6	$27,048	$4,508	Howard Young Med Ctr
Percutaneous Cardiac Procedure	4	$26,670	$6,667	St. Luke's Hospital
Renal Failure	14	$25,782	$1,842	St. Mary's Hosp - Rochester
Craniotomy	2	$22,509	$11,255	Catholic Healthcare
Coronary Atherosclerosis	1	$22,494	$22,494	St. Luke's Medical Center, Inc.
Major Joint Reconst/Replacement	2	$20,567	$10,284	Columbia Hospital
	299	$1,451,745	$4,855	

Total High Cost Admissions = 21


OUTPATIENT

OUTPATIENT PAYMENTS BY DISEASE CATEGORY

The Outpatient Payments by Disease Category graph provides a visual display of the distribution of outpatient payments by a variety of disease categories. Disease categories are determined based on the ICD-9 code associated with the claim.

Outpatient payments include payments for hospital services, room accommodations, equipment, medication, and supplies (except take-home) that are rendered to a patient in an outpatient setting. Outpatient settings include the outpatient department in a hospital, ambulatory surgery centers, and therapy centers. This includes diagnostic X-ray and lab services rendered by a radiologist or pathologist on an outpatient basis.

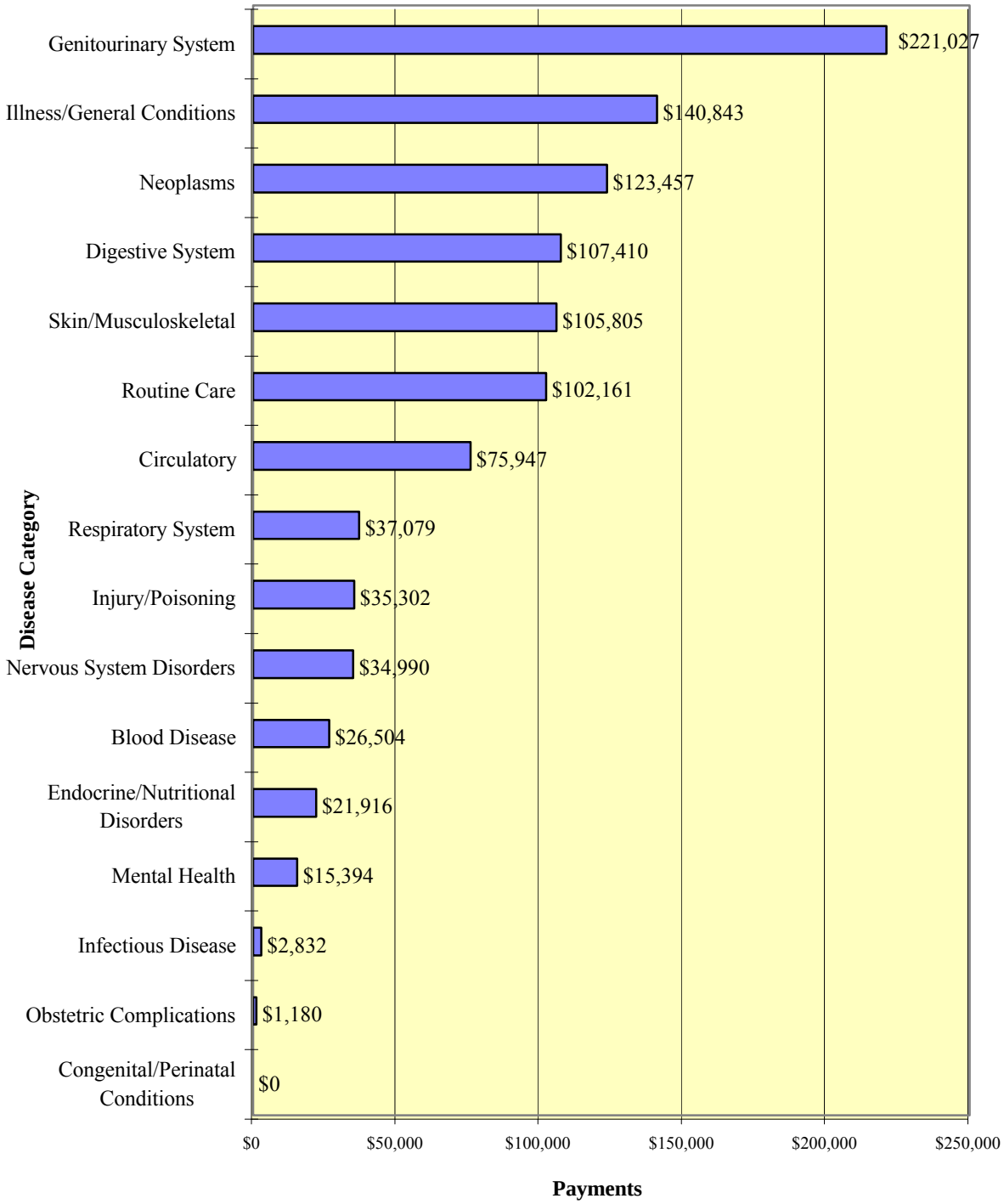
The graph reveals the following:

- Genitourinary disorders accounted for 21% of the outpatient payments. Sixty-one percent of the payments were for treatment of chronic renal failure.
- Thirteen percent of the $1,051,849 outpatient payments were the result of Illness/General Conditions. These visits included diagnoses associated with abdominal pain, chest pain, and respiratory abnormalities.
- Neoplasm diagnoses accounted for 12% of the total payments. Treatment for bone marrow cancer represented 29% of the payments in this category. Also included was treatment of colon and ovarian cancer.

State of Wisconsin - Public Employees

OUTPATIENT PAYMENTS BY DISEASE CATEGORY

Payment Distribution



Total Payments = $1,051,849

OUTPATIENT VISITS BY FACILITY

The Outpatient Visits By Facility table lists the most frequently utilized outpatient facilities.

The table shows:

- Members of WPE experienced 1,187 outpatient visits during the period. This equates to a rate of 1,725.3 visits per 1,000. This exceeds the BCBSWI normative rate by 90%.

- The average payment per outpatient visit was $886. The BCBSWI normative average payment per visit was $622.

- Eleven percent of the outpatient visits were experienced at University Hospitals. Payments for these visits represented only 4% of the total outpatient payments.

- Ten percent of the visits and 12% of the payments were the result of visits to St. Luke's Medical Center. The two most costly visits to this facility were experienced by the same member for treatment of bone marrow cancer. These two visits accumulated $32,116 in payments – 25% of the facility's total payments.

State of Wisconsin - Public Employees
OUTPATIENT VISITS BY FACILITY

Facility	Total Visits	Total Charges	Total Payments
University Hospitals	134	$40,988	$38,023
St. Luke's Medical Center	120	$149,982	$125,974
Dickinson Memorial Hospital	88	$59,771	$58,576
Lakeview Medical Center, Inc.	41	$44,345	$42,792
Sacred Heart Hospital	35	$19,931	$19,527
Cumberland Memorial Hospital	32	$27,668	$22,141
Kenosha Hospital & Medical Center	26	$11,225	$9,116
Childrens Hospital of Wisconsin	25	$41,352	$37,681
West Allis Memorial Hospital	24	$9,405	$7,707
Holy Family Memorial, Inc.	23	$39,763	$35,746
Subtotal	548	$444,429	$397,283
Other	639	$788,821	$654,566
TOTAL	**1,187**	**$1,233,250**	**$1,051,849**

EMERGENCY ROOM UTILIZATION SUMMARY

The Emergency Room Utilization Summary table lists visits, charges and payments by each emergency provider.

Review of the emergency room utilization reveals:

- Members of WPE experienced 145 emergency room visits. The average payment per member per month was $886. The BCBSWI average payment per visit was $368.
- There was a total of 16 emergency room visits to Lakeview Medical Center. These visits accumulated $4,664 in payments.
- The average payment per visit at Cumberland Memorial Hospital was $2,447. A single visit for treatment of acute appendicitis accumulated 79% of the payment incurred at this facility.

State of Wisconsin - Public Employees
EMERGENCY ROOM UTILIZATION SUMMARY

Facility	Total Visits	Total Charges	Total Payments	Avg. Paid Per Visit
Lakeview Medical Center, Inc.	16	$4,759	$4,664	$291
Dickinson Memorial Hospital	11	$7,431	$7,283	$662
Kenosha Hospital & Medical Center	9	$4,239	$3,443	$383
Cumberland Memorial Hospital	6	$14,979	$14,679	$2,447
St. Mary's Medical Center	6	$5,253	$4,239	$706
Aurora Medical Center	4	$7,392	$6,283	$1,571
Sacred Heart Hospital	4	$5,082	$4,975	$1,244
Southwest Health Center	4	$4,846	$4,797	$1,199
Spooner Health System	4	$2,564	$2,509	$627
Fort Atkinson Memorial Health	4	$886	$877	$219
Subtotal	68	$57,431	$53,748	$790
Other Facilities	77	$94,017	$74,673	$970
TOTAL	**145**	**$151,447**	**$128,421**	**$886**

EMERGENCY ROOM VISITS BY DIAGNOSIS

The Emergency Room Visits by Diagnosis table provides a visual display of the distribution of visits by a variety of diagnoses. Many of the diagnoses listed in this table may have been more appropriately treated at an office/clinic setting or at home with self-care treatment.

Review of the data indicates:

- Twelve percent of the outpatient payments and visits were the result of emergency room visits.
- The ten diagnoses listed on the table accounted for 65% of the total visits and 63% of the payments.
- Ill-defined condition diagnoses accounted for 18 emergency room visits and 10% of the payments. This included visits for abdominal pain, syncope and collapse, and vomiting.
- The average payment for the seven visits associated with diseases of the urinary system was $3,496. This included visit for ureteric stones, kidney stones, and urinary tract infections. The most costly of these visits was to Mercy Medical Center totaling $13,324 for treatment of kidney stones.

State of Wisconsin - Public Employees
EMERGENCY ROOM VISITS BY DIAGNOSIS

Diagnosis Category	Total Visits	Total Charges	Total Payments	Avg. Paid Per Visit
Symptoms/Signs/Ill-Defined Cond.	18	$17,135	$13,203	$733
Open Wounds	15	$5,787	$5,044	$336
Respiratory Infections	13	$4,514	$4,152	$319
Diseases of the Heart	9	$27,865	$17,641	$1,960
Contusions	8	$4,365	$3,961	$495
Diseases of the Urinary System	7	$26,259	$24,473	$3,496
Sprains & Strains	7	$3,042	$1,758	$251
Connective Tissue Disease	6	$2,287	$2,152	$359
Ear Conditions	6	$1,230	$1,094	$182
Headaches	5	$8,045	$7,777	$1,555
Subtotal	94	$100,530	$81,255	$864
Other	51	$50,917	$47,166	$925
TOTAL	**145**	**$151,447**	**$128,421**	**$886**

ER Payments as a Percentage of the Total Outpatient Payments = 12%


PROFESSIONAL

PROFESSIONAL PAYMENTS BY DISEASE CATEGORY

The Professional Payments By Disease Category graph provides a visual display of the type of professional treatment by disease category sorted by payments. Disease categories are determined based on the ICD-9 code associated with the claim.

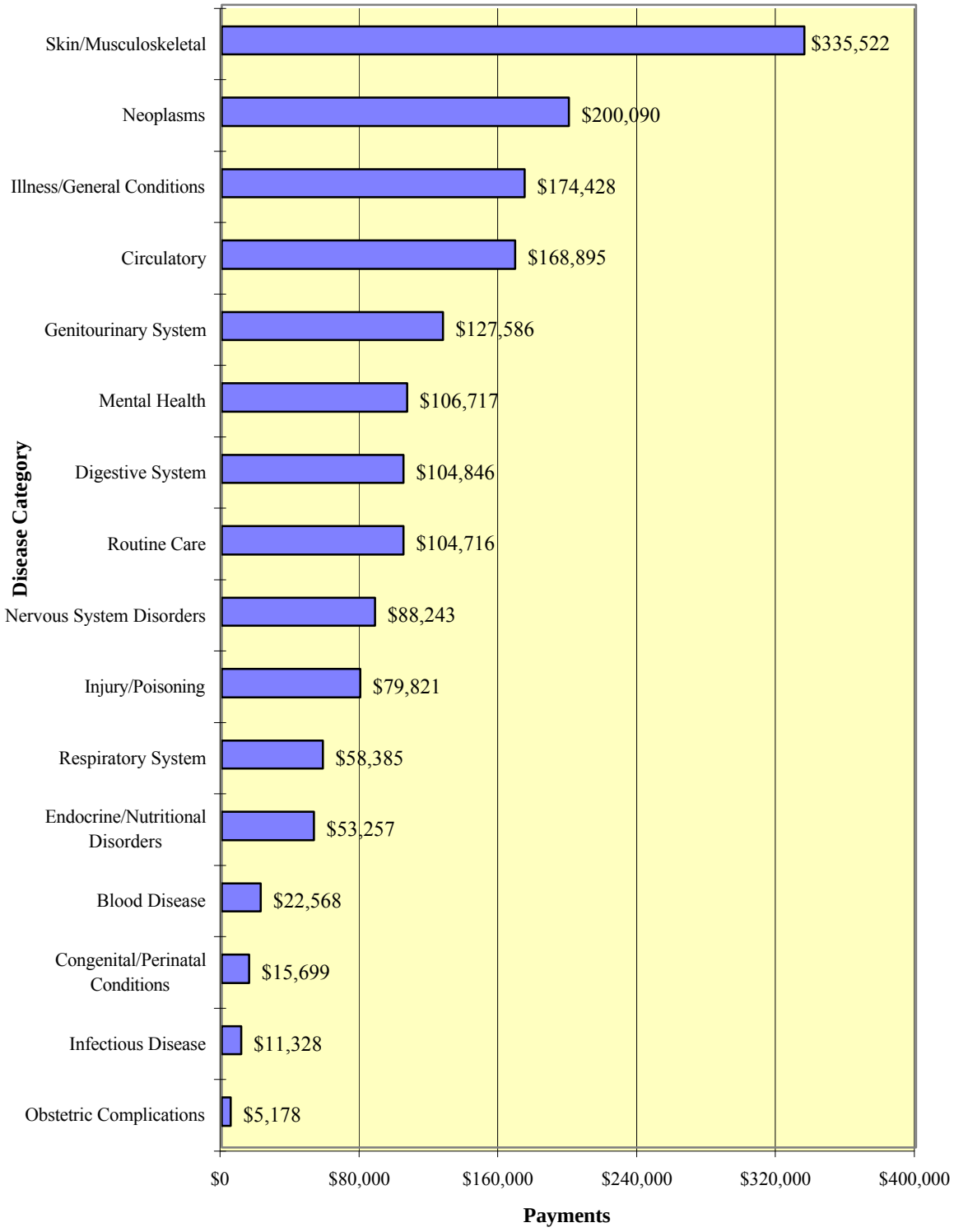
Professional payments include payments for services performed and billed by licensed practitioners such as: surgeons, podiatrists, dentists, optometrists, or chiropractors. Professional services include services prescribed by a physician for drugs, durable medical equipment, lab, X-ray, therapy, etc.

Review of the data indicated:

- Twenty percent of the professional payments were the result of Skin/Musculoskeletal disorders. Twenty-seven percent of the payments in this category were experienced with Neurosurgeon specialists. Included in this category were visits for backaches and disc displacement.

- Neoplasm diagnoses accounted for 12% of the professional payments. Breast cancer, lung cancer, colon cancer and ovarian cancer were some of the primary diagnoses treated in this category.

State of Wisconsin - Public Employees
PROFESSIONAL PAYMENTS BY DISEASE CATEGORY
Payment Distribution



Total Payments = $1,657,276

PROFESSIONAL SPECIALTIES BY VISITS

The Professional Specialties By Visits table summarizes professional visits by frequently utilized specialties. This table provides you with an insight into the types of professional services being used by your members.

Professional specialty data reported during the reporting period revealed:

- Wisconsin Public Employee members experienced 7,383 professional visits. This equated to 10,731.1 professional visits per 1,000 members.
- The average payment per visit was $224. The BCBSWI average payment per visit was $143.
- The ten frequently visited provider types on the table received 51% of the professional visits and 35% of the payments.
- Family Practioners received 13% of the total visits and accumulated 5% of the payments.
- Cardiology specialists accounted for 3% of the visits and 6% of the total payments. The average payment per visit to this specialty type was $476.
- Forty-nine percent of the professional visits were to providers included in the Other category. Radiology specialists accounted for 15% of the payments in the Other category and 22% of the visits. Nine percent of the payments in the Other category were for visits to Oncology specialists. The average payment per visit for this specialty type was $764.

State of Wisconsin - Public Employees
PROFESSIONAL SPECIALTIES BY VISITS

Specialty	Total Visits	Total Charges	Total Payments	% of Professional Payments
Family Practice	951	$139,579	$83,685	5%
Chiropractor	785	$64,916	$41,673	3%
Internal Medicine	559	$118,136	$83,090	5%
Psychiatry/Psychology	419	$90,226	$72,368	4%
Orthopedic Surgery	231	$128,453	$85,025	5%
Cardiology	206	$155,789	$98,070	6%
Obstetrics/Gynecology	182	$77,140	$57,596	3%
Pediatric	163	$23,326	$13,555	1%
General Practice	160	$27,942	$20,210	1%
Dermatology	140	$29,128	$19,821	1%
Subtotal	3,796	$854,636	$575,093	35%
Other	3,587	$1,472,762	$1,082,183	65%
TOTAL	**7,383**	**$2,327,398**	**$1,657,276**	**100%**

APPENDIX

State of Wisconsin - Employees
HIGH COST ADMISSIONS

Diagnosis	Length of Stay	Payments	Average Payment Per Day	Facility
Tracheostomy	44	$220,549	$5,012	Luther Hospital
Pancreas, Liver & Shunt Procedure	21	$139,933	$6,663	Halifax HospMed Ctr
Spinal Procedures	18	$109,575	$6,087	St. Marys Hosp Med Ctr
Acute Leukemia	38	$108,083	$2,844	Maine Med Ctr, ME
Digestive Malignancy W/CC	14	$85,544	$6,110	Midwestern Reg Med Ctr, IL
Cervical Spinal Fusion	12	$83,915	$6,993	Froedtert Mem Luth Hosp
Coronary Bypass w/o Catheter	12	$83,262	$6,939	St. Lukes Med Ctr
Laparoscopic Cholecystectomy W/CC	18	$74,687	$4,149	Meriter Hospital
Coronary Bypass W/ Ptca	5	$71,867	$14,373	St. Marys Hospital
Burn W/ Skin Graft	18	$69,418	$3,857	University Hospitals
Coronary Bypass w/ Catheter	11	$67,073	$6,098	Froedtert Mem Luth Hosp
Craniotomy	21	$64,132	$3,054	St. Mary's Hosp Rochester
Kidney Transplant	12	$58,743	$4,895	UW Hosp Transpl Ctr
Major Joint Replacement/Reconstr.	8	$57,818	$7,227	University Hospitals
Myeloproliferative Disease	11	$54,305	$4,937	Midwestern Reg Med Ctr, IL
Major Chest Procedure	13	$52,599	$4,046	Washoe Medical Ctr, NV
Cardiac Valve Procedures	9	$50,804	$5,645	St. Mary's Hosp Rochester
Pacemaker Implant	2	$48,635	$24,318	St. Agnes Hospital
Fractures of Hip & Pelvis	32	$48,183	$1,506	Sunrise Hosp & Med Ctr
Kidney Procedure	8	$45,854	$5,732	University Hospitals
Percutaneous Cardovascular Proc.	1	$44,390	$44,390	Luther Hospital
Cardiac Valve Procedures	5	$44,014	$8,803	Aurora Baycare Med Ctr
Stomach, Esoph. & Duodenal Proc.	25	$42,560	$1,702	Athens Reg Med Ctr, GA
Non-Actute Leukemia	6	$41,649	$6,941	University Hospitals
Spinal Fusion	16	$40,145	$2,509	All Saints Med Ctr
Lower Extremity & Humer Proc.	11	$39,323	$3,575	St. Lukes Med Ctr
Major Chest Procedure	10	$37,881	$3,788	Froedtert Mem Luth Hosp
Coronary Bypass w/ Catheter	6	$37,266	$6,211	St. Marys Med Ctr
Major Cardiovascular Procedure	12	$37,151	$3,096	University Hospitals

Diagnosis	Length of Stay	Payments	Average Payment Per Day	Facility
Major Joint Replacement/Reconstr.	3	$36,771	$12,257	Evanston Hospital, IL
Cellulitis W/CC	10	$36,397	$3,640	University Hospitals
Endocrine, Nutritional Procedure	8	$36,233	$4,529	Harvard Comm Mem
Coronary Atherosclerosis	2	$35,296	$17,648	St. Lukes Med Ctr
Major Cardiovascular Procedure	5	$35,278	$7,056	Mercy Health System
Cardiac Valve Procedures	7	$35,217	$5,031	Waukesha Mem Hosp
O.R. Procedures for Infectious Disease	15	$34,830	$2,322	St. Marys Hosp Ozaukee
Major Cardiovascular Procedure	10	$34,424	$3,442	University Hospitals
Respiratory System Disease	14	$34,244	$2,446	Baptist Med. Ctr, AR
Extensive O.R. Procedures	15	$34,105	$2,274	St. Mary's Hosp Rochester
Disorders of Personality & Impulse Control	52	$33,713	$648	Waukesha Mem Hosp
Major Small & Large Bowel Proc.	9	$33,604	$3,734	University Hospitals
O.R. Proc. For Multiple Trauma	11	$33,266	$3,024	University Hospitals
Cervical Spinal Fusion	2	$33,199	$16,600	St. Joesph Hosp, CA
Spinal Fusion	4	$33,160	$8,290	Duke Univ Hlth Sys
Fracture	14	$32,762	$2,340	Mercy Health System
Coronary Atherosclerosis	1	$32,594	$32,594	St. Lukes Med Ctr
O.R. Procedure for Obesity	5	$32,561	$6,512	St. Lukes Med Ctr
Respiratory Distress Syndrome	8	$32,409	$4,051	All Saints Med Ctr
Craniotomy	1	$32,401	$32,401	Mass Gen Hosp, MA
Cerebrovascular Disorders	25	$32,189	$1,288	Aurora Baycare Med Ctr
Major Joint Replacement/Reconstr.	5	$32,090	$6,418	Aurora Sinai Med Ctr
Multiple Major Joint Procedure	7	$32,035	$4,576	Oak Leaf Surg Hosp
Renal Failure	7	$31,311	$4,473	Luther Hospital
Major Chest Procedure	13	$29,946	$2,304	All Saints Med Ctr
Gastrointestinal Obstruction W/CC	5	$29,291	$5,858	Midwestern Reg Med Ctr, IL
O.R. Procedure for Obesity	3	$28,744	$9,581	Northwestern Suburban, IL
Spinal Fusion	4	$27,872	$6,968	Columbia Hospital
Musculoskeletal O.R. Procedure	8	$27,794	$3,474	University Hospitals
Major Joint Replacement/Reconstr.	7	$27,588	$3,941	Sauk Prairie Mem Hosp
Major Joint Replacement/Reconstr.	5	$27,470	$5,494	UCSF Standford Hlthcr
Mental Retardation	15	$27,158	$1,811	Aurora Psych Hosp
Major Joint Replacement/Reconstr.	4	$26,985	$6,746	Froedtert Mem Luth Hosp

Diagnosis	Length of Stay	Payments	Average Payment Per Day	Facility
Spinal Fusion	1	$26,131	$26,131	University Hospitals
O.R. Procedures for Infectious Disease	6	$26,126	$4,354	Oconomowoc Mem Hosp
Major Joint Replacement/Reconstr.	4	$25,942	$6,485	University Hospitals
Nutritional & Metabolic Disorder	13	$25,782	$1,983	University Hospitals
Cervical Spinal Fusion	4	$25,768	$6,442	All Saints Med Ctr
O.R. Procedure for Obesity	3	$25,616	$8,539	Northwestern Suburban, IL
Laparoscopic Cholecystectomy W/O CC	10	$25,595	$2,560	W Allis Mem Hosp
Major Joint Replacement/Reconstr.	5	$25,568	$5,114	Meriter Hospital
Coronary Atherosclerosis	1	$25,517	$25,517	St. Agnes Hospital
Digestive System Diagnoses	3	$24,628	$8,209	Presbyterian Hosp, CO
O.R. Procedure for Obesity	4	$24,580	$6,145	Howard Young Med Ctr
Appendectomy W/O CC	1	$24,436	$24,436	Stanford Univ Hosp, CA
Vascular Procedure	2	$24,367	$12,183	Mem Hosp of Burlington
Percutaneous Cardovascular Proc.	1	$24,318	$24,318	Cleveland Clinic, OH
Major Small & Large Bowel Proc.	9	$24,230	$2,692	Mercy Health System
O.R. Procedure for Obesity	3	$24,138	$8,046	St. Theresa Med Ctr, IL
Extracranial Vascular Procedure	6	$24,094	$4,016	University Hospitals
Hearth Failure	10	$23,828	$2,383	All Saints Med Ctr
Nervous System Infection	5	$23,632	$4,726	University Hospitals
Psychosis	22	$23,632	$1,074	Meriter Hospital
Major Joint Replacement/Reconstr.	4	$23,401	$5,850	Meriter Hospital
Spinal Fusion	4	$23,366	$5,841	Aurora Med Ctr Kenosha
O.R. Procedure for Obesity	2	$23,312	$11,656	Gundersen Luth Med Ctr
O.R. Procedure for Obesity	6	$23,293	$3,882	University Hospitals
Spinal Fusion	3	$23,217	$7,739	Aurora Baycare Med Ctr
Major Joint Replacement/Reconstr.	4	$23,065	$5,766	Meriter Hospital
Major Small & Large Bowel Proc.	5	$22,831	$4,566	University Hospitals
Cholecystectomy W/CC	6	$22,729	$3,788	Duke Univ Hlth Sys
Major Joint Replacement/Reconstr.	4	$22,659	$5,665	University Hospitals
Uterine & Adnexa Procedure	5	$22,634	$4,527	University Hospitals
Coronary Atherosclerosis	2	$22,204	$11,102	St. Lukes Med Ctr
Major Joint Replacement/Reconstr.	3	$22,120	$7,373	Condell Med Ctr, IL
Major Joint Replacement/Reconstr.	5	$21,856	$4,371	Meriter Hospital

Diagnosis	Length of Stay	Payments	Average Payment Per Day	Facility
O.R. Procedure for Obesity	3	$21,547	$7,182	Froedtert Mem Luth Hosp
Musculoskeletal O.R. Procedure	8	$21,458	$2,682	Sunrise Hosp & Med Ctr
Psychosis	14	$21,295	$1,521	Two Rivers Hosp, MO
Simple Pneumonia	11	$21,172	$1,925	Waukesha Mem Hosp
Major Joint Replacement/Reconstr.	7	$21,161	$3,023	St. Mary's Hosp Rochester
O.R. Procedure for Obesity	2	$20,941	$10,471	Meriter Hospital
O.R. Procedure for Obesity	4	$20,811	$5,203	St. Marys Hosp Med Ctr
Wound Debridements for Injuries	6	$20,769	$3,461	University Hospitals
Major Joint Replacement/Reconstr.	4	$20,752	$5,188	St. Marys Hosp Ozaukee
O.R. Procedure	4	$20,735	$5,184	St. Lukes Med Ctr
Skin Graft W/CC	14	$20,666	$1,476	Meriter Hospital
Percutaneous Cardovascular Proc.	4	$20,649	$5,162	University Hospitals
Major Joint Replacement/Reconstr.	3	$20,099	$6,700	Columbia Hospital
Interstitial Lung Disease	10	$20,068	$2,007	Mercy Health System
	983	$4,109,027	$4,180	

Total High Cost Admissions = 109

GLOSSARY

GLOSSARY

Accident -- Services related to an unforeseen occurrence caused by an outside or external force.

Admissions per 1,000 Members -- The tendency of an admission to occur within a typical population of 1,000 lives. A statistical calculation which allows for comparison of one population to another regardless of group size.

Ancillary Services -- Supplemental services provided during a hospital stay, including x-ray, laboratory work and therapy.

Average Length of Stay (ALOS) -- The average length of hospitalization experienced for an entire group segment or specific admission category. The calculation is based on the total number of inpatient days divided by the total number of admissions.

BCBSWI Norms -- Data compiled from BCBSWI business to develop standard values for comparison of key elements.

Charges -- Billing received from providers of health services.

Circulatory -- The major diagnostic category which relates to the cardiovascular system. The circulatory system includes the heart, blood vessels, and the lymphatic system.

Days per 1,000 Members -- The tendency of hospital days utilized within a typical population of 1,000 lives. A statistical calculation which allows for a comparison of one population to another regardless of group size.

Diagnostic Category -- Classification of admissions grouped by major body organ systems or diseases often called Major Diagnostic Categories (MDC).

Digestive/Hepatic -- The major diagnostic category that relates to the digestive system and liver. Includes bowel, stomach, intestine, pancreas and liver disorders.

Drugs and Supplies -- Outpatient payment category for medication and non-durable medical supplies which are provided to treat illness or disease at outpatient facilities.

Durable Medical Equipment -- Equipment which withstands repeated use that is useful in the presence of illness, physical condition or injury and is appropriate for use in the home.

EENT -- The major diagnostic category which includes services relating to the eyes, ears, nose and throat.

Genitourinary -- The major diagnostic category pertaining to the kidneys, urinary, bladder, and reproduction organs. Includes procedures for kidney transplants, urinary disorders, prostate, sterilization and hysterectomies.

High Cost Admissions -- Admissions with facility payments of at least $10,000.

Incurred Claims -- Claims for services based on the date the services were provided.

Inpatient Services -- Facility services and their charges or payments, such as room and board and ancillary services, rendered to a patient during a hospital stay.

KUB -- Kidney, Ureter, Bladder

Maternity Treatment -- Treatment for services related to pregnancy.

Medical Treatment -- Treatment by physicians and other health care professionals for illness or disease. Does not include surgery, maternity or mental health/substance abuse reasons.

Medical Emergency -- Services provided in response to the onset of an acute medical condition of sufficient severity that it results in symptoms of a life threatening nature.

Mental Health/ Substance Abuse -- Treatment for mental disorders and substance abuse.

Nervous System -- The major diagnostic category which consists of the central nervous system, including the brain and spinal cord and the peripheral nervous system.

Payments -- Payments made to providers or subscribers as required by their covered benefits.

Obstetrics -- The major diagnostic category relating to pregnancy, childbirth and newborns.

Outpatient Services -- Facility services and their charges or payments rendered to a patient in an outpatient setting (hospital or ambulatory surgical centers).

Other Diagnostic -- The major diagnostic category used to group non-specific DRGs such as: endocrine/nutritional, blood and blood forming organs, bone marrow, infections and parasitic, injuries, poisoning, burns, trauma and HIV infection.

Professional Services -- Charges or payments for services rendered by professional providers.

Respiratory -- Major diagnostic category related to the act of breathing. Includes respiratory infections, pneumonia, bronchitis and tracheostomies.

Routine Diagnostic/Illness -- Care sought prior to an illness or when there is the presence of disease or disability. Includes preventative modalities, annual physicals and mammograms.

Services and Equipment -- Outpatient payment category for services and equipment utilized within the outpatient setting. Includes anesthesia, monitors and operating room services.

Similar Industry -- Normative data based on BCBSWI business, classified by products produced or services rendered, which applies to a group's main activity or purpose.

Skin/Musculoskeletal -- The major diagnostic category relating to the skin, muscles and bones. Includes treatment for back problems, knee replacements and mastectomies.

Surgical Treatment -- Treatment due to a surgical procedure.

Employer Group Reporting Package

State of Wisconsin

January through May 2004 Utilization Summary Report

Prepared by
Reporting and Data Management
October 2004

REPORT STRUCTURE

The purpose of this additional report section is:

- To provide a more recent version of the health care utilization of State of Wisconsin Employees.
- To give an advanced, though incomplete, look at trends that may be identified in 2003 data and to assess whether adverse trends in 2003 continue into 2004.
- To compare your statistics to normative data.

REPORT STRUCTURE

The data presented in the following graphs and tables represent the health care utilization for members of State of Wisconsin Employees.

The content of the report represents State of Wisconsin incurred claims experience from January 1, 2004 through May 31, 2004 and paid through August 31, 2004. Claims are considered incurred on the date that the health care services are rendered.

Many of your health care utilization statistics have been compared to normative data from Blue Cross Blue Shield of Wisconsin (BCBSWI). The normative values used throughout this report represent the cumulative 2002 health care utilization data of BCBSWI's business.

MEMBERSHIP DISTRIBUTION

The Membership Distribution graph provides a visual comparison of membership distribution by gender and relationship classification for the State of Wisconsin – non-Medicare population. This allows you to determine how much of the membership was comprised by each of the six gender/relationship groups and pinpoints the areas that comprise the majority of your membership population.

The membership distribution for the State of Wisconsin revealed:

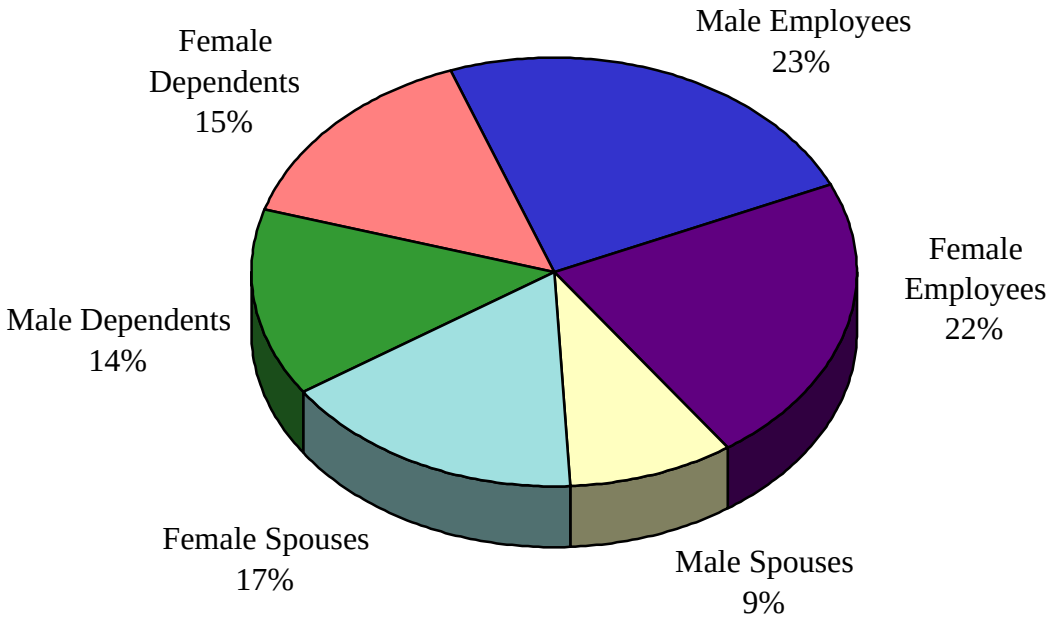
- There was an average of 12,338 members. This is an increase of 132% from the same time period in 2003.
- Employees represented the majority (56%) of the members.
- Twenty-six percent of the 12,338 members were spouses. Male spouses accounted for 9% and females for 17%.
- There was an average of 3,559 dependents during the first five months of 2004. These members were divided almost equally among males and females.

State of Wisconsin
MEMBERSHIP DISTRIBUTION
By Gender/Relationship
Incurred: January 1, 2004 - May 31, 2004
Paid: January 1, 2004 - August 31, 2004

Total Membership

Employees:	5,663
Spouses:	3,116
Dependents:	3,559
Total:	**12,338**

Membership Distribution



UTILIZATION SUMMARY

The Utilization Summary table provides general utilization information pertaining to the State of Wisconsin members.

During the five-month report period outlined:

- Members experienced 374 admissions during the period. This equated to an annualized rate of 72.8 admissions per 1,000 members. The rate of inpatient days per 1,000 was 342.6.
- The average length of stay was 4.7 days. This is 26% higher than the BC&BSUW normative rate. Surgical admissions accounted for 38% of the total days incurred.
- There were a total of 6,653 outpatient visits incurred resulting in an annualized rate of 1,294.1 visits per 1,000.
- Nine percent of the outpatient visits were to the emergency room setting. These visits equated to 119.8 visits per 1,000 members. This rate is 20% lower than the BCBSWI normative rate.
- Members of the State of Wisconsin experienced 47,659 professional visits which resulted in a rate of 9,270.7 visits per 1,000 members.

State of Wisconsin
UTILIZATION SUMMARY
Incurred: January 1, 2004 - May 31, 2004
Paid: January 1, 2004 - August 31, 2004

	State of Wisconsin	BCBSWI Normative
Average Number of Members	12,338	
Inpatient		
Admissions	374	
Admissions per 1,000 Members	72.8	68.4
Days	1,761	
Days per 1,000 Members	342.6	237.1
Average Length of Stay	4.7	3.4
Outpatient		
Outpatient Visits	6,653	
Outpatient Visits Per 1,000 Members	1,294.1	910.2
Emergency Room Visits	616	
Emergency Room Visits Per 1,000 Members	119.8	149.7
Professional		
Professional Visits	47,659	
Professional Visits Per 1,000 Members	9,270.7	7,631.7

PAYMENT SUMMARY

The Payment Summary table provides general information pertaining to the State of Wisconsin members. Specifically, this table reflects total facility and professional payments incurred by each of your six gender/relationship categories.

- Total payments during the five-month period totaled $19,818,904. The average payment per member per month was $321.
- Employees incurred services representing 54% of the total payments.
- Thirty-five percent of the payments were incurred by spouses.
- While representing 29% of the total population, dependents accumulated only 11% of the total payments.

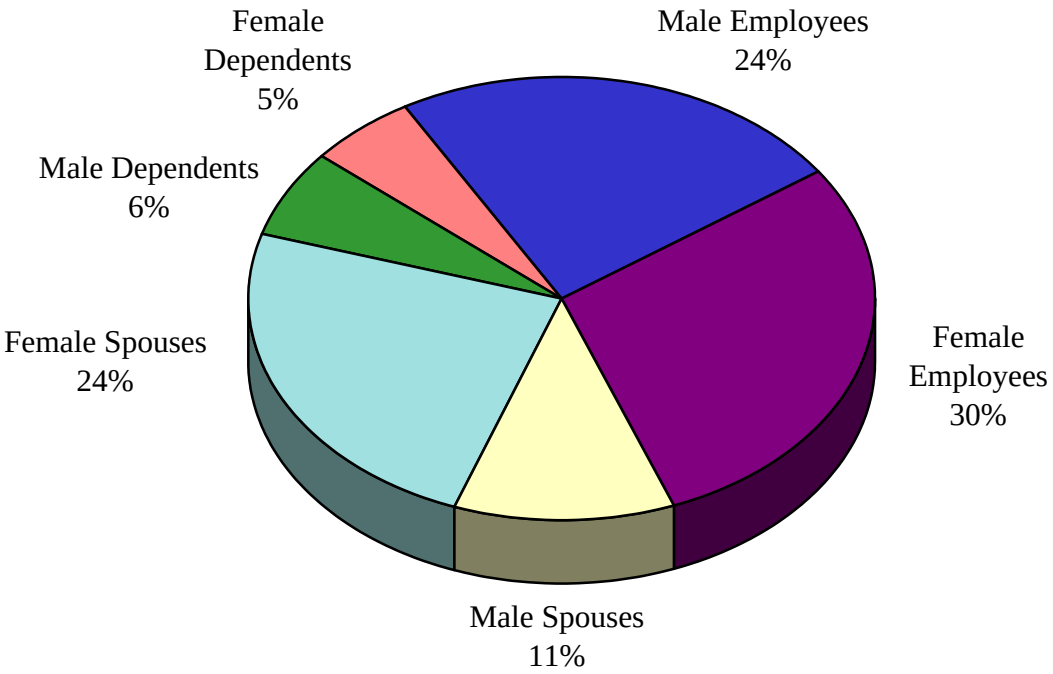
State of Wisconsin
PAYMENT SUMMARY
Incurred: January 1, 2004 - May 31, 2004
Paid: January 1, 2004 - August 31, 2004

Total Payments

Inpatient:	$4,430,058
Outpatient:	$4,973,970
Professional:	$10,414,876
Total:	**$19,818,904**

Average Paid/Member/Month:	$321
Average Membership:	12,338

Payment Distribution



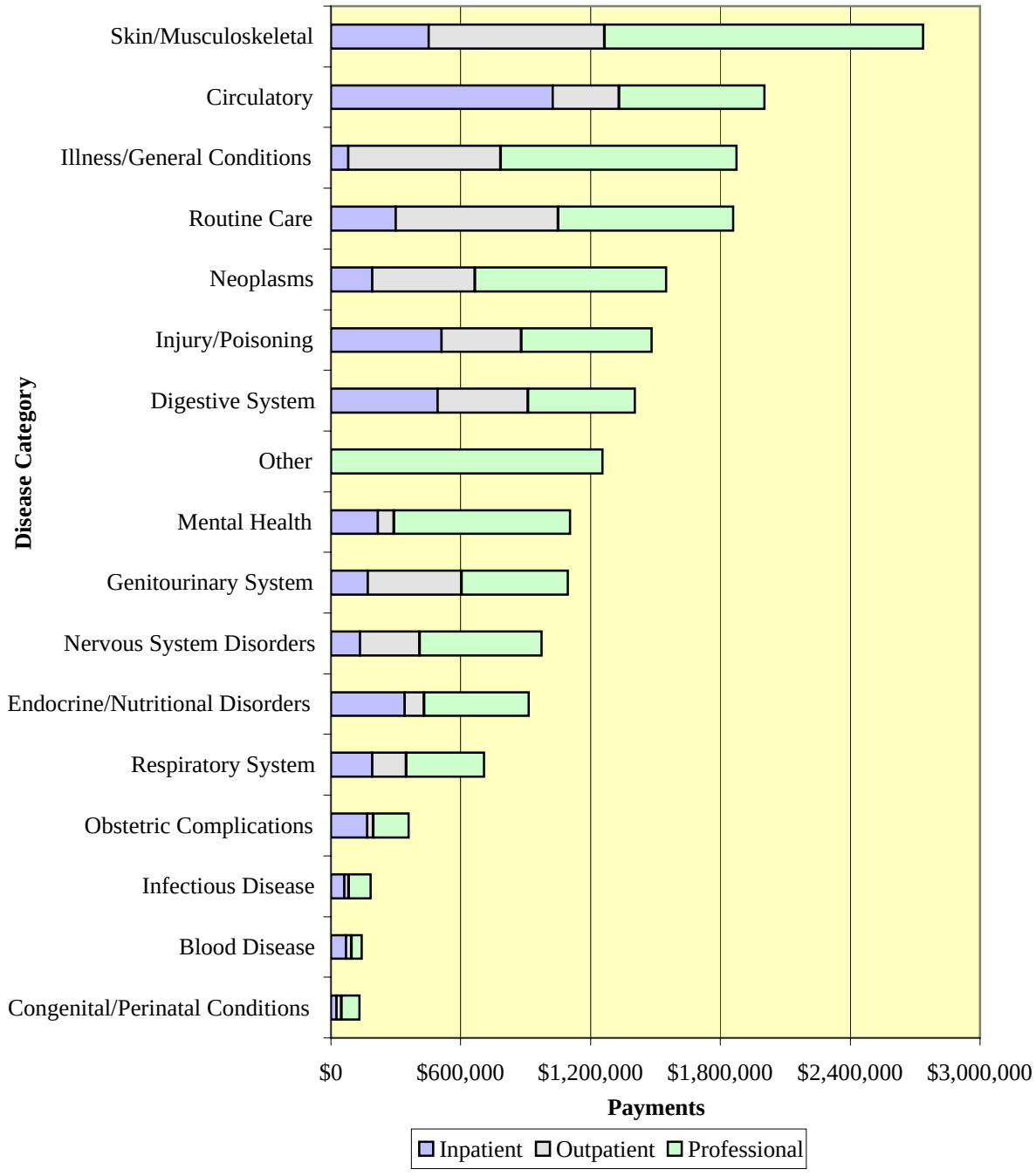
TOTAL PAYMENTS BY DISEASE CATEGORY

The Total Payments by Disease Category graph provides a visual display of the distribution of inpatient, outpatient, and professional payments by a variety of disease categories.

The graph reveals the following:

- Fourteen percent of the payments were for treatment of Skin/Musculoskeletal disorders. Professional services represented 54% of the payments in this category.
- Circulatory disorders resulted in 10% of the total payments. Inpatient care accounted for 51% of the payments.
- Illness/General Conditions accounted for 9% of the $19,818,904 in payments. Fifty-eight percent of the payments were associated with professional care. Included in this category is treatment for syncope/collapse, headaches, chest pain, and abdominal pain.

State of Wisconsin
TOTAL PAYMENTS BY DISEASE CATEGORY
Payment Distribution
Incurred: January 1, 2004 - May 31, 2004
Paid: January 1, 2004 - August 31, 2004



Average Membership: 12,338
Total Payments: $19,818,904

Employer Group Reporting Package

PAR Summary Report

2003 Report

Prepared by
Reporting and Data Management
May 2004

STATE OF WISCONSIN EMPLOYEES AND
WISCONSIN PUBLIC EMPLOYEES
PAR SUMMARY REPORT

Incurred Period: January 1, 2003 – December 31, 2003

INTRODUCTION

This report summarizes State of Wisconsin Employees' and Wisconsin Public Employees' health care experience as it relates to the membership's use of BCBSWI Participating and non-Participating Providers. Observations consist of claims and utilization experience in the inpatient, outpatient and professional care settings. Due to arrangements with providers, inpatient, and outpatient services are reported for Participating in-network and Participating out-of-network.

OBSERVATIONS

The State of Wisconsin Employees and Wisconsin Public Employees received inpatient, outpatient, and professional services that resulted in $29,409,589 in payments. There was a total of $11,015,993 in savings during the 12-month period. These savings represented 27% of the total billed charges. Savings reflect the difference between total charges and paid after discount amounts. Savings as the result of inpatient services accounted for 20% of the total. Outpatient services were responsible for 22% of the savings and the majority (58%) of the savings were incurred through professional services.

INPATIENT

During the 12-month period, members of the State of Wisconsin experienced the following inpatient utilization:

- Inpatient payments represented 30% of the total payments. Savings associated with this type of care accounted for 20% of the total.
- Participating providers accounted for 96% of the inpatient savings of $2,183,826.
- Eighty-six percent of the 513 admissions were at Participating providers.
- The overall average payment per admission was $17,073.

OUTPATIENT

The following utilization occurred during the 12-month period:

- Members of the State of Wisconsin experienced a total of 12,738 outpatient visits during the period. Eighty-eight percent were at Participating providers.
- Outpatient payments totaled $7,718,980. The average payment per visit was $606.
- Ninety-three percent of the outpatient savings were the result of visits incurred at Participating providers.

PROFESSIONAL

The following points highlight State of Wisconsin members' Participating and non-Participating professional experience:

- Professional visits accounted for 44% of the total payments and 58% of the savings.
- Members experienced 65,390 professional visits during the period. Seventy-two percent of these visits were at Participating providers.
- The overall average payment per visit was $198.
- Professional savings as the result of visits to Participating providers accounted for 85% of the total savings.

STATE OF WISCONSIN
PAR NETWORK UTILIZATION
January - December 2003

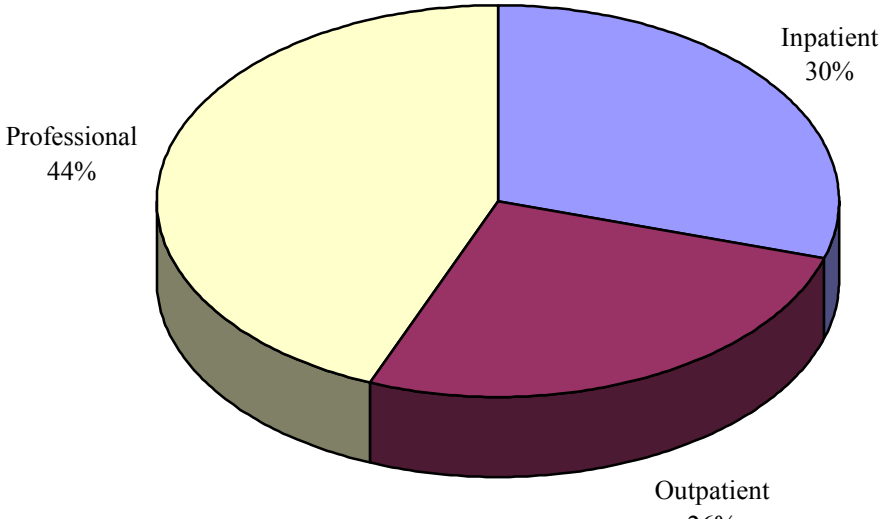
SUMMARY

	Participating	Non-Participating	Total	Participating Percent
Inpatient				
Billed Charges	$9,673,801	$1,268,447	$10,942,248	88.4%
Paid Amount	$7,575,638	$1,182,784	$8,758,421	86.5%
Savings	$2,098,163	$85,664	$2,183,826	96.1%
Paid Amount Per Stay	$17,217	$16,203	$17,073	n/a
Paid Amount Per Day	$3,462	$3,595	$3,480	n/a
Admits	440	73	513	85.8%
Days	2,188	329	2,517	86.9%
Outpatient				
Billed Charges	$8,714,281	$1,373,310	$10,087,591	86.4%
Paid Amount	$6,517,718	$1,201,262	$7,718,980	84.4%
Savings	$2,196,563	$172,049	$2,368,611	92.7%
Paid Amount Per Visit	$584	$766	$606	n/a
Visits	11,169	1,569	12,738	87.7%
Professional				
Billed Charges	$14,658,960	$4,736,783	$19,395,744	75.6%
Paid Amount	$9,175,822	$3,756,366	$12,932,188	71.0%
Savings	$5,483,138	$980,417	$6,463,555	84.8%
Paid Amount Per Visit	$195	$206	$198	n/a
Visits	47,165	18,225	65,390	72.1%

STATE OF WISCONSIN
PAR NETWORK UTILIZATION
January - December 2003

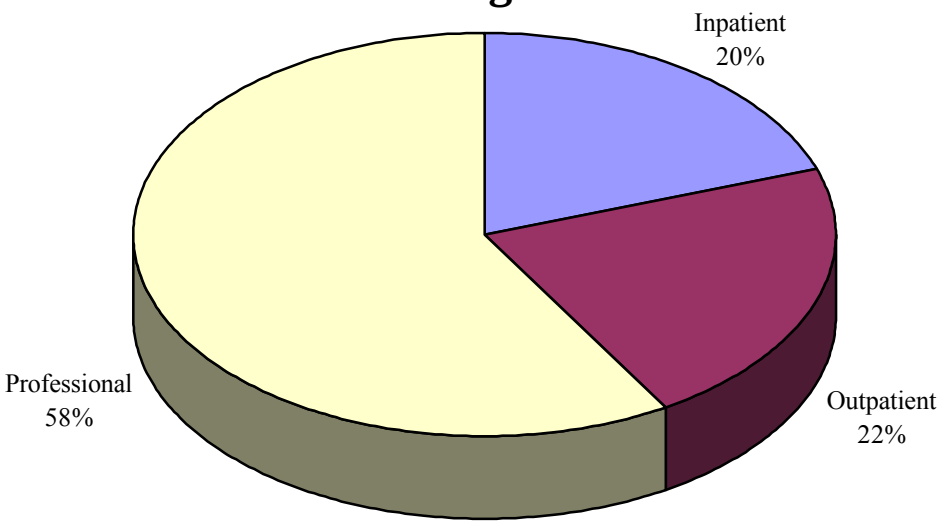
DISTRIBUTION OF PAYMENTS/SAVINGS

Payments



Total Paid Amount = $29,409,589

Savings

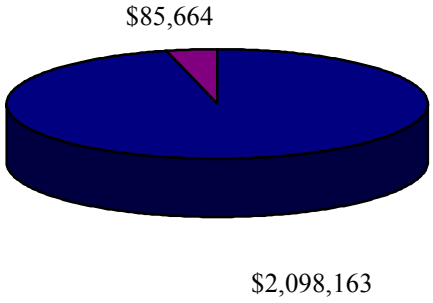


Total Savings = $11,015,993

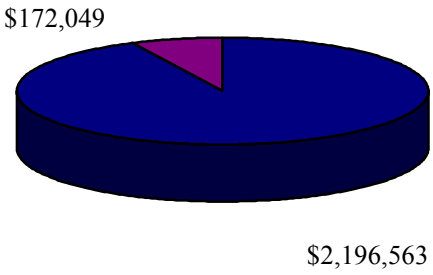
STATE OF WISCONSIN
PAR NETWORK UTILIZATION
January - December 2003

NETWORK SAVINGS

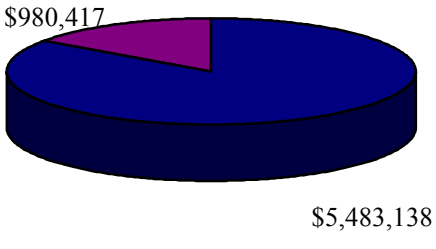
Inpatient



Outpatient



Professional



Employer Group Reporting Package

Advantage Program Summary

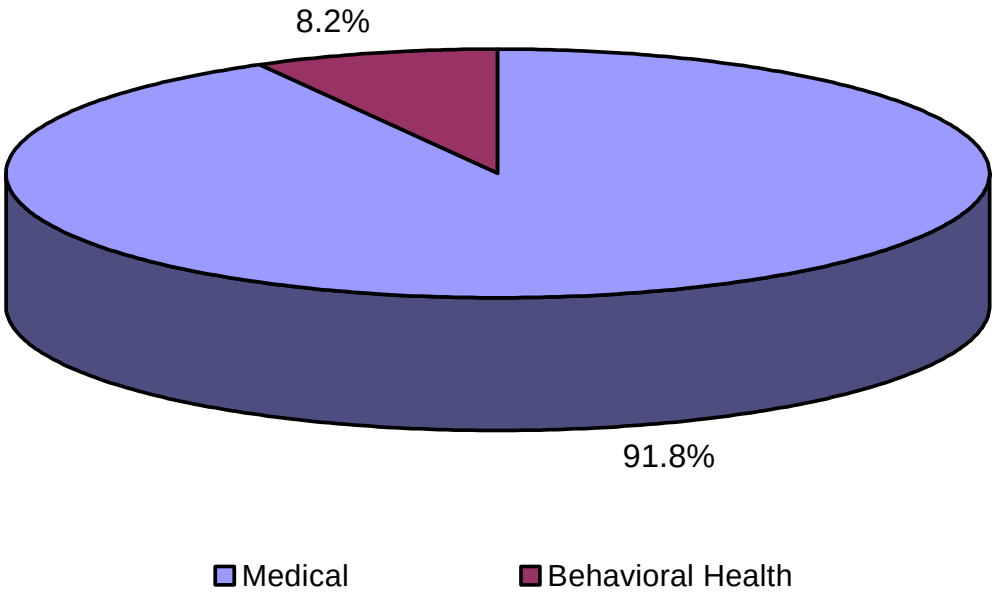
2003 Utilization Summary

Prepared by
Reporting and Data Management
October 2004

STATE OF WISCONSIN
2003 Advantage Program Summary

From January 2003 through December 2003 the State of Wisconsin saved the following total dollars through Advantage program's management of Medical and Behavioral Health Utilization Services.

TOTAL UTILIZATION SAVINGS: $822,868

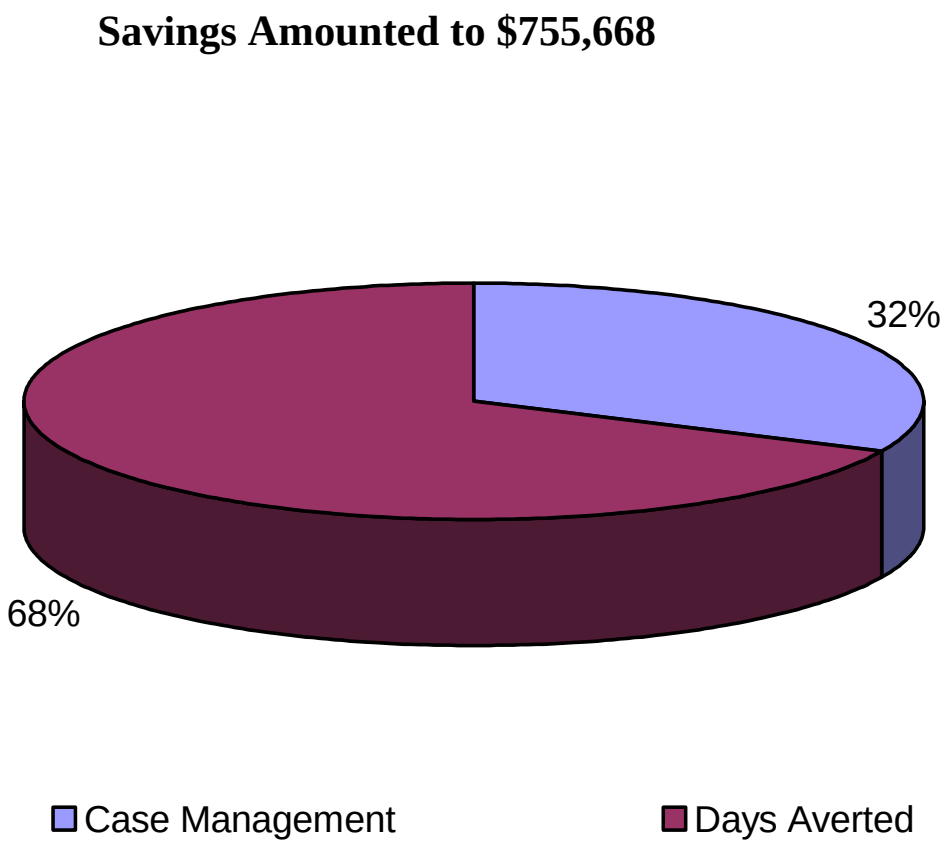


MEDICAL UTILIZATION SAVINGS

- Advantage Program staff saved 223 hospital days YTD at an average charge per day of $2,305 resulting in savings of $514,015.

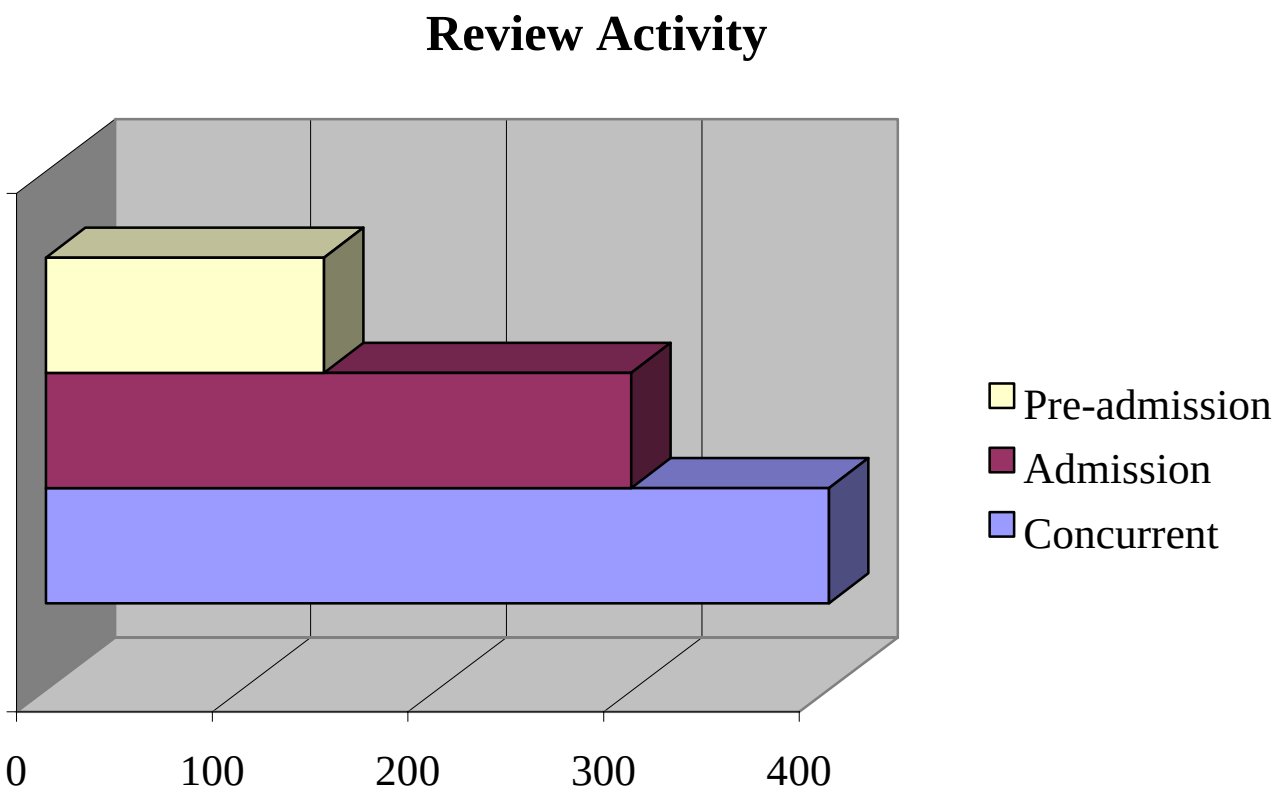
- Advantage staff referred 52 cases to Case Management. Early referral of appropriate cases to case management is a benefit of Utilization Management.

- A total of $241,653 was saved through Individual Case Management efforts on behalf of 89 patients. Savings resulted from the efforts of the Case Managers to determine the most appropriate care setting, as well as negotiation of medical costs.



MEDICAL ACTIVITY

- Review activity was comprised of 142 pre-admission, 299 admissions and 400 concurrent reviews.



MEDICAL UTILIZATION

- In total 441 admission requests were approved through the Advantage Program.
- Of the 441 admission requests, 224 were for Medical treatment (51%), 158 were for Surgical care (36%), 14 were related to Maternity care (3%), and 45 admissions were for the treatment of Mental Health/Substance Abuse related disorders (10%).

BEHAVIORIAL HEALTH

- 31 patients were treated for Behavioral Health this year.
- A conservative estimate of an Inpatient charge per day is $1200.
- The Advantage staff monitored 45 Inpatient stays that resulted in 56 fewer days in the hospital or more than $67,200 in savings.

Savings Amounted to $67,200

State of Wisconsin
Case Management Summary Report
2003

Case: 1022092								
FIRST QUARTER								
Time in Case Management:	3 Months			**Status:**	Open			
Diagnosis	Fractured Hip			**Year to date Cost Savings**			$32,625.00	
IN/Outpatient Savings:	$32,625.00			**Case to date Cost Savings**			$32,625.00	
Case Summary:								
Patient fell and fractured right hip. Hip repaired and patient transferred to inpatient rehab due to medical instability and cognitive decline. Care Management reviewed medical records and transferred appropriately to sub acute rehab and finally home with outpatient therapy and part time return to work. Care Management continuing to follow and reviewing medical records for medical necessity. Will close case when rehab goals are met. Cost savings were noted by averting inpatient rehab and admission to a skilled nursing facility using the actual rate of $2,305.00 per day as compared to $325.00 rate per day at the skilled nursing facility. A savings of $1,980 per day for 15 days is noted. With review of medical records, additional savings were noted due to a recommended discharge to home health services from a skilled nursing facility saving $325.00 per day for 9 days.								
THIRD QUARTER								
Time in Case Management:	10 Months			**Status:**	Closed			
Diagnosis	FX Hip and Cognitive Decline			**Year to date Cost Savings**			$37,175.00	
IN/Outpatient Savings:	$4,550.00			**Case to date Cost Savings**			$37,175.00	
Case Summary:								
Care Management impacted this case by maintaining contact with the staff at Milwaukee Jewish Home to facilitate coordination of services in a cost effective manner on behalf of the State of Wisconsin. As a result of Care Management intervention, cost savings will be noted. Savings were calculated utilizing the actual rate of $900.00 per diem and the negotiated rate of $550.00 for skilled nursing facility stay for dates 7/16/03 to 7/18/03 (three days). Patient admitted to St Mary's for Sepsis. Appropriate records were requested and reviewed from the Milwaukee Jewish Home regarding the patient's condition, treatment plan and progress in therapy in order to anticipate further needs and to make recommendations to Blue Cross for continued stay at the Milwaukee Jewish Home upon discharge on July 25 from St. Mary's Hospital. As a result of Care Management's intervention, cost savings were obtained for the patient's stay at Milwaukee Jewish Home utilizing the actual per diem rate of $900.00 per day versus the negotiated rate for an additional 10 days. Patient was readmitted to St Mary's for Sepsis again on 8-3-03 and transferred to St Mary's Hospice on 8/11 and expired on 8/13/03.								

State of Wisconsin
Case Management Summary Report
2003

Case: 1011843								
FIRST QUARTER								
Time in Case Management:	13 Months			**Status:**	Closed			
Diagnosis	Throat Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$244,651.98	
Case Summary:								
Attempted decannulation of the trach unsuccessful. Patient declined further surgery but is medically stable using G Tube for feeding and oxygen at night. Spouse supportive. and assists with daily needs. Care Management is supportive to family and assists in coordinating services in a cost effective manner. Care Management contacted DME supplier related to rent-to-own contracts and monthly rental fees. Information provided to spouse.								
Case: 1021142								
FIRST QUARTER								
Time in Case Management:	5 Months			**Status:**	Open			
Diagnosis	Breast Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient diagnosed with breast cancer in September 2002. Mastectomy done. Home care services established for dressing changes but patient declined services citing a family member is a physician. Currently undergoing chemotherapy. Care Management coordinating services in cost effective manner. Investigation done to assure chemotherapy medications were appropriate for diagnosis. Care Management providing information and supportive to patient and family.								
Case: 108912								
FIRST QUARTER								
Time in Case Management:	11 Months			**Status:**	Closed			
Diagnosis	Pancreatic Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$72.80	
Case Summary:								
Patient admitted to hospice for end of life care. Received weekly palliative chemotherapy. Patient expired 1/13/03. Care Management coordinated services in a cost effective manner and provided support to family.								

State of Wisconsin
Case Management Summary Report
2003

Case: 1019991								
FIRST QUARTER								
Time in Case Management:	9 Months			**Status:**	Open			
Diagnosis	Mesothelioma			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient completed chemotherapy, tolerating treatments well. Mesothelioma responding well to chemotherapy. Care Management coordinating services with hospital and physician in a cost effective manner. Care Management provides support and information related to in-network providers to family. Care Management to continue monitoring patient until medically stable.								
THIRD QUARTER								
Time in Case Management:	15 Months			**Status:**	Open			
Diagnosis	Mesothelioma			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
During the current reporting period, contact has been maintained with the University of Chicago Medical Center and the physician's staff to assist in coordination of the patient's services in a cost effective manner on behalf of the State of Wisconsin. Contact was maintained with the spouse to provide support, evaluate the patient's condition and assess for further needs. Providers in network were suggested to the spouse. The case will remain in a Level III status to monitor the patient's condition, treatment plan and response to treatment in order to intervene in a cost effective manner on behalf of State of Wisconsin.								
FOURTH QUARTER								
Time in Case Management:	17 Months			**Status:**	Closed			
Diagnosis	Mesothelioma			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Manager assisted in coordination of benefits and services with Hospice staff and offered support to spouse and family. Patient expired at home with family at bedside.								

State of Wisconsin
Case Management Summary Report
2003

Case: 1019558								
FIRST QUARTER								
Time in Case Management:	10 Months			**Status:**	Open			
Diagnosis	Lymphoma/Bone Marrow Transplan			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient underwent Bone Marrow Transplant in October 2002. Discharged to home. Appetite poor. Care Management in contact with the transplant clinic and physician office to coordinate care in a cost effective manner, providing support and information to the patient and spouse and receiving information to evaluate the patient's current medical status. Care Management to keep case open to monitor condition and response to bone marrow transplant.								
Case: 1021505								
FIRST QUARTER								
Time in Case Management:	3 Months			**Status:**	Closed			
Diagnosis	Bilateral Knee Replacement			**Year to date Cost Savings**			$29,030.00	
IN/Outpatient Savings:	$29,030.00			**Case to date Cost Savings**			$29,030.00	
Case Summary:								
Patient had left knee replaced in October 2002 and physician requested inpatient rehab. Care Management reviewed medical records for medical necessity and recommended rehab in a sub acute nursing facility and discharge to home after achieving goals. Cost savings was noted through averting inpatient rehab in lieu of a skilled nursing facility rehab for an 11 days savings at the rate of $2,305 per day. In December the right knee was replaced. Using the same rehab resources, the physician was so pleased with progress that out patient therapy was not necessary to achieve goals therefore saving State of WI $9,450.								
Case: 1021734								
FIRST QUARTER								
Time in Case Management:	4 Months			**Status:**	Open			
Diagnosis	Pancreatic Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient underwent surgery for a Whipple procedure for Pancreatic Cancer. Discharge to home with home care services for dressing changes. The patient is seeing an oncologist for treatment options this month. Care Management assisting in coordination of benefits and services in a cost effective manner and providing support and information to the patient. Care Management to continue to monitor patient for ongoing treatment.								

State of Wisconsin
Case Management Summary Report
2003

State of Wisconsin
Case Management Summary Report
2003

THIRD QUARTER								
Time in Case Management:	10 Months			**Status:**	Closed			
Diagnosis	Pancreatic Cancer			**Year to date Cost Savings**			$2,860.00	
IN/Outpatient Savings:	$2,860.00			**Case to date Cost Savings**			$2,860.00	
Case Summary:								
Contact was maintained with the patient to provide support, evaluate the patient's medical condition and assess for further needs. Contact was extablished with the physician's office to facilitate coordination of the patient's services in a cost effective manner on behalf of the State of Wisconsin. Appropriate records were requested and reviewed for information regarding the patient's condition, treatment plan and progress in order to make recommendations for the home care visits. With Care Management intervention, 22 Home Health Care visits were saved between 3/5 to 5/23/03 for a total savings of $2,860.00. No further case management is required at this time and the case was closed.								
Case: 1020245								
FIRST QUARTER								
Time in Case Management:	6 Months			**Status:**	Closed			
Diagnosis	Ruptured Colon			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Colostomy reversed and patient experiencing no problems. Care Management offering support and assisting in coordination of benefits and services in a cost effective manner. Patient medically stable and case closed.								
Case: 1020382								
FIRST QUARTER								
Time in Case Management:	8 Months			**Status:**	Open			
Diagnosis	Open Wounds			**Year to date Cost Savings**			$3,439.00	
IN/Outpatient Savings:	$3,439.00			**Case to date Cost Savings**			$10,560.00	
Case Summary:								
Patient with multiple medical problems currently suffering with open wounds to the sacrum. Skin flap grafted to site and wound vac in place. Care Management continues to follow this case and monitor the amount of care being rendered at an appropriate rate of reimbursement. Care Management continues to assess the care needs of the patient on a weekly basis to ensure the policy guidelines for skilled nursing facility are met. Skilled nursing facility services were negotiated for an additional cost savings of $3439 through 3/3/03.								

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SECOND QUARTER								
Time in Case Management:	12 Months			**Status:**	Open			
Diagnosis	Open Wounds			**Year to date Cost Savings**			$6,955.00	
IN/Outpatient Savings:	$3,516.00			**Case to date Cost Savings**			$12,507.00	
Case Summary:								
Savings were calculated utilizing the requested reimbursement rate per day and the negotiated reimbursement which reflected a 10% savings. Care Management continues to follow this case to monitor the amount of care being rendered for the patient and to negotiate an appropriate rate of reimbursement . Care Management continues to assess the care needs of the patient on a weekly basis to ensure that the patient is meeting the policy guidelines for a Skilled Nursing Facility.								
THIRD QUARTER								
Time in Case Management:	15 Months			**Status:**	Open			
Diagnosis	Open Wounds			**Year to date Cost Savings**			$6,955.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$12,507.00	
Case Summary:								
Care Management continues to follow this case to monitor the amount of care being rendered to the patient and to negotiate an appropriate rate of reimbursement. It has been learned recently that the facility plans to restart therapy as now the sacral wound is healed and the patient is expressing a desire to return home. The patient has restarted PT and OT in an effort to accomplish the patient's goal of returning home with the spouse. The facility has requested daily reimbursement of $450 to cover all services rendered to the patient, Care Management recommended submitting the therapy charges as outpatient services and have the patient's current payor source continue to provided reimbursement for room and board and nursing care. Cost savings will be noted when the dollar amount for therapy units is obtained.								
FOURTH QUARTER								
Time in Case Management:	18 Months			**Status:**	Open			
Diagnosis	Open Wounds			**Year to date Cost Savings**			$17,686.00	
IN/Outpatient Savings:	$10,731.00			**Case to date Cost Savings**			$23,238.00	
Case Summary:								
result of Care Management intervention, cost savings will be noted. Savings were calculated utilizing the requested reimbursement for care of the patient at Franciscan Woods of $450/day and the typical charges of $50/unit for therapy. The patient typically received 4 units of therapy per day saving $250/day for a total of $10,000 by averting an inpatient sub acute stay and transitioning to home with out patient therapy. Another savings noted this quarter was a request for a wheelchair was reviewed and provided that a more cost effective wheelchair would accomplish the same goals saving State of Wisconsin $731.00.								

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Case: 1020922								
FIRST QUARTER								
Time in Case Management:	4 Months			**Status:**	Closed			
Diagnosis	Anemia			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient discharged to home with home care services for education and teaching regarding Lovenox injections. Care Management coordinating services in a cost effective manner. Patient continuing to use Lovenox and declining further Care Management services. Case to be closed.								
Case: 1021581								
FIRST QUARTER								
Time in Case Management:	2 Months			**Status:**	Closed			
Diagnosis	Respiratory Distress			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient admitted to hospital with respiratory distress. Discharged to home with home therapy visits to increase strength. Care Management monitored therapy progress to insure medical necessity per policy guidelines. Goals met and therapy discontinued and case closed.								
Case: 1021810								
FIRST QUARTER								
Time in Case Management:	4 Months			**Status:**	Open			
Diagnosis	End Stage Renal Disease			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient has had a kidney/pancreas transplant previously that failed. Care Management reviewed Medicare eligibility. Second transplant with husband as donor occured in January. Care Management to continue to monitor patient for response to transplant and medical stability. Care Management to coordinate benefits and services in a cost effective manner.								

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THIRD QUARTER								
Time in Case Management:	7 Months			**Status:**	Closed			
Diagnosis	End Stage Renal Disease			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Management has been monitoring this patient for any post renal transplant needs. The patient has been independent and required no post discharge needs. No cost savings have been reported during this reporting period								
Case: 1021259								
FIRST QUARTER								
Time in Case Management:	5 Months			**Status:**	Open			
Diagnosis	Total Hip Replacement			**Year to date Cost Savings**			$1,400.00	
IN/Outpatient Savings:	$1,400.00			**Case to date Cost Savings**			$1,400.00	
Case Summary:								
Patient increasingly incapacitated by degenerative arthritis to the right hip elected for a replacement. Patient and spouse are both blind. Patient transferred to sub acute nursing facility for rehabilitation therapies. Care Management reviewed medical records for progress and medical necessity according to policy guidelines. Sub acute goals met. With Care Management intervention, 4 skilled nursing days were saved at $350 each. The patient discharged to home and out patient therapies. Care Management is offering support and coordinating services in a cost effective manner. Care Management will continue to monitor services until goals are met.								
Case: 1017015								
FIRST QUARTER								
Time in Case Management:	14 Months			**Status:**	Closed			
Diagnosis	Esophageal Cancer with Brain Meta			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$146.08	
Case Summary:								
Patient admitted to hospice for end of life care. One admission to hospital for pain issues. Care Management providing support to family and coordination of benefits in a cost effective manner. Patient expired 1/7/03.								

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Case: 1022733								
FIRST QUARTER								
Time in Case Management:	1 Month			**Status:**	Closed			
Diagnosis	Thermal Burns			**Year to date Cost Savings**			$1,300.00	
IN/Outpatient Savings:	$1,300.00			**Case to date Cost Savings**			$1,300.00	
Case Summary:								
Patient experienced thermal burns to lower extremities bilaterally at work. Subrogation claim filed. Discharged to home with out patient therapy for rehabilitation. Care Management reviewed medical records for progress and provided support to the patient. With Care Management intervention and review of medical records, 1 skilled nursing visit and 12 physical therapy visits were saved. Goals met and patient returned to work.								
Case: 1017869								
FIRST QUARTER								
Time in Case Management:	13 Months			**Status:**	Open			
Diagnosis	Reproductive & Pancreatic Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Newly diagnosed with Pancreatic Cancer patient began courses of radiation and chemotherapy. Care Management investigated treatments to insure that they are approved for diagnosis. Care Management coordinated services and benefits in a cost effective manner and provided support to the patient and family. Patient is apprehensive of future. Care Management to continue to monitor care.								
SECOND QUARTER								
Time in Case Management:	16 Months			**Status:**	Open			
Diagnosis	Reproductive & Pancreatic CA			**Year to date Cost Savings**			$8,700.00	
IN/Outpatient Savings:	$8,700.00			**Case to date Cost Savings**			$8,700.00	
Case Summary:								
As a result of Care Management intervention, cost savings were calculated utilizing usual and customary rate for a skilled nursing facility of $350/day. The patient was directed to an assisted living facility at family expense minus the cost of nine physical therapy visits. The Care Manager contacted the discharge planner, the assisted living facility, the physicians, and family to coordinate services for the patient, who has a poor prognosis due to numerous primary cancer sites. Many discussions with the patient's spouse, who lives in Wisconsin, have occurred to keep the spouse informed and in charge of the situation. A list of contracted providers were submitted to the family and decisions will be made when it is known where the patient will reside after discharge from the current hospital stay								

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THIRD QUARTER								
Time in Case Management:	19 Months			**Status:**	Closed			
Diagnosis	Reproductive & Pancreatic CA			**Year to date Cost Savings**			$8,700.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$8,700.00	
Case Summary:								
Care Management had been involved with this case and transitioned the patient to home hospice. The patient continued to live at her assisted living facility, but plans were being completed to transition to an inpatient hospice setting as the patient's care had exceeded the care available at the assisted living facility. The patient expired prior to the transfer. Cost savings had been noted on this case in the past when Care Manager recommended transferring the patient to an assisted living facility instead of having the patient remain in a skilled nursing facility.								
Case: 1020812								
FIRST QUARTER								
Time in Case Management:	4 Months			**Status:**	Closed			
Diagnosis	Perforated Colon			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient progressing well with medical supervision and family support and requests Care Management services be discontinued. Case to be closed.								
Case: 1020122								
FIRST QUARTER								
Time in Case Management:	8 Months			**Status:**	Open			
Diagnosis	Osteomyelitis/open wound on foot			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient and spouse deciding on possibility of amputation of foot relating to Osteomyelitis of foot. Second opinion requested and surgeon reviewing medical records. Care Management assisting in coordination of benefits and services and providing support to patient and family.								
SECOND QUARTER								
Time in Case Management:	11 Months			**Status:**	Open			
Diagnosis	Osteomyelitis/open wound on foot			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								

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Patient has resolved the potential change in lifestyle which will result in a pending amputation. Physical therapy was brought in to teach transfer in anticipation of the this surgery and home remodeling is being researched. The patient still remains non-compliant with the diabetic regime. Care Manager continues to coordinate services in a cost effective manner and offering support to the patient's spouse								
THIRD QUARTER								
Time in Case Management:	15 Months			**Status:**	Open			
Diagnosis	Osteomyelitis/open wound on foot			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
The Care Manager provided the family with lists of contracted providers where they may obtain a scooter so that the patient may remain active though off feet. Alternative funding sources were also being investigated to assist in the coverage of this piece of equipment to keep out of pocket costs to a minimum.								
Case: 1021144								
FIRST QUARTER								
Time in Case Management:	4 Months			**Status:**	Closed			
Diagnosis	Abscess of Foot			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Multiple admission to hospital for Congestive Heart Failure and finally a severely broken wrist with a reaction to the antibiotics. COBRA termed 1/1/03 during last hospital stay. Care Management assisted in coordination of benefits and services and reviewed medical progress until insurance termed.								
Case: 1020367								
FIRST QUARTER								
Time in Case Management:	8 Months			**Status:**	Open			
Diagnosis	Mesothelioma			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Diagnosed 3.5 years ago with Mesothelioma. Chemotherapy stabilized tumors and the patient functions independently at home and is tolerating all procedures well. Chemotherapy is palliative. Care Management reviewed medical records and assisted in coordination of services and benefits in a cost effective manner. Care Management provided support and information to spouse and patient.								
THIRD QUARTER								
Time in Case Management:	11 Months			**Status:**	Open			
Diagnosis	Mesothelioma			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	

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Case Summary:								
Care Management has reviewed medical records. Chemotherapy stabilized the tumors. Treatment is pallative. Care Management will close at this time as there are no needs Care Management can impact.								
FOURTH QUARTER								
Time in Case Management:	14 Months			**Status:**	Open			
Diagnosis	Mesothelioma			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
The patient has been started on an experimental chemotherapy and it is reported that there is no charge to the patient for this trial. Care Management will continue to follow this case to facilitate coordination of the patient's services in a cost effective manner on behalf of the State of Wisconsin. No cost savings can be reported during this period as providers are in the PPO network and utilization could not be impacted.								
Case: 1021150								
FIRST QUARTER								
Time in Case Management:	5 Months			**Status:**	Open			
Diagnosis	Breast Cancer			**Year to date Cost Savings**			$800.00	
IN/Outpatient Savings:	$800.00			**Case to date Cost Savings**			$800.00	
Case Summary:								
Patient discharged from out patient physical therapy for soft tissue edema, pain and scapular instability. Patient planning on returning to work. Care Management assisting in coordination of benefits and providers in a cost effective manner and providing support to the patient. Appropriate records were requested and reviewed to evaluate the patient's progression to discharge goals from physical therapy and to anticipate future needs. Care Management intervention provided for a cost savings for aversion of 8 physical therapy visits. Care management will continue to monitor the patient until medically stable.								
THIRD QUARTER								
Time in Case Management:	8 Months			**Status:**	Open			
Diagnosis	Breast Cancer			**Year to date Cost Savings**			$800.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$800.00	
Case Summary:								
Care Management maintained contact with the physician, the patient and the therapist working with the patient after surgeries. During the hospitalizations, Care Management kept in contact with the discharge planner to obtain information regarding the patient's condition, treatment plan and response to treatment in order to anticipate any discharge needs. Care Management made recommendation to the carrier for ongoing outpatient physical therapy. Since this patient utilized PPO Providers, no cost savings can be captured at this time. There is a potential for future cost savings dependent upon if other treatment options are explored.								

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THIRD QUARTER								
Time in Case Management:	10 Months			**Status:**	Closed			
Diagnosis	Breast Cancer			**Year to date Cost Savings**			$800.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$800.00	
Case Summary:								
Care Management continued to monitor medical progress and noted that there was little opportunity to improve the patient's outcome. Patient is medically stable and compliant with self care and follow up appointments. This case will be closed at this time unless needs change.								
Case: 1020345								
FIRST QUARTER								
Time in Case Management:	7 Months			**Status:**	Closed			
Diagnosis	Total Knee Replacement			**Year to date Cost Savings**			$12,402.00	
IN/Outpatient Savings:	$12,402.00			**Case to date Cost Savings**			$13,226.00	
Case Summary:								
Replacement of knee and prosthesis became infected. Inpatient rehab requested, but at Case Management recommendations, patient was discharged to sub acute nursing facility for ongoing therapies. Care Management reviewed appropriate medical records for progression to discharge goals. Care Management assisted in coordination of benefits and services in a cost effective manner. Sub acute rehab facility was out of network and per diem rate negotiated with facility with a cost savings of $12,402.00.								
Case: 1022208								
FIRST QUARTER								
Time in Case Management:	3 Months			**Status:**	Open			
Diagnosis	Multiple Fractures from MVA			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient was a restrained back seat passenger in a motor vehicle accident. Patient continues to have rib pain and lung infiltrates. Discharged from hospital to home with assist of home care agency for teaching on pacemaker care and assessment. Care Management assisted in coordination of services between hospital, physician and home care agency in a cost effective manner. Care Management reviewed appropriate medical records and recommendations to in network providers. Care Management to continue to monitor patient until medically stable.								

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Case: 1022964								
FIRST QUARTER								
Time in Case Management:	1 Month			**Status:**	Open			
Diagnosis	Total Hip Replacement			**Year to date Cost Savings**			$11,305.40	
IN/Outpatient Savings:	$11,305.40			**Case to date Cost Savings**			$11,305.40	
Case Summary:								
Patient with a history of OsteoArthritis was admitted for a right hip replacement and discharged to home with home physical and occupational therapy and skilled nursing visits for wound dressing. The requested inpatient rehabilitation was averted thus saving State of WI $11,525 minus 2 physical therapy visits at home for a total cost savings of $11,305.40. The patient is obese and progression to discharge goals is slow. Care Management assisted in coordination of services and benefits in a cost effective manner. Care Management is reviewing medical records to monitor progression to discharge goals.								
SECOND QUARTER								
Time in Case Management:	4 Months			**Status:**	Closed			
Diagnosis	Total Hip Replacement			**Year to date Cost Savings**			$12,074.00	
IN/Outpatient Savings:	$768.60			**Case to date Cost Savings**			$12,074.00	
Case Summary:								
Care Management continued to monitor medical records until discharge to home with support from home physical and occupational therapy until goals were met. Care Manager assisted in directing cares to in-network providers and monitored coordination of services in a cost effective manner. With Care Management intervention,7 visits were noted not to be medically necessary with savings to the State of WI of $768.60 calculated.								
Case: 1019746								
FIRST QUARTER								
Time in Case Management:	9 Months			**Status:**	Open			
Diagnosis	Colon Cancer			**Year to date Cost Savings**			$880.00	
IN/Outpatient Savings:	$880.00			**Case to date Cost Savings**			$880.00	
Case Summary:								
Patient continues to be treated with oral chemotherapy and routine visits to oncologist. Care Management attempted to have home care agency teach the spouse to administer TPN but spouse has refused and patient is too weak to perform task independently. At Care Management recommendation, patient and spouse were taught to disconnect and flush the lines, saving 1 RN visit per day, which has resulted in the savings noted.								

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SECOND QUARTER								
Time in Case Management:	12 Months			**Status:**	Open			
Diagnosis	Colon Cancer			**Year to date Cost Savings**			$5,280.00	
IN/Outpatient Savings:	$4,400.00			**Case to date Cost Savings**			$5,280.00	
Case Summary:								
As a result of Care Management intervention, cost savings were calculated utilizing the actual charge of $110 per visit and the actual number of visits provided versus the requested number of 58 visits. Visits were averted, when at the recommendation of the Care Manager, the home care agency worked with the spouse until a comfort levels was reached in providing all aspects of care related to the TPN. The patient continues to be treated with oral chemotherapy and follows up with the Oncologist on a routine basis. Care Management continues to monitor services to coordinate them in a cost effective manner.								
THIRD QUARTER								
Time in Case Management:	15 Months			**Status:**	Closed			
Diagnosis	Colon Cancer			**Year to date Cost Savings**			$5,280.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$5,280.00	
Case Summary:								
Care Management continued to be involved with the patient and spouse until the patient expired. Care Management had worked with the spouse, the home care agency and the physician to complete care related to the use of TPN and the IV antibiotics. Through this continued intervention, Care Management eliminated the need for continued home care services. Prior to the patient's death, the patient and spouse were able to complete the administration of the IV antibiotics and the TPN Independently.								
Case: 1022779								
FIRST QUARTER								
Time in Case Management:	1 Month			**Status:**	Closed			
Diagnosis	Fractured Ankle			**Year to date Cost Savings**			$1,890.00	
IN/Outpatient Savings:	$1,890.00			**Case to date Cost Savings**			$1,890.00	
Case Summary:								
Care Management received and reviewed medical record information for requested skilled nursing facility placement. Information gathered from evaluating the physical therapist indicated that the program that the patient was involved in was a restorative program and did not meet plan guidelines. Peer Review done provided that this patient did not meet criteria for this level of care and resulted in the calculated savings of $1,890.								

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Case: 1022709								
FIRST QUARTER								
Time in Case Management:	1 Month			**Status:**	Open			
Diagnosis	Right Knee Replacement			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Right knee replacement performed in February of 2003. Patient discharged to home with home care visits for monitoring of anticoagulation therapy and wound assessment. Home physical therapy brought in for strengthening and balance and gait. Care Management requested and reviewed appropriate medical records for progression to discharge goals. Care Management coordinated services and benefits in a cost effective manner while achieving needs of the patient. Care Management will continue to monitor care.								
SECOND QUARTER								
Time in Case Management:	4 Months			**Status:**	Closed			
Diagnosis	Right Knee Replacement			**Year to date Cost Savings**			$2,200.00	
IN/Outpatient Savings:	$2,200.00			**Case to date Cost Savings**			$2,200.00	
Case Summary:								
The patient is working with a home exercise program and is gaining strength and mobility. A left total knee replacement is planned in the near future. Care Management facilitated a smooth and cost effective transition from home physical therapy to outpatient therapy. Care Management reviewed medical records to assure medical necessity and an ultimate discharge from outpatient therapy. Costs savings are noted as the home care agency requested 18 skilled nursing visits and only 3 were noted to be medically necessary. The agency requested 12 physical therapy visits and only 5 were medically necessary before a transition to outpatient therapy, providing for a total of $2,200.00 in cost savings.There is no further impact that Care Management can have. The case will be closed.								
THIRD QUARTER								
Time in Case Management:	2 Months			**Status:**	Closed			
Diagnosis	Right Hip Replacement			**Year to date Cost Savings**			$600.00	
IN/Outpatient Savings:	$600.00			**Case to date Cost Savings**			$2,800.00	
Case Summary:								
During the reporting period, contact was established with the patient, hospital discharge planner, the physician's office and the home care agency to facilitate coordination of the patient's services in a cost effective manner. Appropriate records were requested and reviewed from Meriter Home Healthcare regarding the patient's condition, treatment plan and progress with therapy. Cost savings were noted with review of these medical records. 8 skilled nursing visits were requested with only 4 determined as medically necessary. Seven physical therapy visits were requested with only 5 being medically necessary thus providing a cost savings of $600.00 in home care visits.								

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Case: 1022839								
FIRST QUARTER								
Time in Case Management:	1 Month			**Status:**	Closed			
Diagnosis	Coronary Artery Bypass Grafting			**Year to date Cost Savings**			$110.00	
IN/Outpatient Savings:	$110.00			**Case to date Cost Savings**			$110.00	
Case Summary:								
Patient discharged to home with home care following a Coronary Artery Bypass Grafting. Care Management assisted in coordinating services and benefits in a cost effective manner. Care Management requested and reviewed appropriate medical records and made the recommendation for discharge from home care when discharge goals appeared to have been met, thus saving 1 skilled nursing visit.								
Case: 1020971								
FIRST QUARTER								
Time in Case Management:	8 Months			**Status:**	Closed			
Diagnosis	Perforated Viscus			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Management monitored the patient's medical records and maintained continuous contact with the discharge planner to insure medical necessity. The patient was discharged from the hospital to a skilled nursing facility because the spouse was unable to care for the patient due to his/her own health status. Care Management will close this case as cares in the skilled nursing facility will not meet the plan guidelines.								
Case: 1023098								
SECOND QUARTER								
Time in Case Management:	3 Months			**Status:**	Open			
Diagnosis	Lung CA with Mets			**Year to date Cost Savings**			$480.00	
IN/Outpatient Savings:	$480.00			**Case to date Cost Savings**			$480.00	
Case Summary:								
The patient's response to radiation and chemotherapy has been poor. The patient and spouse have been advised that the prognosis is terminal, but have declined home health or hospice originally, but later accepted. Care Management has maintained communication with the physician, family and hospital to assess the patient's condition. Coordination of the services provided are being coordinated by Care Management in a cost effective manner. Negotiations with the hospice agency for a per diem rate vs a visit rate has provided cost savings shown. Care Management will continue to monitor this case in order to intervene if necessary.								

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THIRD QUARTER								
Time in Case Management:	4 Months			**Status:**	Closed			
Diagnosis	Lung CA with Mets			**Year to date Cost Savings**			$480.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$480.00	
Case Summary:								
Information regarding eligibility, benefits and network were verified with Blue Cross. Network status of the hospital and physicians was verified with Customer Service to assist in managing costs. Contact was maintained with the family, physician, and hospice agency staff to evaluate the patient's condition. Coordination of the patient's services were faciliated in a cost effective manner. Patient expired at home on July 2, 2003.								
Case: 1023063								
SECOND QUARTER								
Time in Case Management:	4 Months			**Status:**	Open			
Diagnosis	CVA with an MI			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
During a Cardiac Bypass after an MI the patient suffered a stroke. Inpatient rehab was initiated and put on hold after the patient became vent dependent due to Pneumonia. Upon resolution of the pneumonia the patient was discharged to a skilled nursing facility for continued rehabilitation therapies. Continued review of the medical reports from the Skilled Nursing Facility for continued stay needs was maintained. Based on the records received, a Physician Review was requested on 3 separate occasions where a decision of the patient not meeting plan criteria was overturned by a Peer to Peer Review. Care Management will continue to review the patient's needs for skilled nursing facility stay. Care Management will continue to remain in contact with providers and family to assist in future needs.								
THIRD QUARTER								
Time in Case Management:	7 Months			**Status:**	Open			
Diagnosis	CVA with an MI			**Year to date Cost Savings**			$15,384.00	
IN/Outpatient Savings:	$15,384.00			**Case to date Cost Savings**			$15,384.00	
Case Summary:								
During this reporting period, Care Management reviewed notes received from Lakeside Nursing and Rehabilitation for continued stay needs. Based on records received, a Physician Review and Peer to Peer was requested on 6/24/03. The Physician Review determined that the patient did not meet the criteria to continue the stay at a skilled nursing facility. An appeal was requested on 6/26 and the decision was upheld. Care Management will continue to review patient continued needs to assist with any future needs. Continued review of medical records provided another Physician Review on 7/31/03. The Physician Review determined that the patient did not meet plan criteria for the stay at a skilled nursing facility. An appeal was faxed to Care Management for a Peer to Peer Review. The decision was upheld. The patient became Medicare prime on 8-1-03, therefore Care Management will close this case as there are no other needs Care Management can impact. Savings calculated are the result of Physician Review denials.								

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Case: 1023105								
SECOND QUARTER								
Time in Case Management:	2 Weeks			**Status:**	Closed			
Diagnosis	Venous Thrombosis			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
The referral for Care Management was received from the physician's office to assist in providing home care services. In-network status was verifiied and medical necessity for authorizations for skilled nursing visits were reviewed and approved to teach the patient self injection of Lovenox injections. Care Management closed the case as the patient was self sufficient in care, and services could no longer be impacted.								
Case: 1023347								
SECOND QUARTER								
Time in Case Management:	4 Months			**Status:**	Open			
Diagnosis	Lymphoma			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Two lesions were noted on the brain related to Lymphoma. Planned a course of radiation and chemotherapy. The patient was recently hospitalized for Cellulitis and discharged to home with skilled nursing visits for administration of the IV antibiotics. Care Management maintained contact with the hospital and patient to coordinate services, provide support and evaluate for future needs in a cost effective manner.								
THIRD QUARTER								
Time in Case Management:	7 Months			**Status:**	Open			
Diagnosis	Lymphoma			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Contact was initiated and maintained with the patient to provide support, evaluate the patient's condition and assess for further needs. Contact was established and maintained with the home care agency staff to facilitate coordination of the patient's services in a cost effective manner. Care Management will continue to monitor this patient's condition, treatment plan and response to treatment by monitoring medical records and will manage costs on behalf of the State of Wisconsin.								

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FOURTH QUARTER								
Time in Case Management:	10 Months			**Status:**	Open			
Diagnosis	Lymphoma			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient admitted to the hospital for an Angioplasty of the Iliac and Femoral artery relative to a non-healing foot ulcer due to poor circulation. Patient discharged to a skilled nursing facility for further rehabilitation. Care Management to monitor medical records for medical progress and coordinate services in a cost effective manner for the State of Wisconsin and assess for further needs.								
Case: 1023432								
SECOND QUARTER								
Time in Case Management:	6 Weeks			**Status:**	Closed			
Diagnosis	Post Surgical Infection			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Case referred after patient developed a post surgical infection after a right hip replacement. Patient discharged to home with home care for IV antibiotic therapy and physical therapy for strengthening. Skilled nursing taught the spouse to do the IV therapy and goals were met with physical therapy. Case was closed as Care Manager had achieved goals of coordinating services in a cost effective manner.								
Case: 1022638								
SECOND QUARTER								
Time in Case Management:	5 months			**Status:**	Open			
Diagnosis	Stroke			**Year to date Cost Savings**			$1,540.00	
IN/Outpatient Savings:	$1,540.00			**Case to date Cost Savings**			$1,540.00	
Case Summary:								
As a result of Care Management intervention, cost savings are noted for the aversion of skilled nursing visits. Savings were calculated at the actual rate of $110 per visit with a total of 19 visits requested to provide the services. Care Manager recommended 5 visits for teaching for a total of 14 saved visits. Care Management impacted this case by monitoring the patient's discharge needs for ongoing therapy. The patient is a candidate for a future laminectomy and Care Management will be reviewing the request for inpatient rehabilitation and establishing the most appropriate level of care for the needs. There is a potential for cost savings dependent upon the patient's post operative needs.								

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THIRD QUARTER								
Time in Case Management:	8 months			**Status:**	Open			
Diagnosis	Stroke			**Year to date Cost Savings**			$8,290.00	
IN/Outpatient Savings:	$6,750.00			**Case to date Cost Savings**			$8,290.00	
Case Summary:								
Care Management impacted this case by identifying the need for ongoing therapy and nursing care at the skilled nursing facility level. Care Management negotiated the per diem rate of $450.00 to a per diem rate of $325.00 from 7/21/03 to 9/12/03, saving $125 per day for 54 days. But, due to the patient's decrease in participation in therapies, Care Management recommended discontinuation of the therapies at this time with focus on wound healing and nutritional status and negotiationed a per diem rate to $250.00 from the $325 rate. These cost savings will be reports on a future report when therapies commence again. Care Management has been in contact with family and a close friend to discuss potential discharge planning issues. Care Management continues to maintain contact with the Case Manager at the skilled nursing facility to obtain weekly updates on this patient's condition in order to identify medical necessity for ongoing stay.								
FOURTH QUARTER								
Time in Case Management:	10 months			**Status:**	Open			
Diagnosis	Stroke			**Year to date Cost Savings**			$25,818.00	
IN/Outpatient Savings:	$17,528.00			**Case to date Cost Savings**			$25,818.00	
Case Summary:								
Care Management impacted this case by identifying that this patient was not meeting the criteria for ongoing skilled nursing facility stay at $325/day as therapies had been discontinued but skilled nursing for wound care was still required. Per diem rate was negotiated down to $250/day. By 10/14, it was determined that wound care could be handled at a lower level of care and a Physician's Review was requested with the outcome identifying non-coverage for ongoing skilled nursing facility stay resulting in a cost savings of $10,400. Continued cost savings for care 10-31 to 12-14 is $7,128. Care Management will continue to monitor medical records and assist in coordination of services in a cost effective manner.								
Case: 1023374								
SECOND QUARTER								
Time in Case Management:	6 weeks			**Status:**	Closed			
Diagnosis	Pancreas Transplant			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Manager reviewed all information provided. During course of conversations with the transplant staff it was determined that Medicare A was primary payor for the procedure. Case closed as care manager not able to impact services.								

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Case: 1023576								
SECOND QUARTER								
Time in Case Management:	2 Months			**Status:**	Open			
Diagnosis	Stroke			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Case referred to evaluate medical appropriateness of inpatient rehab at a skilled nursing facility after exhaustion of Medicare Part A benefits for year 2002. Medical records have been requested for Care Manager to review. Care Manager will continue to monitor services.								
THIRD QUARTER								
Time in Case Management:	3 Months			**Status:**	Closed			
Diagnosis	Stroke			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
The patient continues at a skilled nursing facility. There are no services that can be impacted this period as all providers are in the PPO network and utilization could not be impacted.								
Case: 1024050								
SECOND QUARTER								
Time in Case Management:	1 Month			**Status:**	Open			
Diagnosis	Lumbar Spinal Stenosis			**Year to date Cost Savings**			$77.00	
IN/Outpatient Savings:	$77.00			**Case to date Cost Savings**			$77.00	
Case Summary:								
As a result of Care Management intervention, cost savings can be noted. Savings were achieved by negotiating the usual and customary rate of $41/per day to a negotiated rate of $30/day for 7 days to date of report. A specialized mattress was authorized for a 1 month trial to reduce pressure and pain. Care Manager will continue to impact this case with the monitoring of therapy needs and DME (durable medical equipment) needs.								

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THIRD QUARTER								
Time in Case Management:	4 Month			**Status:**	Open			
Diagnosis	Lumbar Spinal Stenosis			**Year to date Cost Savings**			$1,177.00	
IN/Outpatient Savings:	$1,100.00			**Case to date Cost Savings**			$1,177.00	
Case Summary:								
Care Management verified network status of Duke Center for Living with Customer Service. During this reporting period, contact was maintained with the patient and spouse to provide support, evaluate the patient's condition and assess for further needs. Contact was established with the Physical Therapist at Duke Center for Living to facilitate coordination of the patient services in a cost effective manner on behalf of the State of Wisconsin. Therapy notes from Duke Center for Living were requested and reviewed for information regarding medical necessity , the patient's condition, response to therapy and progress made during the sessions. Recommendations were made. In response to the review of therapy notes, cost savings will be noted on the report in the next quarter. Care Management services will continue at a Level II status to monitor the patient's condition, treatment plan and response to treatment in order to intervene in a cost effective manner.								
FOURTH QUARTER								
Time in Case Management:	5 Month			**Status:**	Closed			
Diagnosis	Lumbar Spinal Stenosis			**Year to date Cost Savings**			$2,813.25	
IN/Outpatient Savings:	$1,636.25			**Case to date Cost Savings**			$2,813.25	
Case Summary:								
Contact was established with the Physical Therapist to facilitate coordination of services in a cost effective manner. Medical records were reviewed for information regarding the patient's condition, response to therapy and progress made in order to make appropriate recommendations for continued utilization of out patient therapy. As a result of Care Management intervention, a total of 46 therapy visits were request with only 35 recommended saving $1,416.25 and rates were negotiated from $41/day to $30/day for a low air loss overlay mattress for an additional savings of $220.00. Care Management will close this case as the patient is medically stable and no services are being provided that Care Management can impact.								
Case: 1023816								
SECOND QUARTER								
Time in Case Management:	5 weeks			**Status:**	Closed			
Diagnosis	Total Hip Replacement			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Management monitored medical records to ensure medical necessity. Course of treatment was uneventful. Care Management assisted the patient with cost effective durable medical equipment procurement.								

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Case: 1024140								
SECOND QUARTER								
Time in Case Management:	1 Month			**Status:**	Open			
Diagnosis	Chronic Obstructive Pulmonary Dise			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
The Care Manager monitored the patient's inpatient stay and maintained contact with the discharge planner so as to intervene in a cost effective manner. The Care Manager maintained contact with the patient and family to insure all needs were being met and to monitor for discharge needs to coordinate services in a cost effective manner.								
FOURTH QUARTER								
Time in Case Management:	4 Months			**Status:**	Open			
Diagnosis	Chronic Obstructive Pulmonary Dise			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Management has monitored the patient's outpatient care at the hospital. Contact was made and maintained with the radiation oncology department to intervene in a cost effective manner as needed. Contact was established and maintained with the patient to identify healthcare needs and coordinate services. Care Management will continue to monitor healthcare needs and intervene in a cost effective manner as appropriate.								
Case: 1024277								
SECOND QUARTER								
Time in Case Management:	1 Month			**Status:**	Closed			
Diagnosis	Progressive Scoliosis			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Management has determined that the patient has an alternative funding source in place with Title 19 and has a county Social Worker involved in care needs. Care Manager identified the patient will be receiving physical therapy services from a private party in lieu of an in-network home care agency. The case will be closed to Care Management as there are no services for Care Management to impact at this time.								

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Case: 1023920								
SECOND QUARTER								
Time in Case Management:	6 Weeks			**Status:**	Open			
Diagnosis	Lymphocytic Leukemia			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Currently the patient is not requiring any interventions or treatments. The plan is to have the patient receive chemotherapy within 3 months. The chemotherapy regime will consist of Cytoxan, Rotuxin and Fludara. Care Management has been in contact with the patient's family and the physician's office. Care Management will continue to follow the patient for potential intervention and health cares needs and coordinate services in a cost effective manner.								
THIRD QUARTER								
Time in Case Management:	5 Months			**Status:**	Open			
Diagnosis	Lymphocytic Leukemia			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Currently the plan is to have the patient receive chemotherapy in the Outpatient Oncology Clinic. The chemotherapy regime will consist of Cytoxan, Rituxin and								
FOURTH QUARTER								
Time in Case Management:	7 Months			**Status:**	Closed			
Diagnosis	Lymphocytic Leukemia			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
The current plan is to have the patient receive chemotherapy in the outpatient Oncology Clinic. The Care Manager has been in contact with the patient's family and physician's office to coordinate services in a cost effective manner. Care Management will close this case as Medicare is now primary.								
Case: 1024071								
SECOND QUARTER								
Time in Case Management:	1 Month			**Status:**	Open			
Diagnosis	Pulmonary Collapse			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Manager monitored medical records and maintained contact with the hospital discharge planner to determine discharge needs and coordinate services in a cost effect manner. Patient was discharged to home without needs. Care Manager contacted the patient who agreed to contact Care Manager with any ongoing needs. Utilization could not be impacted this reporting period.								

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FOURTH QUARTER								
Time in Case Management:	1 Month			**Status:**	Open			
Diagnosis	Pulmonary Collapse/Liver Ascites			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
The patient has had several hospitalizations due to ascites related to liver failure. The patient has stated to Care Management that continued follow up with current physician was not anticipated although patient continues to have complex medical needs. Care Management will continue to coordinate care with providers to decrease utilization costs.								
Case: 1023765								
SECOND QUARTER								
Time in Case Management:	1 Month			**Status:**	Open			
Diagnosis	Total Hip Replacement			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
The Care Manager accessed that the patient needs to work on balance, especially since this is the second hip surgery in a few months, encouraged the patient to utilize outpatient therapy by the third week of June. Outpatient therapy will increase strength and mobility by using machines, which is more cost effective. Care Manager will monitor medical records for medical appropriateness.								
THIRD QUARTER								
Time in Case Management:	2 Months			**Status:**	Closed			
Diagnosis	Total Hip Replacement			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
The Care Manager worked closely with the patient during the home care visits in order to transition to outpatient therapy when appropriate. However this next level of care was not necessary. Patient used three skilled nursing visits and three physical therapy visits and was productive in the home exercise program and is incorporating these into functional activities. Having been discharged from the orthopedic surgeon, the case was closed as no further needs were identified.								

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Case: 1023649								
SECOND QUARTER								
Time in Case Management:	2 Months			**Status:**	Open			
Diagnosis	CA with Mets			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient admitted to hospital with a three day history of fever. Discharged to home with no discharge needs. Spouse assists with dressing changes at tumor excision site.. Care Manager maintained contact with discharge planner and reviewed medical reports to facilitate a safe discharge to home in a cost effective manner. Patient reports future contact with Oncologist to plan continued treatment of cancer. Patient had a recent toxic reaction to chemotherapy. Care Manager will continue to monitor care to coordinate services in a cost effective manner.								
FOURTH QUARTER								
Time in Case Management:	3 Months			**Status:**	Closed			
Diagnosis	CA with Mets			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Management continued to coordinate services in a cost effective manner. Admitted to Hospice Care for Squamous Cell Carcinoma with metastasis. Patient expired at home on 10-11-03								
Case: 1023319								
SECOND QUARTER								
Time in Case Management:	3 Months			**Status:**	Open			
Diagnosis	Sacral Fracture			**Year to date Cost Savings**			$665.00	
IN/Outpatient Savings:	$665.00			**Case to date Cost Savings**			$665.00	
Case Summary:								
Care Management impacted the patient's care needs through utilization of home health care services to assist with a timely hospital discharge. Cost savings were obtained from home physical therapy visits. The plan of care requested a total of nine therapy visits and a total of four visits were approved with Care Management reviewing medical records for medical appropriateness. Care Management facilitated a request for Acupuncture as a method of pain control. Care Management will continue to monitor patient's recovery process and monitor for need for outpatient therapy and the response to therapy.								

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THIRD QUARTER								
Time in Case Management:	4 Months			**Status:**	Closed			
Diagnosis	Sacral Fracture			**Year to date Cost Savings**			$665.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$665.00	
Case Summary:								
Care Management monitored the patient's recovery process and utilization of outpatient therapy that included the patient's response to the therapy. The case will be closed to Care Management services as there are no needs or services that care management can impact.								
Case: 1024087								
THIRD QUARTER								
Time in Case Management:	2 Months			**Status:**	Open			
Diagnosis	Respiratory Distress Syndrome			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Management recommended that the patient investigate if any of his medical care or medications related to his respiratory condition might be obtained through the VA, since his issues started when he was in the military. A subrogation request was filed on behalf of the State of Wisconsin. Medical records were reviewed for medical necessity and the patient was discharged home to family and home care services. Care Management will continue to monitor care for medical necessity and make recommendations accordingly.								
FOURTH QUARTER								
Time in Case Management:	5 Months			**Status:**	Open			
Diagnosis	Respiratory Distress Syndrome			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient recently hospitalized with recurrent pneumonia requiring ventilatory care for 8 days in ICU. Discharged to home with physical therapy for improved strength and endurance. Care Manager maintained contact with medical providers and the patient to coordinate services and provide support. Care Manager recommended the patient investigate if any medical care or medications could be provided through the VA as condition started when in the military.								

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Case: 1024692								
THIRD QUARTER								
Time in Case Management:	1 Month			**Status:**	Closed			
Diagnosis	Wound Ulceration & Ischemia			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient declined surgical intervention for ulcerations and ischemia. Discharged back to skilled nursing facility with hospice in place and expired 7/28. Care Management assisted in the discharge to the skilled nursing facility with hospice and coordination of services and benefits.								
Case: 1024485								
THIRD QUARTER								
Time in Case Management:	1 Month			**Status:**	Closed			
Diagnosis	Wound Ulceration & Ischemia			**Year to date Cost Savings**			$4,517.40	
IN/Outpatient Savings:	$4,517.40			**Case to date Cost Savings**			$4,517.40	
Case Summary:								
A review was requested for medical necessity. Medical records were obtained and submitted for Physician Review and it was determined that the patient's needs did not meet plan language for benefit coverage. Cost savings were identified through review of the patient's medical records to determine eligibility/criteria for reimbursement of skilled nursing facility days after exhaustion of Medicare benefit utilizing the available insurance benefit for 30 days.								
Case: 1024358								
THIRD QUARTER								
Time in Case Management:	2 Weeks			**Status:**	Closed			
Diagnosis	Fractured Wrist			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient admitted to hospital fafter a fall resulting in a fractured wrist. Care Management reviewed medical records for medical necessity and patient was discharged to home with no discharge needs. Care Management will close case as there are no services care management can impact.								

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Case: 1024101								
THIRD QUARTER								
Time in Case Management:	2 Months			**Status:**	Closed			
Diagnosis	Spinal Fusion			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Spinal fusion provided in response to increase back pain which had begun interferring with functions of daily living. Care Management reviewed medical records. Patient transferred to inpatient rehabilitation post surgery for continued therapy. Progress continues and there was a discharge to out patient therapy. Care Management continues review of medical records for medical necessity.								
Case: 1025128								
THIRD QUARTER								
Time in Case Management:	1 Month			**Status:**	Closed			
Diagnosis	Malignant Pleural Effusion			**Year to date Cost Savings**			$10,500.00	
IN/Outpatient Savings:	$10,500.00			**Case to date Cost Savings**			$10,500.00	
Case Summary:								
Referred for medical necessity as Medicare benefit exhausted. Medical records were review and Physician Review performed. Decision provided that stay did not meet plan language. As a result of Care Management intervention, cost savings will be noted for aversion of continued skilled nursing facility stay. Savings were calculated utilizing the typical rate of $350 for a 30 day length of stay. Care Management services will be discontinued at this time as there are no services that can be impacted by Care Management.								
Case: 1025130								
THIRD QUARTER								
Time in Case Management:	1 Month			**Status:**	Closed			
Diagnosis	Lower Extremity Pain			**Year to date Cost Savings**			$10,500.00	
IN/Outpatient Savings:	$10,500.00			**Case to date Cost Savings**			$10,500.00	
Case Summary:								
Patient not able to tolerate skilled nursing facility therapies and therefore exhausted Medicare benefits. Referred for medical necessaity. Review of medical records and Physician Review decision determined that the stay did not meet medical criteria of paln language. With Care Management intervention, cost savings can be shown for the aversion of continued skilled nursing facility stay. Savings were calculated utilizing the typical rate of $350 per day for a 30 day length of stay. Care Management will be closed at this time as there are no medical needs Care Management can impact.								

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Case: 1024868								
THIRD QUARTER								
Time in Case Management:	2 Month			**Status:**	Open			
Diagnosis	Total Hip Replacement			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Total hip replacmenet surgery and discharged home to home therapy. Patient suffered a fall at home and fractured femur and was readmitted to hospital. Care Management revewed medical records for medical necessity and coordination of services. Discharge plans include discharge to a skilled nursing facility for rehabilitation. Care management will continue to monitor medical records and maintain contact with the discharge planner, social services and physician to coordinate benefits and services in a cost effective manner on behalf of the State of WI.								
FOURTH QUARTER								
Time in Case Management:	3 Months			**Status:**	Closed			
Diagnosis	Total Hip Replacement			**Year to date Cost Savings**			$1,355.00	
IN/Outpatient Savings:	$1,355.00			**Case to date Cost Savings**			$1,355.00	
Case Summary:								
As a result of Care Management intervention, savings were negotiated with the skilled nursing facility form a $325/day rate to $250/day saving $975.00 and physical therapy requested 8 visits at $190/visit and Care Management recommended 6 visits saving 2 visits for a total of $380. The case was closed at this time as no services were being provided that Care Management could impact.								
Case: 1024295								
THIRD QUARTER								
Time in Case Management:	2 Month			**Status:**	Open			
Diagnosis	Total Hip Replacement			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Admitted for a total hip replacement with an uneventful hospital course. Patient only has Medicare B as Primary coverage. Care management reviewed medical records and maintained contact with the discharge planner, physician and social services. Patient discharged to home with no home care needs and will receive out patient physical therapy.								

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Case: 1024651								
THIRD QUARTER								
Time in Case Management:	2 Month			**Status:**	Open			
Diagnosis	Lung Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient with lung cancer with metastasis to the bone. MRI to the brain is planned. Care Management established contact with the patient to provide support, evaluate the patient's condition and assess for future needs. Contact was also established with the Oncologist office to facilitate coordination of services. An internet search was completed to facilitate coordination of providers in a cost effective manner. Care Management will continue to monitor the patient's condition, treatment plan and response to treatment in order to intervene in a cost effective manner on behalf of the State of WI								
THIRD QUARTER								
Time in Case Management:	5 Months			**Status:**	Open			
Diagnosis	Lung Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient has brain and spinal metastasis and prognosis is poor. Care Management established contact with the patient's spouse to provide support and to coordinate services in a cost effective manner. Care Management will continue to monitor the patient's condition, treatment plan and response to treatment in order to intervene in a cost effective manner on behalf of the State of Wisconsin.								
Case: 1025022								
THIRD QUARTER								
Time in Case Management:	2 Months			**Status:**	Open			
Diagnosis	Neoplasm of Kidney			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Management is involved with this case as the patient is currently receiving home health care. The home health agency is providing care for wound care and therapy to improve strength and endurance. Care Management is monitoring the visits being performed and will recommend discharge from the service when the patient is able to demonstrate ability to leave the home safely. Care Management has already advised the home health agency to transition the patient to outpatient services when he is able to leave the home safely. Care management will show savings in the future for the number of home care visits requested and actually utilized.								

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FOURTH QUARTER								
Time in Case Management:	5 Months			**Status:**	Closed			
Diagnosis	Neoplasm of Kidney			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Management had been involved with this case at a very low level of care to monitor follow-up visits eith the physician to determine if there has been any metastasis or any need for further care. Care Management will close this case as the patient is medically stable and has returned to work.								
Case: 1025185								
THIRD QUARTER								
Time in Case Management:	2 Months			**Status:**	Closed			
Diagnosis	Skull Fracture			**Year to date Cost Savings**			$14,673.60	
IN/Outpatient Savings:	$14,673.60			**Case to date Cost Savings**			$14,673.60	
Case Summary:								
Appropriate records were requested and reviewed from the hospital regarding the patient's condition, treatment plan and response to treatment in order to make recommendations for the requested inpatient rehabilitation stay. Recommendations were made to the hospital for sub acute rehabilitation care per the Medical Director upon review of the patient's medical records. A Peer to Peer discussion was also held by the Medical Director and the patient's physician which upheld the recommendation of sub acute rehabilitation stay. The patient was transferred to the inpatient rehabilitation at the family's request. Patient was discharged to home with recommendation for outpatient therapy. Cost savings show the aversion of inpatient rehabilitation stay. Care management advised of an insurance policy change to Prevea effective 9/1/03 and services discontinued.								
Case: 1024787								
THIRD QUARTER								
Time in Case Management:	2 Months			**Status:**	Closed			
Diagnosis	Ankle Fracture			**Year to date Cost Savings**			$5,400.00	
IN/Outpatient Savings:	$5,400.00			**Case to date Cost Savings**			$5,400.00	
Case Summary:								
Referred to review for medical necessity. Patient exhausted Medicare benefits and a request was made from the skilled nursing facility for continued coverage under the State of WI. Appropriate medical records were reviewed and forwarded for a Physician Advisory Review. The Physician Advisory concluded that the days requested did not meet the medical necessity criteria and care appeared to be custodial. There are no services being provided that Care Management can impact. Therefore, this case was closed. Savings incurred were due to days denied by the Physician Review.								

State of Wisconsin
Case Management Summary Report
2003

Case: 1025085								
THIRD QUARTER								
Time in Case Management:	6 Weeks			**Status:**	Closed			
Diagnosis	Pneumonia			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient admitted for difficulty breathing and congestion. IV antibiotics initiated and patient discharged to home with home care for IV administration. Primary carrier, Medicare, covered skilled nursing visits with medical costs being covered by the State of WI. Care Management assisted discharge with coordination of services and benefits for home care medications. Pneumonia resolved and case closed as there are no further services that can be impacted by Care Management.								
Case: 1025025								
THIRD QUARTER								
Time in Case Management:	1 Month			**Status:**	Open			
Diagnosis	Wound Infection			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Post surgical would infection caused an admission to the hospital with an initiation of IV antibiotics. Care Management assisted the discharge planners in locating providers which are in the PPO Network. Care Management will continue to monitor medical records to assure for medical necessity of ongoing skilled nursing visits.								
Case: 1025286								
THIRD QUARTER								
Time in Case Management:	1 Month			**Status:**	Open			
Diagnosis	Total Knee Replacement			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Admitted for a total knee replacement and discharged to home with home health care for physical therapy. Care management assisted the discharge planners and physician office with locating in network providers and coordination of services in a cost effective manner. Care Management will monitor medical records for plan of treatment and progression under the treatment plan and for a timely transition to out patient therapy and medical appropriateness of therapy.								

State of Wisconsin
Case Management Summary Report
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FOURTH QUARTER								
Time in Case Management:	2 Month			**Status:**	Closed			
Diagnosis	Total Knee Replacement			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Discharged from home physical therapy and use of passive range of motion machine to outpatient physical therapy. Care Manager monitored medical records to insure a time transfer from home therapy to outpatient. Patient will be followed by Physical Medicine Review if visits exceed 10 visits.								
Case: 1025252								
THIRD QUARTER								
Time in Case Management:	1 Month			**Status:**	Open			
Diagnosis	Diabetes with Fractured Leg			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
A fall at home resulted in a fractured leg, closed head injury and shoulder contusion. Fluctuating blood sugars extended the hospital stay and ultimate transfer to inpatient rehabilitation. Care Management established contact with the discharge planners and physician's office to assist in coordination of benefits and services in a cost effective manner. Care Management is requesting and reviewing medical records for medical appropriateness and a timely transition to a lower level of care.								
Case: 1025398								
FOURTH QUARTER								
Time in Case Management:	2 Months			**Status:**	Closed			
Diagnosis	Skin Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Surgical intervention for skin cancer with site excision and grafting. Care Manager assisted in transfer to a skilled nursing facility for monitoring of graft site after activity. Care Manager reviewed medical records and recommended two week length of stay. Care Manager will monitor medical records for medical appropriateness and assist with discharge to home.								

State of Wisconsin
Case Management Summary Report
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Case: 1024630								
FOURTH QUARTER								
Time in Case Management:	2 Months			**Status:**	Closed			
Diagnosis	Colon Polyps			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient admitted to hospital for a Colonectomy due to polyps with a temporary ileostomy done. Patient discharged to home with skilled nursing visits to provide teaching and care. Care Management monitored medical necessity for the skilled nursing visits. Care Management also verified that the home care agency was in network. Case was closed as there were no further services Care Management could impact.								
Case: 1025247								
FOURTH QUARTER								
Time in Case Management:	2 Months			**Status:**	Open			
Diagnosis	Colon Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient admitted to the hospital with Pericardial and Pleural Effusion and was diagnosed with Colon Cancer with metastasis to the liver. Discharged to a skilled nursing facility for rehab and discharged to home. Care Management established and maintained contact with the physician's office to facilitate coordination of services in a cost effective manner for the State of Wisconsin. All providers have been kept in network. Care Management will continue to monitor the patient condition, treatment and response to treatment in order to intervene in a cost effective manner								
Case: 1020228								
FOURTH QUARTER								
Time in Case Management:	14 Months			**Status:**	Open			
Diagnosis	Breast Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Care Management has maintained contact with patient, surgeon and oncologist to obtain medical information related to current care being provided and future treatment. Patient is maintaining contact with the surgeon and oncologist on a regular basis to ensure that there has been on recurrence of the disease process. Care Management will continue to monitor patient and providers after discontinuation of chemotherapy.								

State of Wisconsin
Case Management Summary Report
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Case: 1025430								
FOURTH QUARTER								
Time in Case Management:	4 Months			**Status:**	Closed			
Diagnosis	Breast Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Diagnosed with Breast Cancer in June '99. Ongoing chemotherpay with multiple diagnoses related to metastasis of the disease. Care Management established and maintained contact with family, physician, home care staff and hospice staff to facilitate coordination of services in a cost effective manner. Hospice care intiitated at and and the patient was transferred inpatient when pain unmanagable at home. Patient expired 12/11/03.								
Case: 1025192								
FOURTH QUARTER								
Time in Case Management:	2 Months			**Status:**	Open			
Diagnosis	Lymphocytic Leukemia			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient recently admitted to hospital with Agranulocytosis. Patient on oral and IV chemotherapy for the disease. Care Management established and maintained contact with family, physician and out patient oncology clinic to coordinate services in a cost effective manner for State of WI. Care Management provided support to the family and fielded questions related to the disease and process. Care Management will continue monitoring this case for intervention as dictated.								
Case: 1025605								
FOURTH QUARTER								
Time in Case Management:	1 Month			**Status:**	Closed			
Diagnosis	Total Knee Replacement			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient presented with a history of severe Arthritis to left knee and admitted for a total knee replacement. Patient discharged to home with a course of home physical therapy but the patient was not home bound and therefore was transitioned to out patient therapy. Medical records will be monitored after 10 visits for medical appropriateness.								

State of Wisconsin
Case Management Summary Report
2003

Case: 1024490								
FOURTH QUARTER								
Time in Case Management:	3 Months			**Status:**	Closed			
Diagnosis	Total Knee Replacement			**Year to date Cost Savings**			$204.40	
IN/Outpatient Savings:	$204.40			**Case to date Cost Savings**			$204.40	
Case Summary:								
Patient admitted to hospital for a left total knee replacement after a diagnosis of OsteoArthritis. Patient transferred to inpatient rehab then to home with home physical therapy. Care Management established and maintained contact with discharge planners and providers to coordinate care in a cost effective manner. Care Management monitored home health visits for medical necessity cost savings were noted when requested visits were not medically necessary and recommendation proved cost effective saving the State of Wisconsin 2 home health visits.								
Case: 1025727								
FOURTH QUARTER								
Time in Case Management:	2 Months			**Status:**	Open			
Diagnosis	Thyroid Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient presented with a diagnosis of Thyroid Cancer, underwent a thyroidectomy. Care Management established contact with the physician's office and monitored medical records to coordinate services in a cost effective manner. Care Management to continue to monitor this case to intervene in a cost effective maner on behalf of the State of Wisconsin.								
Case: 1025748								
FOURTH QUARTER								
Time in Case Management:	2 Months			**Status:**	Closed			
Diagnosis	Pelvic Fracture			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
After a fall, patient was admitted to the hospital for a pelvic fracture, discharged to an inpatient rehab facility and progressed to discharge to home with home health services. Care Management reviewed medical records to insure timely transfers and discharges. Care Management maintained contact with discharge planners and physical therapist to insure medcial appropriateness of services. Patient stable and no further needs that Care Management can impact. Case closed.								

State of Wisconsin
Case Management Summary Report
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Case: 1025388								
FOURTH QUARTER								
Time in Case Management:	3 Months			**Status:**	Closed			
Diagnosis	Respiratory Failure			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient admitted to hospital with weakness and fatigue, placed on a ventilator. Medicare is primary payor, Care Management continued to monitor and remain available on behalf of the State of Wisconsin to maintain contact with discharge planners to facilitate coordination of the patient's services not covered by the primary insurance in a cost effective manner. The patient expired 12/10/03.								
Case: 1025713								
FOURTH QUARTER								
Time in Case Management:	2 Months			**Status:**	Closed			
Diagnosis	Stroke			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient hospitalized with Cerebral Vascular Accident with discharge to home with no home care needs. Care Management established contact with the patient and physician to coordinate services in a cost effective manner. Patient stated will be traveling out of the country and no time for follow up physician appointments. No services that Care Management can impact so case will be closed.								
Case: 1025768								
FOURTH QUARTER								
Time in Case Management:	2 Months			**Status:**	Open			
Diagnosis	Cellulitis			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient hospitalized with an open wound on foot from Cellulitis. Full thickness skin graft to open wound. Care Management followed the patient's inpatient hospitalization reviewing medical records for timely discharge. and discharge needs that would involve Care Management. Care Management advised the discharge planner of network providers for home healthcare for IV antibiotics and wound care. Utilization could not be impacted during this reporting period. Care Management will continue to monitor this case to intervene if necessary in a cost effective manner.								

State of Wisconsin
Case Management Summary Report
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Case: 1025574								
FOURTH QUARTER								
Time in Case Management:	2 Months			**Status:**	Open			
Diagnosis	Lupus			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient hospitalized following an exacerbation of Lupus and discharged to home with no home care needs. Patient experiences frequent "flare-ups" with hospitalizations for pain control. Care Management reviewed medical records for timely discharge to home. Care Management established contact with patient, physician and discharge planner to assist in coordination of services in a cost effective manner. Care Management will continue to monitor this case.								
Case: 1024872								
FOURTH QUARTER								
Time in Case Management:	5 Months			**Status:**	Closed			
Diagnosis	Atypical Parkinson's			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
records and established and maintain contact with family and discharge planner to assist in a timely discharge to home and to assist with any discharge needs. Care Manager unable to impact any future needs or services and will close case at this time.								
Case: 1026047								
FOURTH QUARTER								
Time in Case Management:	1 Month			**Status:**	Closed			
Diagnosis	Fractured Clavicle			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Elderly patient fell in home and admitted to hospital to monitor medical status. Care Management reviewed medical records and assisted in a timely discharge to a skilled nursing facility for rehabilitation with discharge to previous living situation with outpatient therapy. Primary insurance is Medicare which denied on a technical basis. Care Management will close this case and services have reverted back to primary carrier.								

State of Wisconsin
Case Management Summary Report
2003

Case: 1024012								
FOURTH QUARTER								
Time in Case Management:	7 Month			**Status:**	Closed			
Diagnosis	Total Knee Replacement			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient admitted for a total knee replacement. Discharged to home with home physical therapy visits. Care Management established and maintained contact with the patient, discharge planner, physician and physical therapist. Care Management reviewed medical records for medical necessity appropriateness and a timely discharge to out patient therapy. Patient discharged self from therapy, Care Management will close case.								
Case: 1025878								
FOURTH QUARTER								
Time in Case Management:	1 Month			**Status:**	Open			
Diagnosis	Colon Cancer			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient admitted after 2 weeks of diarrhea with a diagnosis of Colon Cancer with metastasis to the Liver. Patient undergoing chemotherapy. Care Management established and maintained contact with the patient to provide support, evaluate condition and assess for further needs and the discharge planner to facilitate coordination of services in a cost effective manner. Care Management will continue to monitor condition, treatment and response to treatment in order to intervene in a cost effective manner for the State of Wisconsin.								
Case: 1026324								
FOURTH QUARTER								
Time in Case Management:	1 Week			**Status:**	Open			
Diagnosis	Lymphoma			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient newly diagnosed with Lymphoma was admitted to hospital for 4 days for chemotherapy, IV fliuds, antiemetics and parenteral pain medications. Care Management established and maintained contact with the patient and physician, reviewed medical reports and provided support. Care Management will continue to monitor this case in order to intervene in a cost effective manner on behalf of the State of Wisconsin.								

State of Wisconsin
Case Management Summary Report
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Case: 1026308								
FOURTH QUARTER								
Time in Case Management:	1 Week			**Status:**	Open			
Diagnosis	Spondylosis			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient presented with a history of myelopathy, neck pain and numbness. Admitted for fusion and laminectomy. Due to increased weakness and sensation the patient will be discharged to inpatient rehabilitation. Care Management will review medical records to assure a timely transfer to inpatient rehab and other appropriate levels of care. Care Management established and maintained contact with the discharge planner to assist in discharge and further needs in a cost effective manner.								
Case: 1026743								
FOURTH QUARTER								
Time in Case Management:	2 Months			**Status:**	Open			
Diagnosis	Leukemia			**Year to date Cost Savings**			$0.00	
IN/Outpatient Savings:	$0.00			**Case to date Cost Savings**			$0.00	
Case Summary:								
Patient presented with a history of fatigue and high blood counts, diagnosed with Leukemia. Blood infusion began and chemotherapy begun. Discharged to home with home health care. Care Management established and maintain contact with patient, home care agency and discharge planner to coordinate services in a cost effective manner. Care Management reviewed medical records to assure medical necessity appropriateness. Care Management will continue to monitor this case to intervene in a cost effective manner if necessary.								
Case: 1025231								
FOURTH QUARTER								
Time in Case Management:	3 Months			**Status:**	Open			
Diagnosis	Bilateral Knee Replacements			**Year to date Cost Savings**			$15,835.00	
IN/Outpatient Savings:	$15,835.00			**Case to date Cost Savings**			$15,835.00	
Case Summary:								
Admitted for bilateral knee replacements, patient's family requested inpatient rehabilitation. Care Management reviewed medical records and the patient was discharge to home with a passive range of motion machine savings the State of Wisconsin $2,305 per day for 7 days. Patient will continue therapy on an out patient basis. Care Management will continue to follow this case to monitor physical therapy visits.								

BlueCross BlueShield of Wisconsin

Employer Group Reporting Package

Pharmacy Summary

2003 Report

Prepared by

Reporting and Data Management

October 2004

PHARMACY

This Pharmacy section is an addendum to the 2003 State of Wisconsin Utilization Report. Data regarding prescription drug utilization and costs for 2003 is found in this section. Drug utilization and costs for 2004 are now being handled by Navitus.

State of Wisconsin

PRESCRIPTIONS DISPENSED JANUARY 1, 2003 - DECEMBER 31, 2003

PRESCRIPTIONS PAID JANUARY 1, 2003 - DECEMBER 31, 2003

						Drug Card[1]	
						BCBSU	CCB
	Standard Plan	Standard Plan 2	SMP	WPE	Medicare $100,000	Non-Med/Med	Non-Med/Med
Membership							
Avg Mbrs	1,276.0	3,063.0	195.0	914.0	9,886.0		
Mbr Mo	15,312	36,756	2,340	10,968	118,632		
Utilizing Mbrs	NA	NA	NA	NA	NA	NA	NA
% Utilizing Mbrs	NA	NA	NA	NA	NA	NA	NA
Utilization							
T Rx	25,299	56,752	2,789	25,701	408,126		
Rx/Mbr/Yr[2]	19.8	18.5	14.3	28.1	41.3	10.1	14.40
Avg Rx/Util	NA	NA	NA	NA	NA	NA	NA
Avg Days Supply/Rx[3]	35	34	30.0	32	34	27	25
Ratio Avg Days Supply[4]	97.14%	88.24%	0.9	106.25%	79.41%		
Excessive Days Supply Factor [5]	1.03	1.13	1.1	0.94	1.26		
Adj Avg Paid/Rx[6]	$69.30	$58.32	$51.97	$55.53	$43.68		
PMPM	$117.87	$102.06	$68.82	$122.46	$189.24	$36.01	$49.08
Avg Paid/Rx	$71.34	$66.10	$57.74	$52.26	$55.01	$42.93	$41.08
T Copay	$283,601	$353,160	$15,255.83	$268,318	$1,763,104		
Avg Copay/Rx	$11.21	$15.25	$5.47	$10.44	$4.32	$12.96	$11.26
Total Prescriptions							
% Brand	60.37%	59.19%	56.62%	53.92%	53.94%	54.10%	53.40%
% Generic	39.63%	40.81%	43.38%	46.08%	46.06%	45.90%	46.60%
Total Plan Paid							
% Brand	89.60%	85.85%	89.10%	84.70%	86.42%	83.89%	81.30%
% Generic	10.40%	14.15%	10.90%	15.30%	13.58%	16.11%	18.70%
Most Frequent							
1	Lipitor	Lipitor	Paxil	Lipitor	Lipitor	Lipitor	Lipitor
2	Zocor	Zocor	Lipitor	Zocor	Atenolol	Zoloft	Zocor
3	Atenolol	Zoloft	Wellbutrin SR	Atenolol	Fosamax	Ortho Tri-Cyclen	Prevacid
4	Zoloft	Prevacid	Zoloft	Norvasc	Zocor	Prevacid	Atenolol
5	Fosamax	Ambien	Ambien	Prevacid	Norvasc	Hydrocodone/APAP	Hydrocodone/APAP
Most Costly							
1	Lipitor	Lipitor	Lipitor	Lipitor	Lipitor	Lipitor	Lipitor
2	Zocor	Zocor	Prevacid	Zocor	Zocor	Prevacid	Prevacid
3	Zoloft	Prevacid	Celebrex	Prevacid	Prevacid	Zoloft	Zocor
4	Prevacid	Zoloft	Wellbutrin SR	Pravachol	Fosamax	Zocor	Celebrex
5	Celebrex	Nexium	Paxil	Celebrex	Plavix	Advair	Protonix

[1]Inc:01-12/03.Paid:01-06/04

[2]Annualized

[3]Total Days Sup/Total Rx

[4]BCBSU Avg Days Sup/Group Avg Days Sup

[5]Inverse Ratio Avg Days Sup compared to BC. Plan is denominator.

[6]Cost/Rx 27-day sup:[Ratio Avg Day Sup]*[Grp Avg Pd per Rx]