SELECTED FINDINGS

Inpatient Data

- In 2024, Wisconsin hospitals reported 574,303 inpatient hospitalizations, with 574,287 hospitalizations having stays of less than 1,000 days, which qualified them for inclusion in this report. These resulted in 2.8 million days of care and total billed charges of $30.4 billion (see Table 1 for details).
- On average, a hospital patient was charged $52,851 per hospitalization during 2024. In general medical-surgical (GMS) hospitals, the average inpatient charge was $53,666. In the non-GMS (specialty) hospitals, charges differed between long-term care and short-term specialty care. The average charge was $417,685 in LTAC hospitals, $19,286 in psychiatric hospitals, $50,532 in rehabilitation hospitals, and $44,537 at the state-operated mental health institutes (see Table 2 for details).
- The average hospital stay was 4.9 days. Patients stayed an average of 4.5 days at GMS hospitals, 33.7 days at LTAC hospitals, 6.2 days at psychiatric hospitals, 13.1 days at rehabilitation hospitals, and 30.2 days at the state-operated mental health institutes (see Table 2 for details).
- In 2024, there were 52,576 obstetrical hospitalizations and 57,776 neonatal hospitalizations. There were also 75,396 cardiovascular, 41,395 orthopedic, 33,784 psychiatric, and 13,307 AODA-related hospitalizations in Wisconsin (including rehabilitation hospitals and state-operated mental health institutes). Combined, these accounted for 48 percent of all hospitalizations in the state.
- The most common reasons for hospitalization were related to childbirths. These included Normal Newborn, Birthweight 2500+ grams (APR-DRG 640) and Vaginal Delivery (APR-DRG 560). Together, these two APR-DRGs represented 15 percent of all hospitalizations.
- Most neonatal stays were classified as Normal Newborn, Birthweight 2500+ grams (APR-DRG 640), accounting for 48,433 hospitalizations (84 percent of all neonatal hospitalizations) with an average charge of $5,687 and an average length of stay of 1.9 days (see Table 5 for details).
- Seventy-five percent of all childbirths were classified as vaginal deliveries (APR-DRGs 541, 542, and 560). Vaginal-delivery childbirths accounted for 39,450 hospitalizations at an average charge of $16,625. In 6.5 percent of these childbirths, there were complications or additional surgery at the time of delivery (e.g., sterilization, etc.) (see Table 4 for details).
- Twenty-five percent of all newborns were delivered by Cesarean section, also called C-sections (see Table 4 for details).
- Statewide, 5,963 patients had open-heart surgery at 36 GMS hospitals, with an average length of stay of 7.7 days and an average charge of $209,977.
- Four GMS hospitals performed a total of 69 heart transplants (APR-DRG 002; MDC 05), with an average charge of $2,023,690 and an average length of stay of 69.1 days.
- The most expensive APR-DRGs were Heart and/or Lung Transplant (APR-DRG 002), at an average charge of $1,683,359 and Neonate with External Heart and Lung Oxygen Support (APR-DRG 583), at an average charge of $1,480,477.

Combined, they accounted for only 132 hospitalizations, yet their complexity and length of stay resulted in $220 million total charges and 6,839 patient days.

- The APR-DRGs generating the most total charges were Blood Infection/Septicemia (APR-DRG 720), at $2.0 billion, and Heart Failure (APR-DRG 194), at $749.4 million.
- Females accounted for 54 percent of all hospitalizations. Seventeen percent of hospitalizations among females were obstetric-related.
- During 2024, injury-related hospitalizations and ambulatory surgeries accounted for $7.7 billion in charges at hospitals and FASCs.

Ambulatory Surgery Data

- Ambulatory surgery procedures were performed at 132 Wisconsin GMS hospitals and 85 FASCs in 2024. Data for 1,154,918 cases were collected: 861,481 from hospitals and 293,437 from FASCs.
- Lesion Removal Colonoscopy by Snare was the most frequently reported principal ambulatory procedure in 2024, with 115,091 cases.
- The principal procedure producing the highest average charge among the 20 common principal procedures was Total Hip Arthroplasty (CPT 27130), at $53,101. The least expensive among the top 20 most common principal procedures After Cataract Laser Surgery (CPT 66821) with an average charge of $2,422.

Emergency Department Data

- In 2024, Wisconsin hospitals reported over 1.9 million visits to hospital emergency departments.
- The most common primary diagnoses associated with emergency department visits was symptoms and signs involving the digestive system and abdomen, representing about nine percent of all visits.
- Included in the 2024 emergency department visits were 418,188 visits (approximately 21 percent of the overall total) related to all types of injury and poisoning.
- Injury-related emergency department visits accounted for $1.7 billion in charges (approximately 21 percent of the overall total).

Comparison to 2023 Data

- Compared to 2023, the number of hospitalizations in 2024 increased by 4.4 percent while the number of patient days increased by 2.8 percent. The average length of stay decreased by 1.6 percent (see Table 1 for details).
- Statewide, the average charge per hospitalization rose from $49,982 to $52,851 (5.7 percent) between 2023 and 2024 (see Table 1 for details).
- The average charge per hospitalization increased from $50,835 to $53,666 (5.6 percent) at GMS hospitals, from $317,497 to $417,685 (31.6 percent) at LTAC hospitals, from $19,016 to $19,286 (1.4 percent) at psychiatric hospitals, and from $39,418 to $44,537 (13.0 percent) at the state-operated mental health institutes.
- The average charge per hospitalization decreased from $52,798 to $50,532 (4.3 percent) at the rehabilitation hospitals (see Table 3 for details).
- The average length of stay increased from 31.9 days to 33.7 days (5.6 percent) at the LTAC hospitals, and from 29.2 days to 30.2 days (3.2 percent) at the state-operated mental health institutes.
- The average length of stay decreased from 4.6 days to 4.5 days (2.4 percent) at GMS hospitals, from 6.3 days to 6.2 days (1.1 percent) at the psychiatric hospitals, and from 13.1 days to 13.1 days (0.5 percent) at the rehabilitation hospitals.
- The 40 most frequently performed ambulatory surgery procedures comprised 61 percent of all reported cases. Charges for the top 40 procedures combined increased 14 percent from 2023. Some fluctuations in utilization may be observed compared to previous years.
- The number of reported emergency department visits increased by 1.4 percent, from 1.95 million in 2023 to 1.98 million in 2024.

READER'S GUIDE TO THE REPORT

This Reader's Guide provides a basis for understanding and evaluating the data in this report. It explains the kinds of data collected and the terminology needed to understand it.

Data Source

This report presents selected data from 2024 patient-level data submitted by Wisconsin hospitals and FASCs and collected by WHA Information Center, LLC.

The patient-level data submitted include items such as patient characteristics (age, sex, and race), diagnoses, procedures, and charges. Data is derived from billing forms and includes information on each patient served in a hospital or FASC. Patient name is not collected in order to maintain patient confidentiality. Hospitals and FASCs submit patient level data every three months.

What You Can Learn From this Report

The following is a summary of the information presented in this report:

- The report identifies the average charges for selected medical or surgical inpatient and ambulatory treatments. It does not address how much an individual will actually be billed by the facility for that service because each case is different.
- The report does not provide information on physician charges because those data are not collected.
- The report identifies the variation in inpatient and ambulatory charges among facilities. Facility charges vary for many reasons.
- The report identifies trends in inpatient and ambulatory utilization and charges.
- The report provides information about the volume and types of services delivered through Wisconsin hospital emergency departments.

Charges vs. Revenues

The amount a facility bills for a patient's care is known as the charge. The payment a facility actually receives is known as revenue. This report lists the average charges billed by facilities for selected services. These charges are derived from billing forms, which list the actual charges for each patient. However, government health care programs like Medicare and Medical Assistance (Medicaid) generally pay substantially less than the actual charges. In addition, facilities frequently negotiate discounts with insurance companies or other private purchasers of health care services. As a result, the amount actually collected by the facility may differ substantially from the amount billed. In addition, changes in charges from year to year do not necessarily imply that revenues are changing at the same rate.

Adjusting the Data for Patient Risk

Many factors affect how much hospitals charge patients for care. One major factor is patient risk, or the severity of illness of patients served by a facility. Sicker patients tend to stay in the hospital longer, require more intensive care, and use more resources than patients who are less ill. Because these factors affect how much patients are charged, comparing charges among patients with the same illness but different degrees of severity is problematic. However, differences in severity of patient illness can be

estimated, and adjustments can be made that allow better comparisons of charges between patients with varying severity.

In recent years, a number of methods have been developed to measure and adjust for variations in hospital charges caused by illness severity differences in patients. WHA Information Center used a computer software product to risk adjust the inpatient data submitted by hospitals.

The risk adjustment software used for this report looks at the diagnosis and procedure codes, sex, age, and discharge status for each inpatient discharge to determine the base APR-DRG classification, and severity of illness. The severity of illness is then used to compute the risk adjusted charge. The risk adjusted charge is an estimate of what a patient's charges would have been if the patient's severity of illness was the same as the "average" patient's.

For example, if the hospital charge is $100 and the patient is of "average" risk, then the risk adjusted charge is also $100. If the charge is $100 and the patient had a greater than average severity of illness, the risk adjusted charge would be higher than $100. If the charge is $100 and the patient had a less than average severity of illness, the risk adjusted charge would be less than $100.

Once a facility's charges have been risk adjusted, they may be compared to other risk adjusted charges, such as those of another hospital or group of hospitals.

In this report, risk adjusted APR-DRG (All Patient Refined Diagnosis Related Group) charge data is presented for each GMS hospital and the following three comparison groups: analysis area, inpatient volume group, and all GMS hospitals as a single group. Analysis areas group GMS hospital geographically; inpatient volume groups allow comparisons between GMS hospitals of similar size; the "all GMS hospitals" data permit comparison to statewide totals and averages.

The report does not risk adjust charges for psychiatric and alcohol and other drug abuse (AODA) APR-DRGs because difference in charges for these APR-DRGs usually reflect program differences rather than variations in illness severity. For example, one hospital may treat psychiatric patients in longer-term inpatient programs, while another hospital may stabilize similar patients and then transfer them to residential facilities following a short inpatient stay.

Why Charges May Differ Between Facilities

There are many reasons that charges may differ between facilities. Among them are the following:

Payer mix – As with other businesses, hospitals cannot survive if costs exceed revenues over a long period of time. Government programs (like Medicare, Medicaid, BadgerCare and General Relief) generally reimburse hospitals at rates that do not cover the costs they incur to provide care. Therefore, facilities that have a relatively high percentage of government-program patients are forced to recover a greater percentage of their operational costs from privately insured and self-pay patients through higher charges.

Facility cost structures – Facilities differ in their approach to pricing based on operational costs. Some facilities try to spread the cost of all services and equipment among all patients. Others establish charges for specific services based on the cost to provide each specific service. Furthermore, some facilities may decide, or be forced to provide certain services at a loss while other facility operations subsidize

the losses. Any of these situations can result in significantly different charges among facilities for a given type of service.

New technology - The equipment facilities use to provide services differs in age, sophistication, and frequency of use. Facilities with the latest technology may have higher charges than those with older, less sophisticated equipment.

Staffing costs - Salary scales may differ by region and are typically higher in urban areas than rural areas. Shortages of nurses and other medical personnel may affect different regions differently. Where shortages are more severe, staffing costs, and therefore charges, may be higher.

Intensity of care - Some facilities are equipped to care for more severely ill patients than others. Patients within the same diagnosis or procedure category may need very different levels of service and staff attention, causing variation in charges.

Range of services provided - Facilities differ in the range of services they provide to patients. Some may provide the full range of services required for diagnosis and treatment during the stay. Others may stabilize patients and then transfer them to another facility for more specialized or rehabilitative care.

Service frequency – The per-patient cost of services is generally higher if the type of service occurs infrequently at the facility. Furthermore, a single case with unusually high or low charges can greatly affect a facility's average charge if the facility reported only a few cases in a given time period.

Differences in coding - Facilities vary in their coding methods and personnel, and in the number of billing codes they routinely include on a billing form. This may result in similar types of services being classified differently from facility to facility.

Capital expenses - Facilities differ in the amount of debt and depreciation they must cover in their charge structure. A facility with a lot of debt may have higher charges than a facility not facing such expenses. Furthermore, facilities may choose to lease or purchase equipment or facilities. The choices made about financing of capital projects may affect charges in different ways.

Basic Terms and Concepts

Statistical Terms

Distribution – Distribution is term referring to a set of events, or data. The charges in the following example could be referred to as a distribution. The distribution can be described in many ways, such as the range, which indicates the low and high values in the distribution (in the case below, $4,984-$7,002).

Mean (Average) – The mean, or average, is the sum of all values in a distribution divided by the number of values in the distribution. For example, to determine the average charge per discharge for seven pneumonia patients at a particular hospital, the charges for each patient are added together and divided by seven. If the charges for the seven patients were $6,216, $5,425, $4,984, $5,733, $7,002, $6,558, and $5,193, the average charge per discharge would be computed as follows:

$6,216	
5,425	
4,984	
5,733	$41,111 / 7 = $5,873
7,002	
6,558	
+ 5,193	
$41,111	

Median – The median is the middle value in a distribution when all the values are ranked in order from low to high or high to low. To determine the median charge for the same seven pneumonia patients, the charges are first ranked in order:

$4,984, $5,193, $5,425, **$5,733**, $6,216, $6,558, and $7,002

The median charge is the middle value: $5,733

Averages (means) can be significantly affected by a few unusually low or high values (called “outliers”). Since median figures are not affected to such a degree by outliers, they may be more representative of the distribution. Notice if the highest charge for the seven pneumonia patients was $10,502 instead of $7,002, the average charge would climb from $5,873 to $6,373, but the median charge would remain at $5,733. In this case the median charge is a better representation of the facility’s charges for pneumonia patients.

Percentile and percentile distribution – A percentile marks a point in a distribution above and below which some percentage of the events, or data, fall. For instance, if $2,000 represents the 25th percentile of charges for a certain APR-DRG or ambulatory surgical procedure, it means 25 percent of the patients who were in the APR-DRG or who had the procedure were charged $2,000 or less. Conversely, 75 percent of the patients were charged $2,000 or more. The 25th, 50th (median), and 75th percentiles are also referred to as quartiles, because they mark the points in the distribution above and below which lie one-quarter, one-half, and three-quarters of the data in the distribution.

Standard deviation – This is a measure of the average variation above or below the mean. When data are in a normal distribution, approximately 68 percent of the values

will fall within one standard deviation of the mean, 95 percent within two standard deviations, and 99.7 percent within three standard deviations.

Inpatient Data Terms

Analysis areas – These are groups of counties originally established as health planning districts for federal and state governments. The analysis areas are: Southern (Area 1), Southeastern (Area 2A), Milwaukee County (Area 2B), Lake Winnebago (Area 3), Northeastern (Area 4), West Central (Area 5A), Southwestern (Area 5B), North Central (Area 6), and Western Lake Superior (Area 7).

Average (mean) charge – This is the sum of all charges for a service or facility or group of services or facilities divided by the number of discharges for that service or facility. The average charge is an approximation of what an average patient would be charged. The charges listed in these reports do not include fees for physician services.

Average (mean) length of stay – This is the total number of days spent in a hospital or group of hospitals by a group of patients divided by the number of discharges. Length of stay affects charges because longer stays generally produce higher charges. In addition, it is a rough indicator of hospital efficiency, assuming similar severity of illness or program philosophy. For example, two hospitals may have significantly different average stays for similar psychiatric diagnoses. These differences may indicate that a facility offers extended inpatient stays, which tend to have higher charges, or alternatives, such as outpatient treatment, which tend to have lower charges. Differences in physician practice patterns can also affect length of stay.

Discharge – A patient is discharged once he or she officially leaves the hospital. The number of discharges affects how a hospital is staffed, what types of services it offers, and how well it competes in the broader health care system. To some degree it also affects costs because, when viewed relative to the facility's capacity, the number of discharges is a partial indicator of efficiency. The number of discharges is used to calculate the average charge and average length of stay at a facility. In some cases, transfers of patients between distinct units of a hospital are submitted to WHA Information Center as separate discharges. This reflects standard billing guidelines and data submission requirements developed by the Wisconsin Bureau of Health Information.

APR-DRG – The basic unit of analysis for inpatient hospitalizations in this report is the All Patient Refined Diagnosis Related Group, or APR-DRG. It is one method of patient classification. Prior to the 2008 report, DRG (Diagnosis Related Group) was used as the unit of analysis for inpatient hospitalizations. The federal government established DRGs as a way to pay hospitals for care of Medicare patients. The DRG system focused on the resources consumed by patients. APR-DRGs expand the basic DRG structure by adding four subclasses to each DRG and considering the entire patient population, not just Medicare patients. The addition of the four subclasses addresses patient differences relating to severity of illness and risk of mortality. More than a third of the hospitals in the United States are using APR-DRG software to analyze comparative hospital performance.

For this report, WHA Information Center used APR-DRGs to classify all hospital inpatient stays, except those at rehabilitation hospitals. A description of each of the APR-DRGs referenced in this report is included in Chapter IV.

To describe patients at rehabilitation hospitals, WHA Information Center used a classification system developed by the federal Centers for Medicare and Medicaid

Services (formerly the Health Care Financing Administration). This system groups patients into rehabilitation categories (e.g., stroke, spinal cord injury, etc.). Appendix 2 – Methodology and Technical Notes describes in greater detail the methodology used to determine rehabilitation categories.

External cause codes – Health care providers and death certificate coders use external cause codes to describe an injury resulting in treatment or death. External cause codes are part of the International Classification of Diseases (ICD-10-CM codes), which are used to describe all diagnoses and some surgical procedures. WHA Information Center collected external cause codes for injury related hospitalizations, emergency department visits and outpatient surgeries in Wisconsin.

Expected payer – Data on expected payers are compiled from bills for hospital or FASC services. The bills indicate who the facility expects will pay for the services; however, the expected payer is not always the actual payer. A patient's insurance may not cover the particular procedure. The indicated insurer may not actually cover a patient. Therefore, expected pay sources are to be viewed as preliminary.

Expected pay sources include the following:

Medicare – reimbursement under Part A (facility care) of Title XVIII. Medicare is a federal health insurance program for the elderly and disabled.

Medicaid/BadgerCare – reimbursement from Wisconsin's Medicaid (Title XIX) and BadgerCare programs. Medicaid is a federal/state program that helps pay for health care for indigent and other eligible persons. BadgerCare provides Medicaid benefits to certain persons whose income would otherwise disqualify them from Medicaid eligibility.

Other Government – reimbursement from Tri-Care (formerly known as CHAMPUS, Civilian Health and Medical Program of the Uniformed Services – health benefits for military personnel and dependents), county general relief, county 51.42/51.437 programs, and other government sources. Reimbursement from Medicaid programs in other states is also included.

Commercial or Private Insurance – reimbursement from Blue Cross/Blue Shield and other traditional insurance companies, alternative payment systems (e.g., HMOs, PPOs), self-funded plans, and Worker's Compensation.

Self-Pay – reimbursement from a patient's own resources. Self-Pay may also include insurance that has not been assigned (i.e., reimbursement is made by the insurer directly to the patient, rather than to the facility).

Unknown – the facility had not yet determined from whom it expected reimbursement.

For more information regarding Payer Code Assignment, please refer to Appendix 2 – Methodology and Technical Notes.

Hospital Types – There are five types of hospitals providing services in Wisconsin:

General medical-surgical (GMS) hospitals – provide diagnostic and therapeutic services to patients for a variety of medical conditions, both surgical and non-surgical.

Long-Term Acute Care (LTAC) hospitals – focus on patients who, on average, stay more than 25 days. They specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home.

Psychiatric hospitals – provide diagnostic and therapeutic services to patients with mental, emotional, or developmental disorders.

Rehabilitation hospitals – provide a comprehensive array of restoration services for the disabled and support services necessary to help patients attain their maximum functioning.

State-operated mental health institutes – provide comprehensive and intensive diagnostic, therapeutic, and support services to patients with unusually complex or difficult mental, emotional, or developmental disorders.

ICD-10-CM codes –The tenth version of a coding scheme (International Classification of Diseases-Clinical Modification) used by health care providers and third-party payers to classify diagnoses and procedures.

Inpatient volume groups – A system for classifying hospitals based on the total number of discharges, adjusted yearly to account for patient mix. The number of patients within each APR-DRG at a hospital was multiplied by the statewide average charge for that APR-DRG. These adjusted charges were then totaled for each hospital, and the hospitals were ranked from lowest to highest adjusted total charges. Based on these data, six inpatient volume groups for GMS hospitals were created: the smallest, Volume Group 1, to the largest, Volume Group 6. All specialty hospitals were placed in a group by themselves (Inpatient Volume Group 7).

MDC – A broad grouping, or Major Diagnostic Category, of APR-DRGs according to type of disease, condition or body part treated.

Median charge and median length of stay – Charges and lengths of stay may also be presented as medians. The median charge is the midpoint between the highest charge and the lowest charge. The median length of stay is expressed as a number of days. Half the patients stayed in the hospital longer than the median length of stay, and half stayed a shorter period of time.

Newborn – A discharge reported in the range of ICD-10-CM codes Z381 through Z389 under *Principal Diagnosis*. The term refers to a baby born in a hospital or admitted on the day of its birth.

Racial distribution – Data on the racial background self-reported by patients. Racial groups appearing in this report include American Indian/Alaskan Native, Asian, Black/African American, Native Hawaiian/Pacific Islander, White, Multiracial, Declined, and Unavailable. Patients are not required by facilities to identify their racial background. The data are based solely on how patients classify themselves.

Risk adjusted rate – A modification of the unadjusted rate that takes into account a hospital's case-mix severity. It can be thought of as the rate that would be expected if the hospital had an "average" case mix. Generally, risk adjusted rates lower than the unadjusted rate suggests that case mix severity is greater than average. A risk adjusted rate higher than the unadjusted rate suggests that the case mix is less severe than average.

Risk adjustment – Also known as **severity adjustment**, the modification of hospital data to account for differences in the severity of illness of patients. By adjusting for variation caused by differences in patient risk or severity of illness, more valid comparisons of data (e.g., charges) can be made between hospitals.

Severity adjustment – see risk adjustment, risk adjusted rate.

Specialty hospital – A hospital other than a GMS hospital that provides services to patients with specified medical conditions or for special categories of patients. In Wisconsin, this includes long-term acute care (LTAC), psychiatric, alcohol and other drug abuse (AODA), and rehabilitation hospitals, as well as the state-operated mental health institutes. Specialty hospitals were placed in a group by themselves (Inpatient Volume Group 7).

Ambulatory Surgery Data Terms

Ambulatory surgery – Also called outpatient surgery, ambulatory surgery refers to surgical procedures for which patients require less than a 24-hour stay. For purposes of this report, certain invasive diagnostic procedures are reported as ambulatory surgeries.

Patients undergoing ambulatory surgery are not necessarily comparable to those undergoing the same procedure on an inpatient basis. An inpatient may have greater severity of illness than an outpatient or may have additional, more complicated procedures performed at the same time. Physicians may differ regarding the choice of an inpatient versus an outpatient setting for surgery on the same type of patient.

However, there is probably little difference between the patients treated in hospital-based ambulatory surgery units and freestanding ambulatory centers (FASCs). FASCs tend to be located in urban areas and compete with hospitals for patients.

Average (mean) charge – see definition under **Inpatient Data Terms**

Case – Defined as one patient visit, even though more than one procedure may be performed during the same surgical episode. For instance, if a myringotomy (incision in the middle ear) is performed on each ear during one visit, only one case will be counted, even though two procedures are performed.

CPT-4[2] codes – A coding scheme (Physicians' Current Procedural Terminology) developed by the American Medical Association to classify procedures performed in an ambulatory setting.

Freestanding ambulatory surgery center (FASC) – A facility dedicated solely to the provision of surgery on an outpatient basis. FASCs are owned and operated independently of a hospital. WHA Information Center collects data only from FASCs certified to treat Medicare patients, although these facilities typically treat many patients whose services are reimbursed by a variety of third-party payers. The FASC data include data related to all patients who underwent ambulatory surgery, regardless of payer type.

Hospital-based outpatient surgery unit – A section of a hospital that provides ambulatory surgery. Such units may be part of a hospital campus or in separate buildings. They are owned and controlled by the parent hospital facility.

ICD-10-CM codes – see definition under **Inpatient Data Terms**

Median charge – see definition under **Inpatient Data Terms**

Number (#) of cases – The number of cases at the facility for which the CPT-4 code was listed as the principal procedure.

Percentile charges – Mark the point above and below which some percentage of the patients' charges fall. For instance, half the patients were charged less than the 50th percentile, or median charge, and half were charged more. Similarly, 95 percent were charged less than the 95th percentile, and 5 percent were charged more.

Procedure – A surgical operation performed on a person during a patient visit, as identified by the CPT-4 procedure codes. A person may undergo more than one procedure during a single surgical operation. For example, a patient who had arthroscopy with tendon repair on one leg undergoes two separate procedures.

Standard deviation – A measure of the average variation above and below the average, or mean, charge. When charges are in a normal distribution, approximately 68 percent of the cases will fall within one standard deviation of the mean, 95 percent within two standard deviations, and 99.7 percent within three standard deviations.

Three-digit ZIP code area – Used for geographic comparisons of ambulatory surgery utilization and charge data. Each area contains all facilities whose ZIP code begins with the same three digits (e.g., 530, 537). Refer to the map in Appendix 3 for the three-digit ZIP code area boundaries.

Emergency Department Data Terms

External cause code – see definition under **Inpatient Data Terms**

Visit rate – The number of visits per 100 or 100,000 population. The rate is calculated by dividing the total number of visits in a particular age, sex, or diagnosis category by the U.S. Census Bureau's 2024 population estimate for that age, sex, analysis area or statewide total, then multiplying the result by 100 or 100,000, as applicable.

CHAPTER I. OVERVIEW OF HOSPITAL INPATIENT UTILIZATION AND CHARGES

Since Wisconsin hospitals began publicly reporting inpatient data in 1989, the average length of stay at GMS hospitals declined until 2008. Between 1999 and 2007 the average length of stay decreased from 4.4 days to 4.0 days. From 2008 thru 2024, the average length of stay has varied between 4.0 and 4.9 days. The upward trend in average charges at GMS hospitals continued, with average charges rising from $50,835 in 2023 to $53,666 in 2024. It is important to recognize, however, that since hospitals do not collect their total charges, actual hospital revenues have increased at a much slower rate.

The average charge per stay at LTAC hospitals increased 31.6 percent from 2023 to 2024. The number of hospitalizations increased 5.0 percent, patient days increased 10.8 percent, and average length of stay increased 5.6 percent.

The average charge per stay at psychiatric hospitals decreased 1.4 percent from 2023 to 2024. The number of hospitalizations increased 6.9 percent, patient days increased 5.8 percent, and average length of stay decreased 1.1 percent.

The average charge per stay at rehabilitation facilities decreased 4.3 percent from 2023 to 2024. The number of hospitalizations increased 61.1 percent, patient days increased 60.3 percent, and average length of stay increased 3.2 percent.

The average charge per stay at the state-operated mental health institutes increased 13.0 percent from 2023 to 2024. The number of hospitalizations decreased 7.2 percent, patient days decreased 4.2 percent, and average length of stay increased 3.2 percent.

Note: In this report, the terms *hospitalization* and *discharge* are used interchangeably.

Table 1. Comparative Summary of Utilization and Charges for Hospitalizations in Wisconsin, 2023 and 2024

	2024	2023	% Difference
Number of Hospitalizations	574,287	549,830	4.4%
Total Patient Days	2,838,114	2,761,727	2.8%
Average Stay (days)	4.9	5.0	-1.6%
Hospitalizations per 1,000 population	97.2	93.0	4.5%
Patient Days per 1,000 population	480.2	467.3	2.8%
Total Charges	$30,351,821,766	$27,481,619,887	10.4%
Average Charge per Hospitalization	$52,851	$49,982	5.7%

Note: Except for the state-operated mental health institutes, hospitalizations with lengths of stay greater than 100 days were not included when computing the charge data above. These hospitalizations **were** included to compute the number of hospitalizations, patient days, average length of stay, and population-based rates. All hospitalizations of more than 999 days were excluded entirely from the data. During 2024 there were 16 such hospitalizations. Lengths of stay for inpatients who remained in the hospital less than 24 hours were counted as one-day stays.

Source: Inpatient Data, WHA Information Center, LLC.

Table 2. Summary data for Wisconsin hospitals, by type, 2024

Type	Number of Hospitals	Number of Hospitalizations	Patient Days	Average Stay (days)	Average Charge per Day	Average Charge per Stay
GMS	143	538,247	2,443,404	4.5	$11,822	$53,666
LTAC	4	1,183	39,837	33.7	$12,404	$417,685
PSYCH	14	24,498	152,406	6.2	$3,100	$19,286
REHAB	9	6,428	83,932	13.1	$3,870	$50,532
STATE	2	3,931	118,535	30.2	$1,477	$44,537
TOTAL	172	574,287	2,838,114	4.9	$10,694	$52,851

Note: Except for the state-operated mental health institutes, hospitalizations with lengths of stay greater than 100 days were not included when computing the charge data above. These hospitalizations **were** included to compute the number of hospitalizations, patient days, average length of stay, and population-based rates. All hospitalizations of more than 999 days were excluded entirely from the data. During 2024 there were 16 such hospitalizations. Lengths of stay for inpatients who remained in the hospital less than 24 hours were counted as one-day stays.

Source: Inpatient Data, WHA Information Center, LLC.

Table 3. Percent change in utilization and charges in Wisconsin hospitals, by type, 2023 to 2024

Type	Number of Hospitalizations	Patient Days	Average Length of Stay	Average Charge per Stay
GMS	4.0%	1.6%	-2.4%	5.6%
LTAC	5.0%	10.8%	5.6%	31.6%
PSYCH	6.9%	5.8%	-1.1%	1.4%
REHAB	61.1%	60.3%	-0.5%	-4.3%
STATE	-7.2%	-4.2%	3.2%	13.0%
TOTAL	4.4%	2.8%	-1.6%	5.7%

Note: Except for the state-operated mental health institutes, hospitalizations with lengths of stay greater than 100 days were not included when computing the charge data above. These hospitalizations **were** included to compute the number of hospitalizations, patient days, average length of stay, and population-based rates. All hospitalizations of more than 999 days were excluded entirely from the data. During 2024 there were 16 such hospitalizations. Lengths of stay for inpatients who remained in the hospital less than 24 hours were counted as one-day stays.

Source: Inpatient Data, WHA Information Center, LLC.

CHAPTER II. SERVICES PROVIDED TO INPATIENTS

This chapter has two sections. The first presents statewide information on six broad categories of hospitalizations: obstetrical, neonatal, cardiovascular, orthopedic, psychiatric, and alcohol and other drug abuse (AODA). Data reported include the number of hospitalizations, the average length of stay, the average charge, and the median charge per hospitalization.

The second section reviews the ten most common reasons for hospitalization, the top ten types of hospitalizations by average charge, and the ten types of hospitalizations that generated the greatest total charges. Three tables are presented, again containing the number of hospitalizations, the average length of stay, the average charge, and the median charge per hospitalization, or total charges.

This chapter's analysis is restricted to GMS, LTAC, and psychiatric facilities. Patients in these facilities accounted for 98.2 percent of all Wisconsin hospitalizations in 2024.

Patients in the state-operated mental health institutes and the rehabilitation hospitals are excluded because of their atypical characteristics (unusually long lengths of stay and high charges). Additional data on these specialty facilities are available upon request.

Patient hospitalizations are defined in terms of major diagnostic categories (MDCs) and All Patient Refined Diagnosis Related Groups (APR-DRGs). APR-DRGs are a method of classifying hospital stays according to the diagnosis of the patient, the procedures performed, and other factors, such as age and the presence of complications or comorbidities (other conditions that affect the amount of care required by a patient). MDCs are broad groupings of APR-DRGs. The APR-DRG system is widely used in many kinds of health data analysis. This report uses APR-DRGs to compare similar patients.

Section 1: Hospitalization Categories

Birth-Related Hospitalizations: The Mothers

In 2024, 52,576 women delivered babies (single and multiple births) in Wisconsin hospitals, down from 53,403 in 2023.

Most childbirths (70.2 percent) were normal and uncomplicated (APR-DRG 560). The remaining vaginal deliveries, including those with complicating diagnoses or concurrent procedures, such as sterilization (APR-DRGs 541 and 542), represented 4.9 percent of childbirths.

Statewide, the rate for Cesarean sections, also called C-sections (APR-DRG 540) increased to 25.0 percent of childbirths compared to 24.8 percent in 2023.

Differences in C-section rates by hospital are often studied because they reflect individual physician practices, socioeconomic factors, access to and availability of prenatal care, and other factors. Hospitals with few childbirths may have higher C-section rates simply because small changes in the number of C-sections affect rates more when the number of childbirths is small than when it is large. However, hospitals with many childbirths may also have high C-section rates because they have programs aimed at treating high-risk pregnancies. Therefore, a C-section rate by itself is not an indicator of hospital quality or performance but may highlight an area for further review.

Among hospitals with more than 500 obstetric cases, Ascension All Saints Hospital, Racine, had the highest C-section rate at 34.0 percent of all childbirths, ProHealth Waukesha Memorial Hospital had a rate of 30.4 percent, and ThedaCare Regional Medical Center - Neenah had a rate of 29.9 percent.

Table 4. Childbirths in Wisconsin, 2024

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
540	Cesarean Delivery	13,126	3.4	$31,158	$27,362
541	Vaginal Delivery with Sterilization	685	2.1	$26,128	$23,890
542	Vaginal Delivery with Proc Except Sterilization	1,866	2.7	$25,134	$20,779
560	Vaginal Delivery	36,899	2.1	$16,019	$14,422
	Total Childbirths	52,576	2.4	$20,254	$17,247

Note: Data exclude hospitalizations at rehabilitation facilities and state-operated mental health institutes.

Source: Inpatient Data, WHA Information Center, LLC.

Birth-Related Hospitalizations: The Babies

Obstetric hospitalizations refer to the delivering mothers. The inpatient stays of newborn babies are referred to as neonatal hospitalizations. They include newborns and other neonates with conditions originating in the perinatal period.

Neonatal hospitalizations in GMS facilities decreased to 57,776 in 2024 from 58,082 in 2023.

Table 5. Neonatal Hospitalizations (MDC 15) in Wisconsin, 2024

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
580	Neonate, Transferred <5 Days Old, Not Born Here	151	1.2	$13,736	$11,571
581	Neonate, Transferred <5 Days Old, Born Here	1,600	1.2	$6,000	$2,673
583	Neonate with External Heart and Lung Oxygen Support	10	50.8	$1,480,477	$1,373,270
588	Neonate Birthwt <1500g with Major Procedure	22	95.9	$1,178,006	$867,749
589	Neonate Birthwt <500g or Gestational Age <24 weeks	79	36.0	$425,368	$85,631
591	Neonate Birthwt 500-749g without Major Procedure	77	68.1	$632,389	$581,674
593	Neonate Birthwt 750-999g without Major Procedure	114	72.4	$588,163	$588,617
602	Neonate Birthwt 1000-1249g with Respiratory Distress Syndrome	128	62.1	$472,658	$451,746
603	Other Neonate Birthwt 1000-1249g	7	28.6	$181,076	$172,717
607	Neonate Birthwt 1250-1499g with Respiratory Distress Syndrome	180	47.4	$328,471	$304,360
608	Other Neonate Birthwt 1250-1499g	24	25.8	$130,254	$140,472
609	Neonate Birthwt 1500-2499g with Major Procedure	39	62.0	$796,839	$629,670
611	Neonate Birthwt 1500-1999g with Major Anomaly	76	31.3	$237,504	$187,843
612	Neonate Birthwt 1500-1999g with Respiratory Distress Syndrome	347	30.8	$187,637	$169,826
613	Neonate Birthwt 1500-1999g with Congenital Or Perinatal Infections	3	29.0	$161,477	$136,025
614	Other Neonate Birthwt 1500-1999g	313	13.5	$74,030	$56,044
621	Neonate Birthwt 2000-2499g with Major Anomaly	138	19.3	$141,531	$91,600
622	Neonate Birthwt 2000-2499g with Respiratory Distress Syndrome	409	18.9	$113,085	$98,361
623	Neonate Birthwt 2000-2499g with Congenital Or Perinatal Infections	7	9.6	$57,133	$62,287
625	Neonate Birthwt 2000-2499g with Other Significant Condition	190	14.4	$73,915	$58,678
626	Normal Newborn Birthweight 2000g - 2499g	1,666	4.5	$18,555	$7,478
630	Neonate Birthwt >2499g with Major Cardiovascular Procedure	55	61.9	$1,266,810	$550,798
631	Neonate Birthwt >2499g with Other Major Procedure	54	45.9	$679,419	$317,817
633	Neonate Birthwt >2499g with Major Anomaly	831	8.9	$74,697	$11,523
634	Neonate Birthwt >2499g with Respiratory Distress Syndrome	1,545	9.4	$65,817	$39,998
636	Neonate Birthwt >2499g with Congenital or Perinatal Infections	80	7.4	$43,720	$31,557
639	Neonate Birthwt >2499g with Other Significant Condition	1,198	5.4	$27,460	$10,910
640	Normal Newborn, Birthweight 2500g+	48,433	1.9	$5,687	$4,746
	Total Neonatal Hospitalizations	57,776	3.6	$20,021	$5,044

Note: Includes newborns in the hospital of birth, newborns transferred to other hospitals, and low-birthweight infants readmitted when less than 28 days old after their initial hospital stay. Data exclude hospitalizations at rehabilitation facilities and state-operated mental health institutes.

Cardiovascular Hospitalizations

In 2024, cardiovascular diagnoses accounted for 75,396 hospitalizations (up from 71,319 in 2023) (not including patients treated at rehabilitation hospitals or state-operated mental health institutes). These patients represented 13.1 percent of all hospitalizations and 20.8 percent of all inpatient charges, compared to 13.0 percent and 20.8 percent, respectively, the year before. Charges for cardiovascular-related hospitalizations in 2024 totaled $6.3 billion, up from $5.7 billion the previous year.

Thirty-six GMS hospitals performed open-heart surgery (APR-DRGs 162-163, and 165-167) on 5,963 patients, a 1.9 percent increase from 2023.

The largest number of open-heart surgeries (1,219) was performed by Aurora St. Luke’s Medical Center in Milwaukee.

Four hospitals performed a total of 69 heart transplants in 2024. These four urban teaching hospitals performed all heart transplants in 2024. Froedtert Hospital, Milwaukee, performed 28 transplants, Aurora St. Luke’s Medical Center, Milwaukee, performed 19 transplants, UW Hospital and Clinics Authority, Madison, performed 18, and Children's Wisconsin-Milwaukee Hospital performed 4.

Table 6. Cardiovascular Hospitalizations (MDC 05) in Wisconsin, 2024

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
002	Heart Transplant	69	69.1	$2,023,690	$1,500,693
161	Defibrillator and Heart Assist Implant	38	40.9	$1,441,692	$1,251,738
162	Cardiac valve procedures w AMI or complex PDX	305	14.6	$374,309	$304,502
163	Cardiac valve procedures w/o AMI or complex PDX	1,781	7.1	$216,582	$185,632
165	Coronary bypass w AMI or complex PDX	1,074	9.7	$222,347	$194,779
166	Coronary bypass w/o AMI or complex PDX	2,161	6.5	$170,163	$152,072
167	Other cardiothoracic & thoracic vascular procedures	642	7.0	$226,905	$172,525
170	Pacemaker Implant with Heart Attack, Heart Failure or Shock	22	8.5	$159,696	$129,060
171	Pacemaker Implant without Heart Attack, Heart Failure or Shock	2,050	4.0	$84,160	$70,771
174	Percutaneous coronary intervention w AMI	5,058	2.9	$92,242	$78,040
175	Percutaneous coronary intervention w/o AMI	4,799	2.5	$110,305	$97,725
176	Pacemaker/Defibrillator Replacement	116	4.9	$123,228	$100,803
177	Pacemaker/Defibrillator Revision Except Replacement	82	5.9	$107,508	$71,012
190	Circulatory Disorders with Heart Attack	3,813	3.0	$42,567	$34,892
191	Cardiac catheterization for coronary artery disease	1,059	2.0	$44,324	$39,836
192	Cardiac catheterization for other non-coronary conditions	4,175	5.3	$75,385	$58,934
194	Heart Failure	19,439	4.7	$38,550	$29,851
196	Cardiac arrest & shock	429	4.6	$68,862	$45,129
198	Chest Pain with Angina Pectoris or Coronary Atherosclerosis	929	2.1	$25,650	$22,258
199	Hypertension	1,916	2.7	$31,588	$26,553
200	Heart Structural and Valve Disorders	296	4.1	$42,762	$28,564
201	Heart Abnormal Rhythm and Conduction Disorders	8,198	2.9	$27,857	$21,418
203	Chest Pain	388	1.8	$25,146	$22,860
204	Fainting and Collapse	1,832	3.1	$33,255	$27,996
206	Malfunction/ Reaction/Complication of Heart Device or Procedure	717	5.5	$61,522	$39,453
	All Other Cardiovascular Hospitalizations	14,008	5.3	$137,202	$101,444
	Total Cardiovascular Hospitalizations	75,396	4.4	$83,646	$49,070

Note: Data exclude hospitalizations at rehabilitation facilities and state-operated mental health institutes.

Orthopedic Hospitalizations

Diseases and injuries related to muscles and the skeletal system resulted in 41,395 hospitalizations in 2024 (not including patients treated at rehabilitation hospitals or state-operated mental health institutes). Orthopedic patients accounted for 7.2 percent of all hospitalizations and 10.6 percent of total inpatient charges.

Hip & Femur Fracture Repair (APR-DRG 308) was the most frequent reason for Orthopedic Hospitalizations

Table 7. Orthopedic Hospitalizations (MDC 08) in Wisconsin, 2024

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
303	Dorsal and Lumbar Fusion with Principal Diagnosis of Back Curvature	192	5.3	$201,803	$174,780
304	Dorsal and Lumbar Fusion Without Principal Diagnosis of Back Curvature	3,458	3.9	$144,354	$115,690
305	Amputation of Lower Limb Except Toes	1,509	10.1	$105,592	$72,079
308	Hip & femur fracture repair	4,647	5.7	$76,980	$64,900
309	Other significant hip & femur surgery	634	5.4	$95,047	$75,241
310	Back/Neck Procedures Except Dorsal and Lumbar Fusion	704	4.3	$72,393	$61,218
313	Other Knee/Lower Leg Surgery	2,398	5.7	$90,972	$73,436
314	Foot/Toe Surgery	1,323	6.3	$65,844	$49,634
315	Shoulder, upper arm & forearm procedures except joint replacement	904	4.6	$87,428	$72,862
316	Hand/Wrist Surgery	377	4.1	$54,421	$43,319
321	Upper Spinal Fusion	1,713	4.0	$96,307	$82,731
323	Non-elective or complex hip joint replacement	3,387	5.3	$86,230	$74,125
324	Elective hip joint replacement	1,277	2.4	$69,781	$63,434
325	Non-elective or complex knee joint replacement	1,487	3.6	$100,408	$88,488
326	Elective knee joint replacement	1,780	2.0	$65,010	$59,934
340	Thigh Fracture	751	4.2	$29,392	$21,394
341	Pelvis Fracture/Hip Dislocation	592	4.4	$31,378	$25,168
342	Fracture or Dislocation Except Thigh, Pelvis, Back	1,770	4.4	$34,685	$27,432
343	Musculoskeletal Malignancy	489	7.3	$72,557	$50,780
347	Other Back/Neck Disorders, Fractures, Injuries	3,560	4.6	$38,555	$30,767
351	Other Musculoskeletal System and Connective Tissue Diagnoses	3,185	4.4	$33,446	$25,825
	All Other Orthopedic Hospitalizations	5,258	6.0	$85,829	$57,750
	Total Orthopedic Hospitalizations	41,395	5.0	$77,661	$60,847

Note: Data exclude hospitalizations at rehabilitation facilities and state-operated mental health institutes.

Psychiatric Hospitalizations

GMS, and psychiatric hospitals treated 33,784 psychiatric inpatients in 2024 (down from 34,050 in 2023). They represented 5.9 percent of all hospitalizations and 2.3 percent of total inpatient charges.

The number of psychiatric hospitalizations decreased by 0.8 percent from 2023, and patient days decreased by 0.8 percent.

The average charge for psychiatric hospitalizations increased by 3.3 percent in 2024 to $20,704, from $20,034 the year before.

Table 8. Psychiatric Hospitalizations (MDC 19) in Wisconsin, 2024

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
740	Mental Illness Diagnosis with O.R. Procedure	39	10.1	$81,695	$61,946
750	Schizophrenia	4,383	8.2	$24,739	$18,200
751	Psychoses	14,413	5.7	$18,392	$16,053
752	Personality and Impulse Control Disorders	514	4.2	$15,567	$12,816
753	Bipolar Disorders	6,534	6.2	$19,551	$16,366
754	Depression	2,224	4.3	$15,785	$13,463
755	Neuroses Other Than Depression	1,481	4.2	$14,373	$10,449
756	Acute Adjust React Psychosocial Dysfunction	1,667	4.5	$21,654	$17,213
757	Organic Disturbances and Mental Retardation	230	6.6	$34,475	$24,078
758	Behavioral disorders	719	6.3	$23,076	$20,972
759	Eating Disorders	509	17.4	$66,154	$44,902
760	Other Mental Disorders	465	12.5	$48,163	$31,297
	All Other Psychiatric Hospitalizations	606	8.0	$22,991	$17,972
	Total Psychiatric Hospitalizations	33,784	6.2	$20,704	$16,474

Note: Data exclude hospitalizations at rehabilitation facilities and state-operated mental health institutes.

Source: Inpatient Data, WHA Information Center, LLC.

AODA Hospitalizations

Inpatient treatment of alcohol and other chemical dependencies accounted for 13,307 hospitalizations in 2024 in GMS and psychiatric facilities, down from 14,008 in 2023.

Table 9. AODA Hospitalizations (MDC 20) in Wisconsin, 2024

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
770	Substance Abuse/Dependence, Left Against Medical Advice	1,203	2.0	$14,356	$10,362
772	Substance Abuse/Dependence with Rehab and/or Detox	1,134	4.0	$20,916	$14,148
773	Opioid Abuse/Dependence	1,612	4.4	$20,669	$17,589
774	Cocaine Abuse/Dependence	840	4.0	$19,042	$16,971
775	Alcohol Abuse/Dependence	8,096	3.8	$23,202	$17,000
776	Other Substance Abuse/Dependence	387	4.2	$18,321	$13,871
	All Other AODA Hospitalizations	35	12.9	$128,695	$93,738
	Total AODA Hospitalizations	13,307	3.8	$21,774	$16,059

Note: Data exclude hospitalizations at rehabilitation facilities and state-operated mental health institutes.

Source: Inpatient Data, WHA Information Center, LLC.

Section 2: Reasons for Hospitalization: Most Frequently Occurring, Highest Average Charges and Highest Total Charges

Most Frequently Occurring APR-DRGs

The ten most frequently occurring APR-DRGs (see Table 10) accounted for 35.5 percent of all hospitalizations and 18.6 percent of all inpatient charges at GMS, LTAC, and psychiatric facilities in 2024.

Birth-related hospitalizations (APR-DRGs 540, 541, 542, and 560 and MDC 15) accounted for 19.6 percent of all hospitalizations at these facilities, but only 7.3 percent of charges.

The average hospital stays for patients with the most frequently reported APR-DRGs were relatively short at 3.6 days. Average charges were also relatively low for the most common APR-DRGs ($27,868) compared to the average charge for all inpatients at GMS, LTAC, and psychiatric facilities ($54,079).

Table 10. Most Common Hospitalizations in Wisconsin, 2024

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
640	Normal Newborn, Birthweight 2500g+	48,433	1.9	$5,687	$4,746
560	Vaginal Delivery	36,899	2.1	$16,019	$14,422
720	Blood Infection/Septicemia	36,166	5.7	$56,477	$38,426
194	Heart Failure	19,439	4.7	$38,550	$29,851
751	Psychoses	14,413	5.7	$18,392	$16,053
540	Cesarean Delivery	13,126	3.4	$31,158	$27,362
133	Respiratory failure	9,553	4.9	$50,440	$29,744
139	Pneumonia	9,203	3.9	$33,131	$26,021
469	Acute kidney injury	8,299	4.8	$39,745	$27,582
201	Heart Abnormal Rhythm and Conduction Disorders	8,198	2.9	$27,857	$21,418
	Above Hospitalizations Total	203,729	3.6	$27,868	$18,012

Note: Data exclude hospitalizations at rehabilitation facilities and state-operated mental health institutes.

Source: Inpatient Data, WHA Information Center, LLC.

Highest Average Charges

The top ten APR-DRGs in 2024 based on the average charge accounted for only 0.2 percent of all hospitalizations but 3.3 percent of total inpatient charges among GMS, LTAC, and psychiatric hospitals in 2024 (see Table 11).

These APR-DRGs required specialized treatment and long hospital stays. Together, they represented only 980 hospitalizations.

Table 11. Top 10 Hospitalizations by Average Charge in Wisconsin, 2024

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
002	Heart and/or Lung Transplant	122	51.9	$1,683,359	$1,289,901
583	Neonate with External Heart and Lung Oxygen Support	10	50.8	$1,480,477	$1,373,270
161	Defibrillator and Heart Assist Implant	38	40.9	$1,441,692	$1,251,738
630	Neonate Birthwt >2499g with Major Cardiovascular Procedure	55	61.9	$1,266,810	$550,798
841	Burns, 3rd Degree with Skin Graft	7	33.3	$1,205,275	$481,162
588	Neonate Birthwt <1500g with Major Procedure	22	95.9	$1,178,006	$867,749
011	Chimeric antigen receptor (CAR) T-cell and other immunotherapies	86	10.6	$977,367	$870,193
004	Tracheostomy w MV 96+ hours w extensive procedure	430	44.2	$842,098	$622,013
001	Liver Transplant	171	25.3	$823,380	$614,033
609	Neonate Birthwt 1500-2499g with Major Procedure	39	62.0	$796,839	$629,670
	Above Hospitalizations Total	980	41.7	$1,017,364	$710,511

Note: Data exclude hospitalizations at rehabilitation facilities and state-operated mental health institutes.

Source: Inpatient Data, WHA Information Center, LLC.

Highest Total Charges

The ten APR-DRGs that generated the highest total charges accounted for 21.8 percent of all hospitalizations and 23.1 percent of total charges among GMS, LTAC, and psychiatric hospitals in 2024 (see Table 12). They included a mixture of high-cost conditions (e.g., Cardiac Procedures), high-volume APR-DRGs (e.g., Vaginal Delivery), and APR-DRGs that were relatively high both in volume and charges (e.g., Blood Infection/Septicemia).

Table 12. Highest Total Charge-generating Hospitalizations in Wisconsin, 2024

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Total Charges
720	Blood Infection/Septicemia	36,166	5.7	$56,477	$2,042,543,128
194	Heart Failure	19,439	4.7	$38,550	$749,375,386
710	Infectious & parasitic diseases including HIV w O.R. procedure	4,508	11.5	$151,802	$684,321,585
560	Vaginal Delivery	36,899	2.1	$16,019	$591,076,991
183	Percutaneous structural cardiac procedures	2,971	2.9	$183,302	$544,589,895
175	Percutaneous coronary intervention w/o AMI	4,799	2.5	$110,305	$529,356,018
304	Dorsal and Lumbar Fusion Without Principal Diagnosis of Back Curvature	3,458	3.9	$144,354	$499,176,897
133	Respiratory failure	9,553	4.9	$50,440	$481,849,316
021	Craniotomy Except For Trauma	2,371	8.3	$197,325	$467,858,408
174	Percutaneous coronary intervention w AMI	5,058	2.9	$92,242	$466,558,932
	Above Hospitalizations Total	125,222	4.3	$56,354	

CHAPTER III. INJURY-RELATED HOSPITALIZATIONS AND AMBULATORY SURGERIES (External Cause Codes)

External cause codes are part of the International Classification of Diseases (ICD-10-CM) system that all hospitals and death certificate coders use for the disease or injury resulting in hospitalization or death. External cause codes are required to be reported when diagnoses are reported in a certain ICD-10-CM diagnostic range.

Ranges of external cause codes are reserved for broad categories of injuries, such as those arising from motor vehicle accidents, falls, firearms, and so forth. ICD-10 codes within the range of V00-Y99 are external cause codes. The range of T36-T65 is also included for poisoning, as external causes codes are not required for this diagnosis range. Only initial visits are included in the Wisconsin Injury tables. With ICD-10 external cause codes were greatly expanded so an individual code can provide the nature of the injury, the location of the injury, and also the intent (accidental, self-inflicted, assault, and undetermined).

In this report external cause codes have been grouped into broader categories, like those described above. These groups are similar to those being suggested nationally for reporting injury mortality and morbidity.

Although many categories are self-explanatory, some merit further explanation:

- *Motor vehicle traffic* accidents are those involving motor vehicles that occur on public roads.
- *Motor vehicle nontraffic* accidents are those involving a motor vehicle that occur entirely off public roads.

Motor vehicles are defined as mechanically or electrically powered devices that can transport people or property on a highway. They include both on-road (e.g., automobile, motorcycle, bus) and off-road (e.g., snowmobile, ATV) devices.

- *Other pedal cycle* accidents include bicycle or tricycle accidents that are either non-motor vehicle or motor vehicle nontraffic in nature.
- *Other transport* includes all types of accidents involving trains, watercraft, aircraft, or transport animals, but not involving motor vehicles or pedal cycles. For instance, watercraft accidents include injuries arising from collisions with other boats, overturning or sinking of boats, fires and explosions on boats, etc.
- *Natural/environmental* injuries include those caused by exposure, hunger, thirst, venomous animals and plants, other animals (e.g., dog bites), and cataclysmic storms, lightning, or earth movement (e.g., mudslides).
- *Striking/struck by* includes injuries caused by falling objects, accidentally striking against or being struck by objects or persons (e.g., sports accidents), unarmed fights, and being intentionally struck by blunt or thrown objects.

This chapter includes information on injuries for hospital inpatients and patients treated in hospital-based ambulatory surgery settings and FASCs. The database excludes persons treated in emergency rooms but not admitted to the hospital (because they either died or were treated and released). In Chapter VIII of this report, you can find similar information for emergency department visits.

The table on the next page presents statewide data; tables follow it for each of nine analysis areas dividing the state. The tables show the number of cases, the rate per

100,000 population (based on the 2024 population estimates acquired from the U.S. Census Bureau – see Appendix 1), and the total charges for each injury category. Totals are also shown for self-inflicted injuries and injuries caused by assault. Inpatient and ambulatory surgery data are combined.

The Analysis Areas referenced in the tables are located in Appendix 3, Wisconsin Analysis Areas.

This chapter concludes with two additional statewide tables: one displays data on self-inflicted injuries by sex; the other presents data on assaultive injuries by sex.

To be consistent with previous reports, “Legal Intervention” external cause codes were categorized as “Assault” for purposes of Tables 13-22.

Table 13. Wisconsin Injuries (to persons treated as hospital inpatients or in hospital-based ambulatory surgery settings and freestanding ambulatory surgery centers), All Analysis Areas - Statewide, 2024

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	2,113	35.4	$68,206,350
Accidental	1,404	23.6	$38,443,712
Self-Inflicted	606	10.2	$23,288,574
Assault	97	1.6	$6,242,032
Undetermined	6	0.1	$232,032
Drown/Submersion	36	0.6	$5,008,051
Accidental	29	0.5	$4,412,258
Self-Inflicted/Assault/Undetermined	7	0.1	$595,793
Falls	43,971	737.6	$2,648,426,064
Accidental	43,944	737.2	$2,642,450,477
Self-Inflicted/Assault/Undetermined	27	0.5	$5,975,587
Fire/Flames	318	5.3	$42,053,917
Accidental	284	4.8	$33,129,741
Self-Inflicted/Assault/Undetermined	34	0.6	$8,924,175
Firearms	681	11.4	$88,255,758
Accidental	267	4.5	$25,274,903
Self-Inflicted	55	0.9	$8,809,767
Assault	348	5.8	$53,664,900
Undetermined	11	0.2	$506,188
Hot Objects/Scalds	833	14.0	$37,919,904
Accidental	346	5.8	$16,121,682
Self-Inflicted/Assault/Undetermined	487	8.2	$21,798,223
Machinery	518	8.7	$19,566,960
Motor Veh Traffic	4,026	67.5	$438,452,594
Accidental	4,011	67.3	$437,244,991
Self-Inflicted/Assault/Undetermined	15	0.3	$1,207,602
Oth Pedal Cycle	753	12.6	$44,829,980
Oth Mot Veh Nontraffic	977	16.4	$73,212,679
Oth Transport	233	3.9	$10,958,405
Natural/Environmental	39,025	654.7	$1,545,658,262
Overexertion	4,989	83.7	$144,382,033
Poisoning	35,261	591.5	$2,344,254,636
Accidental	751	12.6	$37,944,909
Self-Inflicted	1,012	17.0	$26,624,239
Assault	2	0.0	$254,106
Undetermined	33,496	561.9	$2,279,431,383
Striking/Struck By	3,161	53.0	$135,464,331
Accidental	2,676	44.9	$110,148,185
Assault	485	8.1	$25,316,146
Other Injury	835	14.0	$33,047,132
Accidental	763	12.8	$28,511,995
Self-Inflicted	8	0.1	$669,216
Assault	52	0.9	$3,354,446
Undetermined	8	0.1	$302,933
Others	4	0.1	$208,543
Total Injuries	137,730	2,310.5	$7,679,697,055
Total Self-Inflicted	2,104	35.3	$92,718,240
Total Assaults	990	16.6	$89,047,665

Source: Inpatient Data, WHA Information Center, LLC.

Table 14. Wisconsin Injuries (to persons treated as hospital inpatients or in hospital-based ambulatory surgery settings and freestanding ambulatory surgery centers), Analysis Area 1 - Southern, 2024

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	358	29.8	$13,187,311
Accidental	253	21.1	$7,117,736
Self-Inflicted	96	8.0	$5,268,816
Assault	9	0.7	$800,758
Undetermined	0	N/A	N/A
Drown/Submersion	9	0.7	$1,230,889
Accidental	7	0.6	$755,011
Self-Inflicted/Assault/Undetermined	2	0.2	$475,878
Falls	7,918	659.2	$561,294,108
Accidental	7,914	658.8	$560,558,559
Self-Inflicted/Assault/Undetermined	4	0.3	$735,549
Fire/Flames	99	8.2	$14,390,980
Accidental	94	7.8	$14,221,307
Self-Inflicted/Assault/Undetermined	5	0.4	$169,674
Firearms	59	4.9	$10,424,502
Accidental	37	3.1	$5,813,617
Self-Inflicted	11	0.9	$2,556,979
Assault	11	0.9	$2,053,906
Undetermined	0	N/A	N/A
Hot Objects/Scalds	182	15.2	$12,822,418
Accidental	98	8.2	$8,014,041
Self-Inflicted/Assault/Undetermined	84	7.0	$4,808,376
Machinery	90	7.5	$3,299,103
Motor Veh Traffic	747	62.2	$107,670,868
Accidental	743	61.9	$107,160,843
Self-Inflicted/Assault/Undetermined	4	0.3	$510,025
Oth Pedal Cycle	171	14.2	$15,004,689
Oth Mot Veh Nontraffic	201	16.7	$26,240,710
Oth Transport	55	4.6	$3,078,839
Natural/Environmental	7,839	652.6	$325,889,588
Overexertion	1,016	84.6	$28,707,119
Poisoning	6,092	507.2	$562,947,205
Accidental	127	10.6	$8,556,809
Self-Inflicted	226	18.8	$8,570,477
Assault	2	0.2	$254,106
Undetermined	5,737	477.6	$545,565,814
Striking/Struck By	516	43.0	$28,004,578
Accidental	445	37.0	$22,703,736
Assault	71	5.9	$5,300,842
Other Injury	143	11.9	$8,198,790
Accidental	127	10.6	$6,450,562
Self-Inflicted	2	0.2	$217,694
Assault	10	0.8	$1,348,108
Undetermined	4	0.3	$182,426
Others	0	N/A	N/A
Total Injuries	25,495	2,122.5	$1,722,391,697
Total Self-Inflicted	397	33.1	$21,807,909
Total Assaults	104	8.7	$9,802,964

Source: Inpatient Data, WHA Information Center, LLC.

Table 15. Wisconsin Injuries (to persons treated as hospital inpatients or in hospital-based ambulatory surgery settings and freestanding ambulatory surgery centers), Analysis Area 2A - Southeastern, 2024

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	290	25.8	$8,669,816
Accidental	184	16.4	$5,431,395
Self-Inflicted	97	8.6	$2,932,111
Assault	7	0.6	$270,603
Undetermined	2	0.2	$35,707
Drown/Submersion	4	0.4	$287,335
Accidental	2	0.2	$236,649
Self-Inflicted/Assault/Undetermined	2	0.2	$50,686
Falls	8,332	741.8	$474,070,417
Accidental	8,331	741.8	$474,063,698
Self-Inflicted/Assault/Undetermined	1	0.1	$6,720
Fire/Flames	25	2.2	$1,349,137
Accidental	20	1.8	$1,272,032
Self-Inflicted/Assault/Undetermined	5	0.4	$77,105
Firearms	33	2.9	$2,926,644
Accidental	20	1.8	$681,296
Self-Inflicted	6	0.5	$902,510
Assault	7	0.6	$1,342,838
Undetermined	0	N/A	N/A
Hot Objects/Scalds	100	8.9	$5,706,593
Accidental	18	1.6	$809,459
Self-Inflicted/Assault/Undetermined	82	7.3	$4,897,133
Machinery	41	3.7	$1,378,965
Motor Veh Traffic	437	38.9	$30,744,391
Accidental	434	38.6	$30,631,404
Self-Inflicted/Assault/Undetermined	3	0.3	$112,987
Oth Pedal Cycle	85	7.6	$4,344,735
Oth Mot Veh Nontraffic	84	7.5	$5,835,091
Oth Transport	24	2.1	$1,008,096
Natural/Environmental	7,659	681.9	$294,259,201
Overexertion	489	43.5	$18,763,768
Poisoning	5,411	481.8	$268,543,137
Accidental	106	9.4	$4,710,261
Self-Inflicted	113	10.1	$3,107,179
Assault	0	N/A	N/A
Undetermined	5,192	462.3	$260,725,697
Striking/Struck By	438	39.0	$16,837,695
Accidental	389	34.6	$15,441,001
Assault	49	4.4	$1,396,694
Other Injury	93	8.3	$2,564,495
Accidental	86	7.7	$2,219,774
Self-Inflicted	0	N/A	N/A
Assault	6	0.5	$333,874
Undetermined	1	0.1	$10,847
Others	0	N/A	N/A
Total Injuries	23,545	2,096.3	$1,137,289,514
Total Self-Inflicted	273	24.3	$11,350,513
Total Assaults	69	6.1	$3,344,010

Source: Inpatient Data, WHA Information Center, LLC.

Table 16. Wisconsin Injuries (to persons treated as hospital inpatients or in hospital-based ambulatory surgery settings and freestanding ambulatory surgery centers), Analysis Area 2B - Milwaukee County, 2024

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	476	51.5	$24,990,297
Accidental	293	31.7	$12,064,827
Self-Inflicted	125	13.5	$9,043,310
Assault	57	6.2	$3,791,861
Undetermined	1	0.1	$90,299
Drown/Submersion	12	1.3	$2,919,962
Accidental	12	1.3	$2,919,962
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Falls	9,050	978.7	$804,611,934
Accidental	9,039	977.5	$800,520,620
Self-Inflicted/Assault/Undetermined	11	1.2	$4,091,313
Fire/Flames	139	15.0	$25,051,890
Accidental	128	13.8	$16,535,114
Self-Inflicted/Assault/Undetermined	11	1.2	$8,516,776
Firearms	481	52.0	$70,375,809
Accidental	142	15.4	$16,548,671
Self-Inflicted	18	1.9	$4,085,721
Assault	316	34.2	$49,401,348
Undetermined	5	0.5	$340,070
Hot Objects/Scalds	375	40.6	$12,783,893
Accidental	163	17.6	$4,650,224
Self-Inflicted/Assault/Undetermined	212	22.9	$8,133,669
Machinery	82	8.9	$5,751,178
Motor Veh Traffic	1,298	140.4	$182,258,506
Accidental	1,295	140.0	$181,984,572
Self-Inflicted/Assault/Undetermined	3	0.3	$273,934
Oth Pedal Cycle	154	16.7	$12,109,392
Oth Mot Veh Nontraffic	143	15.5	$13,991,257
Oth Transport	41	4.4	$2,545,280
Natural/Environmental	7,147	772.9	$387,180,110
Overexertion	574	62.1	$21,897,507
Poisoning	11,912	1,288.1	$1,049,539,577
Accidental	238	25.7	$15,658,604
Self-Inflicted	210	22.7	$5,990,302
Assault	0	N/A	N/A
Undetermined	11,464	1,239.7	$1,027,890,671
Striking/Struck By	792	85.6	$46,642,513
Accidental	587	63.5	$33,392,099
Assault	205	22.2	$13,250,413
Other Injury	190	20.5	$12,440,921
Accidental	159	17.2	$10,595,141
Self-Inflicted	3	0.3	$239,604
Assault	27	2.9	$1,529,008
Undetermined	1	0.1	$77,169
Others	0	N/A	N/A
Total Injuries	32,866	3,554.1	$2,675,090,028
Total Self-Inflicted	534	57.7	$37,980,797
Total Assaults	607	65.6	$68,090,191

Source: Inpatient Data, WHA Information Center, LLC.

Table 17. Wisconsin Injuries (to persons treated as hospital inpatients or in hospital-based ambulatory surgery settings and freestanding ambulatory surgery centers), Analysis Area 3 - Lake Winnebago, 2024

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	261	40.9	$4,186,088
Accidental	155	24.3	$2,203,941
Self-Inflicted	100	15.7	$1,756,156
Assault	5	0.8	$221,531
Undetermined	1	0.2	$4,460
Drown/Submersion	4	0.6	$124,412
Accidental	1	0.2	$55,183
Self-Inflicted/Assault/Undetermined	3	0.5	$69,229
Falls	4,299	673.9	$164,800,358
Accidental	4,297	673.6	$164,661,456
Self-Inflicted/Assault/Undetermined	2	0.3	$138,902
Fire/Flames	16	2.5	$312,086
Accidental	10	1.6	$245,588
Self-Inflicted/Assault/Undetermined	6	0.9	$66,498
Firearms	24	3.8	$1,114,601
Accidental	14	2.2	$347,504
Self-Inflicted	5	0.8	$423,061
Assault	4	0.6	$300,869
Undetermined	1	0.2	$43,167
Hot Objects/Scalds	44	6.9	$2,077,733
Accidental	6	0.9	$95,374
Self-Inflicted/Assault/Undetermined	38	6.0	$1,982,359
Machinery	79	12.4	$1,462,771
Motor Veh Traffic	342	53.6	$21,463,673
Accidental	342	53.6	$21,463,673
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Oth Pedal Cycle	84	13.2	$3,609,211
Oth Mot Veh Nontraffic	79	12.4	$2,944,200
Oth Transport	17	2.7	$720,622
Natural/Environmental	4,158	651.8	$114,265,486
Overexertion	529	82.9	$14,255,521
Poisoning	2,193	343.8	$75,457,238
Accidental	40	6.3	$834,797
Self-Inflicted	88	13.8	$1,288,751
Assault	0	N/A	N/A
Undetermined	2,065	323.7	$73,333,690
Striking/Struck By	264	41.4	$6,816,469
Accidental	229	35.9	$5,731,229
Assault	35	5.5	$1,085,240
Other Injury	110	17.2	$1,579,933
Accidental	101	15.8	$1,378,115
Self-Inflicted	2	0.3	$104,104
Assault	5	0.8	$77,270
Undetermined	0	N/A	N/A
Others	2	0.3	$20,444
Total Injuries	12,503	1,959.9	$415,190,401
Total Self-Inflicted	240	37.6	$5,754,762
Total Assaults	51	8.0	$1,705,353

Source: Inpatient Data, WHA Information Center, LLC.

Table 18. Wisconsin Injuries (to persons treated as hospital inpatients or in hospital-based ambulatory surgery settings and freestanding ambulatory surgery centers), Analysis Area 4 - Northeastern, 2024

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	231	35.4	$5,530,162
Accidental	188	28.8	$4,249,414
Self-Inflicted	35	5.4	$813,370
Assault	7	1.1	$439,250
Undetermined	1	0.2	$28,128
Drown/Submersion	1	0.2	$17,669
Accidental	1	0.2	$17,669
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Falls	5,006	766.6	$243,822,931
Accidental	5,002	766.0	$243,503,214
Self-Inflicted/Assault/Undetermined	4	0.6	$319,717
Fire/Flames	9	1.4	$209,609
Accidental	7	1.1	$176,077
Self-Inflicted/Assault/Undetermined	2	0.3	$33,532
Firearms	28	4.3	$1,050,361
Accidental	12	1.8	$247,815
Self-Inflicted	9	1.4	$502,217
Assault	5	0.8	$238,936
Undetermined	2	0.3	$61,392
Hot Objects/Scalds	38	5.8	$934,558
Accidental	19	2.9	$442,076
Self-Inflicted/Assault/Undetermined	19	2.9	$492,482
Machinery	64	9.8	$1,554,752
Motor Veh Traffic	418	64.0	$33,026,339
Accidental	417	63.9	$32,993,551
Self-Inflicted/Assault/Undetermined	1	0.2	$32,788
Oth Pedal Cycle	107	16.4	$4,450,278
Oth Mot Veh Nontraffic	144	22.1	$8,152,390
Oth Transport	31	4.7	$1,167,511
Natural/Environmental	6,668	1,021.2	$254,059,585
Overexertion	1,086	166.3	$28,787,529
Poisoning	3,308	506.6	$156,753,240
Accidental	68	10.4	$3,256,870
Self-Inflicted	99	15.2	$2,604,992
Assault	0	N/A	N/A
Undetermined	3,141	481.0	$150,891,379
Striking/Struck By	430	65.9	$14,989,358
Accidental	379	58.0	$13,061,084
Assault	51	7.8	$1,928,273
Other Injury	134	20.5	$3,473,365
Accidental	130	19.9	$3,252,775
Self-Inflicted	0	N/A	N/A
Assault	0	N/A	N/A
Undetermined	2	0.3	$32,491
Others	2	0.3	$188,099
Total Injuries	17,703	2,711.1	$757,979,636
Total Self-Inflicted	162	24.8	$4,437,375
Total Assaults	64	9.8	$2,639,247

Source: Inpatient Data, WHA Information Center, LLC.

Table 19. Wisconsin Injuries (to persons treated as hospital inpatients or in hospital-based ambulatory surgery settings and freestanding ambulatory surgery centers), Analysis Area 5A - West Central, 2024

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	195	38.0	$4,282,517
Accidental	110	21.5	$2,223,592
Self-Inflicted	80	15.6	$1,605,583
Assault	5	1.0	$453,342
Undetermined	0	N/A	N/A
Drown/Submersion	2	0.4	$80,937
Accidental	2	0.4	$80,937
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Falls	3,026	590.1	$113,027,107
Accidental	3,025	589.9	$112,839,460
Self-Inflicted/Assault/Undetermined	1	0.2	$187,647
Fire/Flames	7	1.4	$197,978
Accidental	7	1.4	$197,978
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Firearms	11	2.1	$638,095
Accidental	9	1.8	$524,207
Self-Inflicted	1	0.2	$59,437
Assault	1	0.2	$54,451
Undetermined	0	N/A	N/A
Hot Objects/Scalds	38	7.4	$1,064,851
Accidental	12	2.3	$492,271
Self-Inflicted/Assault/Undetermined	26	5.1	$572,579
Machinery	38	7.4	$1,266,960
Motor Veh Traffic	208	40.6	$15,402,632
Accidental	207	40.4	$15,371,454
Self-Inflicted/Assault/Undetermined	1	0.2	$31,178
Oth Pedal Cycle	37	7.2	$1,411,727
Oth Mot Veh Nontraffic	84	16.4	$4,736,355
Oth Transport	17	3.3	$672,173
Natural/Environmental	2,201	429.2	$54,821,516
Overexertion	462	90.1	$11,533,038
Poisoning	1,792	349.5	$56,580,261
Accidental	49	9.6	$1,410,776
Self-Inflicted	101	19.7	$1,737,944
Assault	0	N/A	N/A
Undetermined	1,642	320.2	$53,431,540
Striking/Struck By	222	43.3	$5,694,758
Accidental	203	39.6	$5,246,575
Assault	19	3.7	$448,183
Other Injury	52	10.1	$1,237,490
Accidental	48	9.4	$1,072,829
Self-Inflicted	1	0.2	$107,814
Assault	3	0.6	$56,848
Undetermined	0	N/A	N/A
Others	0	N/A	N/A
Total Injuries	8,392	1,636.5	$272,648,395
Total Self-Inflicted	209	40.8	$4,273,963
Total Assaults	28	5.5	$1,012,824

Source: Inpatient Data, WHA Information Center, LLC.

Table 20. Wisconsin Injuries (to persons treated as hospital inpatients or in hospital-based ambulatory surgery settings and freestanding ambulatory surgery centers), Analysis Area 5B - Southwestern, 2024

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	124	44.3	$3,507,997
Accidental	85	30.3	$2,264,384
Self-Inflicted	34	12.1	$1,029,460
Assault	5	1.8	$214,153
Undetermined	0	N/A	N/A
Drown/Submersion	1	0.4	$25,569
Accidental	1	0.4	$25,569
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Falls	1,796	641.2	$77,851,708
Accidental	1,793	640.2	$77,434,392
Self-Inflicted/Assault/Undetermined	3	1.1	$417,315
Fire/Flames	6	2.1	$119,797
Accidental	5	1.8	$98,632
Self-Inflicted/Assault/Undetermined	1	0.4	$21,164
Firearms	16	5.7	$732,652
Accidental	13	4.6	$591,454
Self-Inflicted	1	0.4	$59,616
Assault	1	0.4	$67,018
Undetermined	1	0.4	$14,564
Hot Objects/Scalds	11	3.9	$404,209
Accidental	5	1.8	$153,958
Self-Inflicted/Assault/Undetermined	6	2.1	$250,252
Machinery	42	15.0	$1,450,739
Motor Veh Traffic	202	72.1	$14,482,275
Accidental	200	71.4	$14,282,130
Self-Inflicted/Assault/Undetermined	2	0.7	$200,145
Oth Pedal Cycle	35	12.5	$1,656,484
Oth Mot Veh Nontraffic	85	30.3	$4,860,704
Oth Transport	21	7.5	$849,903
Natural/Environmental	1,200	428.4	$38,189,706
Overexertion	328	117.1	$10,414,515
Poisoning	1,369	488.8	$45,874,791
Accidental	40	14.3	$895,025
Self-Inflicted	102	36.4	$1,769,974
Assault	0	N/A	N/A
Undetermined	1,227	438.1	$43,209,791
Striking/Struck By	186	66.4	$7,168,365
Accidental	167	59.6	$6,554,235
Assault	19	6.8	$614,130
Other Injury	39	13.9	$997,149
Accidental	38	13.6	$987,810
Self-Inflicted	0	N/A	N/A
Assault	1	0.4	$9,338
Undetermined	0	N/A	N/A
Others	0	N/A	N/A
Total Injuries	5,461	1,949.8	$208,586,561
Total Self-Inflicted	149	53.2	$3,747,926
Total Assaults	26	9.3	$904,640

Source: Inpatient Data, WHA Information Center, LLC.

Table 21. Wisconsin Injuries (to persons treated as hospital inpatients or in hospital-based ambulatory surgery settings and freestanding ambulatory surgery centers), Analysis Area 6 - North Central, 2024

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	160	33.5	$3,584,747
Accidental	130	27.2	$2,816,127
Self-Inflicted	27	5.7	$644,649
Assault	2	0.4	$50,533
Undetermined	1	0.2	$73,438
Drown/Submersion	3	0.6	$321,278
Accidental	3	0.6	$321,278
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Falls	4,180	875.4	$201,699,381
Accidental	4,179	875.2	$201,620,956
Self-Inflicted/Assault/Undetermined	1	0.2	$78,425
Fire/Flames	16	3.4	$404,817
Accidental	13	2.7	$383,012
Self-Inflicted/Assault/Undetermined	3	0.6	$21,805
Firearms	29	6.1	$993,094
Accidental	20	4.2	$520,339
Self-Inflicted	4	0.8	$220,225
Assault	3	0.6	$205,534
Undetermined	2	0.4	$46,995
Hot Objects/Scalds	41	8.6	$2,043,034
Accidental	22	4.6	$1,388,464
Self-Inflicted/Assault/Undetermined	19	4.0	$654,570
Machinery	81	17.0	$3,392,547
Motor Veh Traffic	364	76.2	$33,161,207
Accidental	363	76.0	$33,114,660
Self-Inflicted/Assault/Undetermined	1	0.2	$46,546
Oth Pedal Cycle	68	14.2	$1,969,876
Oth Mot Veh Nontraffic	145	30.4	$6,239,960
Oth Transport	26	5.4	$888,134
Natural/Environmental	1,820	381.2	$70,262,308
Overexertion	422	88.4	$8,303,462
Poisoning	2,902	607.8	$123,380,895
Accidental	75	15.7	$2,521,147
Self-Inflicted	63	13.2	$1,442,105
Assault	0	N/A	N/A
Undetermined	2,764	578.9	$119,417,643
Striking/Struck By	281	58.9	$8,733,381
Accidental	252	52.8	$7,543,265
Assault	29	6.1	$1,190,116
Other Injury	68	14.2	$2,459,564
Accidental	68	14.2	$2,459,564
Self-Inflicted	0	N/A	N/A
Assault	0	N/A	N/A
Undetermined	0	N/A	N/A
Others	0	N/A	N/A
Total Injuries	10,606	2,221.2	$467,837,686
Total Self-Inflicted	116	24.3	$3,032,936
Total Assaults	34	7.1	$1,446,183

Source: Inpatient Data, WHA Information Center, LLC.

Table 22. Wisconsin Injuries (to persons treated as hospital inpatients or in hospital-based ambulatory surgery settings and freestanding ambulatory surgery centers), Analysis Area 7 - Western Lake Superior, 2024

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	18	11.9	$267,415
Accidental	6	4.0	$72,296
Self-Inflicted	12	8.0	$195,120
Assault	0	N/A	N/A
Undetermined	0	N/A	N/A
Drown/Submersion	0	N/A	N/A
Accidental	0	N/A	N/A
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Falls	364	241.6	$7,248,121
Accidental	364	241.6	$7,248,121
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Fire/Flames	1	0.7	$17,622
Accidental	0	N/A	N/A
Self-Inflicted/Assault/Undetermined	1	0.7	$17,622
Firearms	0	N/A	N/A
Accidental	0	N/A	N/A
Self-Inflicted	0	N/A	N/A
Assault	0	N/A	N/A
Undetermined	0	N/A	N/A
Hot Objects/Scalds	4	2.7	$82,616
Accidental	3	2.0	$75,813
Self-Inflicted/Assault/Undetermined	1	0.7	$6,803
Machinery	1	0.7	$9,946
Motor Veh Traffic	10	6.6	$242,703
Accidental	10	6.6	$242,703
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Oth Pedal Cycle	12	8.0	$273,588
Oth Mot Veh Nontraffic	12	8.0	$212,011
Oth Transport	1	0.7	$27,849
Natural/Environmental	333	221.1	$6,730,762
Overexertion	83	55.1	$1,719,573
Poisoning	282	187.2	$5,178,292
Accidental	8	5.3	$100,620
Self-Inflicted	10	6.6	$112,515
Assault	0	N/A	N/A
Undetermined	264	175.3	$4,965,157
Striking/Struck By	32	21.2	$577,215
Accidental	25	16.6	$474,961
Assault	7	4.6	$102,254
Other Injury	6	4.0	$95,424
Accidental	6	4.0	$95,424
Self-Inflicted	0	N/A	N/A
Assault	0	N/A	N/A
Undetermined	0	N/A	N/A
Others	0	N/A	N/A
Total Injuries	1,159	769.4	$22,683,137
Total Self-Inflicted	24	15.9	$332,059
Total Assaults	7	4.6	$102,254

Source: Inpatient Data, WHA Information Center, LLC.

Table 23. Self-inflicted Injuries (to persons treated as hospital inpatients or in hospital-based ambulatory surgery settings and freestanding ambulatory surgery centers), 2024

Injury Category	Number of Cases		
	Male	Female	Total Cases
Cutting/Piercing	245	361	606
Drowning/Submersion	2	5	7
Firearms And Explosives	50	6	56
Jumping From A High Place	10	12	22
Other Self-Inflicted Injuries	162	238	401
Poisoning	322	690	1,012
Total Self-Inflicted Injuries	791	1,312	2,104

Source: Inpatient Data, WHA Information Center, LLC.

Table 24. Assaultive Injuries (to persons treated as hospital inpatients or in hospital-based ambulatory surgery settings and freestanding ambulatory surgery centers), 2024

Injury Category	Number of Cases		
	Male	Female	Total Cases
Bite Of Human Being	11	5	16
Cutting/Piercing	77	20	97
Firearms And Explosives	276	65	341
Other Assaultive Injuries	42	18	60
Poisoning	1	1	2
Striking By Blunt Or Thrown Object	36	10	46
Unarmed Fight Or Brawl	290	138	428
Total Self-Inflicted Injuries	733	257	990

Source: Inpatient Data, WHA Information Center, LLC.

CHAPTER IV. OVERVIEW OF INDIVIDUAL HOSPITAL INPATIENT TABLES

Hospitals that Reported Data

Data were collected from 143 general medical-surgical hospitals, four long-term acute care hospitals (LTAC), fourteen psychiatric hospitals, nine rehabilitation facilities, and two state-operated mental health institutes on all inpatients discharged between January 1, 2024, and December 31, 2024. The database includes partial-year data from hospitals that opened or closed during the calendar year. Please refer to Appendix 4 for all openings, closings, and mergers as they relate to facilities that submitted data in 2024.

How to Read the Tables

GMS Hospital Tables

Each individual GMS hospital table contains the following two pages of information:

First Page

Heading: The heading identifies basic facility information. This includes the hospital's three-digit facility number, name, address, and telephone number; the hospital type (in this case, GMS); the county in which the hospital is located; and the analysis area and inpatient volume group to which it was assigned by WHA Information Center.

Middle Section: The middle section contains utilization data. This is divided into the following six subsections: Overall Hospital Utilization, Obstetrical Utilization, Psychiatric Utilization, AODA Utilization, Patient Discharge Status Distribution, and Expected Pay Source Distribution.

Overall Hospital Utilization: These data provide an overall picture of utilization and charges at the facility. Included are total discharges, total patient days, average length of stay, and average charge per discharge for the calendar year. These items describe the number of inpatients discharged by a facility, the total number of days those patients stayed at the hospital, the number of days an average patient stayed, and the average charge billed for patients at the facility.

Obstetrical Utilization: The obstetric data identify the number of mothers who gave birth at the hospital (Total Childbirths) and the percentage of those childbirths that were "normal," that involved C-sections, or that had complications or involved additional procedures (e.g., sterilization).

Below that, in the category "Total Newborns," appears the number of newborns reported by the hospital during the calendar year. The number of childbirths and newborns may differ because, for example, some babies may have died during delivery, and some mothers may have given birth to twins, triplets, etc. "Total Newborns" includes those who were born elsewhere but admitted on the day of their birth.

Psychiatric/AODA Utilization: These sections list the number of discharges and patient days attributed to those patients undergoing treatment for psychiatric disorders or alcohol and other drug abuse (AODA).

The table also lists the percentage of the hospital's total discharges and patient days that were attributable to patients in either psychiatric or AODA inpatient care. For example, if a hospital reported 10 patients discharged from psychiatric care out of 1,000 total discharges, then 1.0 percent of the hospital's discharges would be attributed to patients receiving psychiatric inpatient services.

Patient Discharge Status Distribution: This section describes where patients went after being discharged from the hospital. It lists the percentage of patients who went home, were transferred to another GMS or CAH hospital, were sent to another facility (skilled nursing, intermediate care, rehabilitation facility or hospice), were sent to another type of institution (e.g., a half-way house or residential facility), were referred to a home health agency (for home care or intravenous drug therapy), left the hospital against medial advise, expired (i.e., died), were sent to jail, prison, or other detention facilities or were discharged to some other type of care (which includes transfer to a federal hospital, a Medicare approved swing bed, a Medicare certified long-term hospital, or a nursing facility certified under Medicaid but not certified under Medicare).

Expected Pay Source Distribution: This section lists the primary payer that is expected to reimburse the hospital for services. The payer categories are Medicare, Medicaid/BadgerCare, other government (e.g., county general relief, 51.42 Boards), commercial insurance, self-pay, and unknown. The category "Commercial Insurance" includes traditional and self-funded plans, private alternate payment systems (e.g., HMOs, PPOs), and Workers' Compensation.

Note: Primary payer data reflects the party billed for the service at the time of patient discharge. The actual payer may differ if the facility cannot collect from an expected payer or a third-party payer later finds a patient to be ineligible for coverage. Summary data on actual payers can be found in the Guide to Wisconsin Hospitals, published annually.

Bottom Section: This section describes patient characteristics including age, sex, and race.

Age Distribution: This section presents the percentage of total discharges and patient days reported for various age groups. The groups are based on U.S. Census categories and have been expanded from previous years.

Sex Distribution: This section presents the percentage of total discharges and patient days reported for males and females.

Race Distribution: This section presents the percentage of total discharges and patient days reported for various racial groups. The groups are based on census categories and include American Indian/Alaskan Native, Asian, Black/African American, Native Hawaiian/Pacific Islander, White, Multiracial, Declined, and Unavailable. This information is not part of the standard billing form that hospitals use. Patients are not required to provide race information; hospitals rely on the cooperation of patients.

Second Page

The second page of each GMS hospital table presents utilization and charge data for selected APR-DRGs. Data are presented for the individual hospital and for three comparison groups. The comparison groups include all GMS hospitals in the same analysis area, all hospital in the same inpatient volume group, and all GMS hospitals statewide.

APR-DRGs were selected by choosing the 15 most common APR-DRGs at hospitals in each of the inpatient volume groups. Therefore, the APR-DRGs used to compare hospitals in one inpatient volume group may differ from those used to compare hospitals in another inpatient volume group.

Note: The Normal Newborn, Birthweight 2500g+ (APR-DRG 640) category will not always correspond with the number of newborns on page 1. Some babies who are admitted after the day of their birth are classified as APR-DRG 640.

Average Length of Stay (ALOS): This section lists the number of discharges and the average length of stay at the hospital for each of the 15 selected APR-DRGs. The hospital averages are then compared to the average length of stay at the three comparison groups, and a ratio of that comparison is computed.

If the hospital reported a length of stay for a given APR-DRG that was greater than the average reported by hospitals in a comparison group, the ratio would be greater than 1.00; if it was equal, the ratio would be 1.00; if it was less at the hospital than in the comparison groups the ratio would be less than 1.00.

Example: If the average length of stay for an APR-DRG at Hospital A was 2.1 days and the analysis area average was 2.0, the ratio in the analysis area column would be 1.05 (2.1 divided by 2.0). This means that the average length of stay at Hospital A was 5 percent longer than the average stay for the analysis area as a whole.

Average Charge: This section displays actual and risk adjusted average charge data for the selected APR-DRGs. Actual average charges are presented for the hospital. Risk adjusted average charges are shown for the hospital and for the comparison groups. Risk adjusted average charges were calculated by removing the effect of severity variation from each patient's charges and averaging the results for the hospital and comparison groups.

The hospital's risk adjusted average charges may be compared to the risk adjusted average charges of the comparison groups. While risk adjustment attempts to remove severity differences, other "unadjusted" factors may influence variation. For example, differences in the accuracy and completeness of coding can affect the apparent severity of illness.

Some of these factors stem from the inherent constraints of using administrative data in risk adjustment. For example, administrative data may indicate that a patient has congestive heart failure, but relevant clinical details (e.g., left ventricular ejection fraction) may not be included in the billing record and therefore may not be available for use in calculating severity of illness.

The table lists the risk adjusted charge for each of the comparison groups (analysis area, inpatient volume group, and all GMS hospitals) and calculates the ratio of the hospital's risk adjusted average charge for an APR-DRG to that of the comparison group. These ratios are calculated and may be interpreted in the same manner as the ratios for average length of stay.

No ratios are calculated for an APR-DRG when a hospital had fewer than five discharges assigned to that APR-DRG.

Specialty Hospital Tables

LTAC Hospitals, Psychiatric and State-Operated Mental Health Institutes

The tables for the LTAC hospitals, psychiatric and the state-operated mental health institutes are presented on one page. They include much of the same descriptive data as the GMS tables, including data on APR-DRGs, but exclude risk adjusted data, and inpatient volume group and analysis area comparisons.

Heading: The top of the page contains the same information as the heading on a GMS hospital table, except that no volume group is listed since all specialty hospitals have been assigned to Inpatient Volume Group 7.

Middle Section: The middle section contains the utilization and patient characteristic data contained in the middle and bottom sections of the first page of the GMS tables, except obstetrical utilization. It is divided into the following eight subsections: Overall Hospital Utilization, Psychiatric Utilizations, AODA Utilization, Patient Discharge Status, Expected Pay Source Distribution, Age Distribution, Sex Distribution, and Race Distribution.

Bottom Section for LTAC Hospitals: This section of the table includes data on the 13 most common APR-DRGs in LTAC hospitals statewide. Facility-specific data are compared to statewide LTAC data for patients treated in LTAC hospitals only.

The first column lists the APR-DRG number and its description. The table then lists the number of discharges at the hospital for that APR-DRG.

In the columns under the broader heading "Average Length of Stay (ALOS)," the hospital's average length of stay for the APR-DRG is compared to that of patients assigned to the same APR-DRG among all LTAC hospitals only, and a ratio of that comparison is computed. These ratios are calculated and may be interpreted in the same manner as the ratios for average length of stay at GMS hospitals.

In the columns under the broader heading "Average Charge per Discharge," the hospital's average charge for patients assigned to an APR-DRG is compared to the average charge for all patients assigned to that APR-DRG among all LTAC hospitals only. As with length of stay, a ratio computed from this comparison is also provided.

Bottom Section for Psychiatric Hospitals: This section of the table includes data on the 13 most common APR-DRGs in psychiatric hospitals statewide. Facility-specific data are compared to statewide psychiatric data for patients treated in psychiatric facilities only.

The first column lists the APR-DRG number and its description. The table then lists the number of discharges at the hospital for that APR-DRG.

In the columns under the broader heading "Average Length of Stay (ALOS)," the hospital's average length of stay for the APR-DRG is compared to that of patients assigned to the same APR-DRG among all psychiatric hospitals only, and a ratio of that comparison is computed. These ratios are calculated and may be interpreted in the same manner as the ratios for average length of stay at GMS hospitals.

In the columns under the broader heading "Average Charge per Discharge," the hospital's average charge for patients assigned to an APR-DRG is compared to the average charge for all patients assigned to that APR-DRG among all psychiatric hospitals only. As with length of stay, a ratio computed from this comparison is also provided.

Psychiatric charge data were not risk adjusted because differences in charges among psychiatric patients typically reflect programmatic differences, rather than difference in severity of illness.

Bottom Section for the State-Operated Mental Health Institutes: This section of the table includes data on the 13 most common APR-DRGs in state-operated mental health institutes. It presents the number of discharges, ALOS, and average charge per discharge for patients in the state-operated mental health institutes.

Since patients at the state-operated mental health institutes are unique in terms of illness severity, charges, and length of stay, no comparisons are made to other groups and no ratios are calculated. Average charge data are not risk adjusted for state-operated mental health institutes.

Rehabilitation Hospitals

Rehabilitation hospitals are dedicated solely to rehabilitation medicine and treat a unique class of patients. Because the federal government has not yet developed APR-DRGs for rehabilitation conditions, these facilities are exempt from APR-DRG reimbursement requirements imposed on other hospitals. In addition, the rehabilitation hospitals report data differently from other hospitals that have rehabilitation units within their facilities. For these reasons, APR-DRG-based comparisons of rehabilitation hospitals with other hospitals are not valid. Although comparisons are not currently possible, this report provides a summary of the rehabilitation hospitals' utilization and charge data.

Heading: The top of the page contains the same information as the heading on a GMS hospital table, except that no volume group is listed since all specialty hospitals have been assigned to Inpatient Volume Group 7.

Middle Section: The middle section contains the utilization and patient characteristic data contained in the middle and bottom sections of the first page of the GMS tables, except obstetrical utilization. It is divided into the following eight subsections: Overall Hospital Utilization, Psychiatric Utilization, AODA Utilization, Patient Discharge Status, Expected Pay Source Distribution, Age Distribution, Sex Distribution, and Race Distribution.

Bottom Section for the Rehabilitation Hospitals; Selected Patient Groups: Utilization and charge data for rehabilitation hospital patients are presented using the rehabilitation diagnostic categories of the federal Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration). This methodology aggregates patients into broad categories, such as stroke and amputation. The rehabilitation hospital tables list the number of discharges, average length of stay, and average charge for each of the following categories:

Stroke
Brain Injury
Neurologic Conditions
Spinal Cord Injury
Arthritis
Congenital Deformities
Systemic Vasculidities
Amputation
Cardiac Disorders
Debility
Infections
Medically Complex Conditions
Pulmonary Disorders
All Other Rehabilitation

Note: The "All Other Rehabilitation" category is composed of all diagnostic codes not found in the other thirteen categories.

Average charge data for rehabilitation hospitals are not risk adjusted.

APR-DRGs Used in this report

Computer software was used to assign each hospitalization a particular APR-DRG. WHA Information Center used 3M™ Core Grouping Software which includes 3M™ APR-DRG Software to assign the APR-DRG to each hospitalization.

The grouping software used up to 30 diagnoses and 30 procedures, if submitted, for each record, along with sex, discharge status, birth date, date of admission, date of discharge, and birth weight of the patient. Since 2005, WHAIC has been collecting unlimited diagnoses and procedures on each record.

Prior to the 2007 report, WHA used DRG (Diagnosis Related Group) to classify the hospitalizations. Since there is no one-to-one crosswalk from DRGs to APR-DRGs, comparison of utilization and charges over several years may be affected.

The following APR-DRGs appear in the report:

APR-DRG	Description
001	Liver Transplant
002	Heart and/or Lung Transplant
004	Tracheostomy w MV 96+ hours w extensive procedure
011	Chimeric antigen receptor (CAR) T-cell and other immunotherapies
021	Craniotomy Except For Trauma
044	Intracranial Hemorrhage
045	Stroke and Precerebral Occlusion with Infarct
049	Bacterial & tuberculous infections of nervous system
055	Head trauma w coma >1 hr or hemorrhage
058	Other Disorders of Nervous System
130	Respiratory System DX w/ Vent Support 96+ Hrs
133	Respiratory failure
137	Respiratory Infections and Inflammations
139	Pneumonia
140	Chronic Obstructive Pulmonary Disease
161	Defibrillator and Heart Assist Implant
162	Cardiac valve procedures w AMI or complex PDX
163	Cardiac valve procedures w/o AMI or complex PDX
165	Coronary bypass w AMI or complex PDX
166	Coronary bypass w/o AMI or complex PDX
167	Other cardiothoracic & thoracic vascular procedures
170	Pacemaker Implant with Heart Attack, Heart Failure or Shock
171	Pacemaker Implant without Heart Attack, Heart Failure or Shock
174	Percutaneous coronary intervention w AMI
175	Percutaneous coronary intervention w/o AMI
176	Pacemaker/Defibrillator Replacement
177	Pacemaker/Defibrillator Revision Except Replacement
183	Percutaneous structural cardiac procedures

APR-DRG	Description
190	Circulatory Disorders with Heart Attack
191	Cardiac catheterization for coronary artery disease
192	Cardiac catheterization for other non-coronary conditions
193	Acute & Subacute Endocarditis
194	Heart Failure
196	Cardiac arrest & shock
198	Chest Pain with Angina Pectoris or Coronary Atherosclerosis
199	Hypertension
200	Heart Structural and Valve Disorders
201	Heart Abnormal Rhythm and Conduction Disorders
203	Chest Pain
204	Fainting and Collapse
206	Malfunction/ Reaction/Complication of Heart Device or Procedure
247	Intestinal Obstruction without Surgery
248	Major G.I. Bacterial Infections
249	Other gastroenteritis, nausea & vomiting
282	Disorders of Pancreas Except Malignancy
303	Dorsal and Lumbar Fusion with Principal Diagnosis of Back Curvature
304	Dorsal and Lumbar Fusion Without Principal Diagnosis of Back Curvature
305	Amputation of Lower Limb Except Toes
308	Hip & femur fracture repair
309	Other significant hip & femur surgery
310	Back/Neck Procedures Except Dorsal and Lumbar Fusion
313	Other Knee/Lower Leg Surgery
314	Foot/Toe Surgery
315	Shoulder, upper arm & forearm procedures except joint replacement
316	Hand/Wrist Surgery
321	Upper Spinal Fusion
323	Non-elective or complex hip joint replacement
324	Elective hip joint replacement
325	Non-elective or complex knee joint replacement
326	Elective knee joint replacement
340	Thigh Fracture
341	Pelvis Fracture/Hip Dislocation
342	Fracture or Dislocation Except Thigh, Pelvis, Back
343	Musculoskeletal Malignancy
344	Osteomyelitis and Infectious Arthritis
347	Other Back/Neck Disorders, Fractures, Injuries
351	Other Musculoskeletal System and Connective Tissue Diagnoses

APR-DRG	Description
380	Skin Ulcers
383	Cellulitis & other skin infections
420	Diabetes
463	Kidney/Urinary Tract Infection
466	Malfunction, reaction, complic of genitourinary device or proc
469	Acute kidney injury
540	Cesarean Delivery
541	Vaginal Delivery with Sterilization
542	Vaginal Delivery with Proc Except Sterilization
560	Vaginal Delivery
580	Neonate, Transferred <5 Days Old, Not Born Here
581	Neonate, Transferred <5 Days Old, Born Here
583	Neonate with External Heart and Lung Oxygen Support
588	Neonate Birthwt <1500g with Major Procedure
589	Neonate Birthwt <500g or Gestational Age <24 weeks
591	Neonate Birthwt 500-749g without Major Procedure
593	Neonate Birthwt 750-999g without Major Procedure
602	Neonate Birthwt 1000-1249g with Respiratory Distress Syndrome
603	Other Neonate Birthwt 1000-1249g
607	Neonate Birthwt 1250-1499g with Respiratory Distress Syndrome
608	Other Neonate Birthwt 1250-1499g
609	Neonate Birthwt 1500-2499g with Major Procedure
611	Neonate Birthwt 1500-1999g with Major Anomaly
612	Neonate Birthwt 1500-1999g with Respiratory Distress Syndrome
613	Neonate Birthwt 1500-1999g with Congenital Or Perinatal Infections
614	Other Neonate Birthwt 1500-1999g
621	Neonate Birthwt 2000-2499g with Major Anomaly
622	Neonate Birthwt 2000-2499g with Respiratory Distress Syndrome
623	Neonate Birthwt 2000-2499g with Congenital Or Perinatal Infections
625	Neonate Birthwt 2000-2499g with Other Significant Condition
626	Normal Newborn Birthweight 2000g - 2499g
630	Neonate Birthwt >2499g with Major Cardiovascular Procedure
631	Neonate Birthwt >2499g with Other Major Procedure
633	Neonate Birthwt >2499g with Major Anomaly
634	Neonate Birthwt >2499g with Respiratory Distress Syndrome
636	Neonate Birthwt >2499g with Congenital or Perinatal Infections
639	Neonate Birthwt >2499g with Other Significant Condition
640	Normal Newborn, Birthweight 2500g+
710	Infectious & parasitic diseases including HIV w O.R. procedure

APR-DRG	Description
720	Blood Infection/Septicemia
721	Postoperative and Post-Traumatic Infections
740	Mental Illness Diagnosis with O.R. Procedure
750	Schizophrenia
751	Psychoses
752	Personality and Impulse Control Disorders
753	Bipolar Disorders
754	Depression
755	Neuroses Other Than Depression
756	Acute Adjust React Psychosocial Dysfunction
757	Organic Disturbances and Mental Retardation
758	Behavioral disorders
759	Eating Disorders
760	Other Mental Disorders
761	Schizoaffective Disorders
770	Substance Abuse/Dependence, Left Against Medical Advice
772	Substance Abuse/Dependence with Rehab and/or Detox
773	Opioid Abuse/Dependence
774	Cocaine Abuse/Dependence
775	Alcohol Abuse/Dependence
776	Other Substance Abuse/Dependence
813	Complications Of Treatment
841	Burns, 3rd Degree with Skin Graft
861	Signs & Symptoms
862	Other Factors Influencing Health Status

Caveats/Data Limitations for Inpatient Data

1. The charge data in this report has not been audited. **As a result, the charge data provided in this report may differ from audited financial data.** All charge data provided has been rounded to the nearest whole number.
2. The reported payment sources are *expected* sources of payment at the time of billing rather than actual revenue sources. Therefore, the reported distribution of payment sources in this report may differ from the actual distribution of final revenue sources.
3. The utilization and charge figures in the narrative portion of this report were not adjusted for disease severity or any of a variety of other factors that could affect facility averages. However, risk adjustment was performed on hospital-specific APR-DRG charge data in the individual tables of GMS hospitals. In addition to differences in case mix and intensity of illness, regional pricing differentials and variations in services can affect utilization or charge figures. Also, differences in hospital patient record-keeping systems and internal information systems may affect the quality of the data submitted by individual facilities.
4. Care should be taken when comparing data from hospitals that reported small numbers of cases. A few unusual cases may unduly affect the average lengths of stay or charges for a given APR-DRG with a small number of total cases.
5. Lengths of stay for inpatients that remained in the hospital less than 24 hours were counted as one day in this report. In other analyses these may be considered zero-day lengths of stay.
6. In some cases, transfers of patients between distinct units of a hospital are submitted to WHA Information Center as separate discharges. This reflects standard billing guidelines and data submission requirements developed by the Wisconsin Bureau of Health Care Information.
7. Calculation of average charge per discharge in the following summary tables excluded any discharge with a stay longer than 100 days. An exception occurs for the two state-operated mental health institutes: charge data are included for all patients at these hospitals, except those whose length of stay was 1,000 days or greater.
    - Table 1: Comparative Summary of Utilization and Charges for Hospitalizations in Wisconsin
    - Table 2: Summary data for Wisconsin hospitals, by type
    - Table 3: Percent change in utilization and charges in Wisconsin hospitals, by type
    - Appendix 1: Comparison by Hospital Type
8. All hospitalizations of 1,000 days or longer were excluded from the data entirely.
9. Data from both rehabilitation facilities and state-operated mental health institutes were excluded from the following tables:
    - Table 4: Childbirths in Wisconsin
    - Table 5: Neonatal hospitalizations in Wisconsin
    - Table 6: Cardiovascular hospitalizations in Wisconsin
    - Table 7: Orthopedic hospitalizations in Wisconsin

- Table 8: Psychiatric hospitalizations in Wisconsin
- Table 9: AODA hospitalizations in Wisconsin
- Table 10: Most common hospitalizations in Wisconsin
- Table 11: Top 10 hospitalizations by average charge in Wisconsin
- Table 12: Hospitalizations with the highest total charge-generating APR-DRGs in Wisconsin

10. Inpatient hospitalizations were categorized by APR-DRG in this report. Previous versions of this report categorized inpatient hospitalizations by "standard" (Medicare) DRG. APR-DRGs were developed by 3M^{tm} Corporation to be more applicable to the general patient population. There are more main categories within APR-DRGs than "standard" DRGs although differences in severities of illness or complications are generally recognized by the assignment of one of four severities of illness subcategories within each APR-DRG. "Standard" DRG's would often distinguish between hospitalizations with and without complications by assigning the stays to different DRGs.