

SELECTED FINDINGS

Inpatient Data

- In 2025, Wisconsin hospitals reported 593,704 inpatient hospitalizations, with 593,688 hospitalizations having stays of less than 1,000 days, which qualified them for inclusion in this report. These resulted in 2.9 million days of care and total billed charges of \$34.2 billion (see Table 1 for details).
- On average, a hospital patient was charged \$55,879 per hospitalization during 2025. In general medical-surgical (GMS) hospitals, the average inpatient charge was \$56,731. In the non-GMS (specialty) hospitals, charges differed between long-term care and short-term specialty care. The average charge was \$510,565 in LTAC hospitals, \$19,827 in psychiatric hospitals, \$49,064 in rehabilitation hospitals, and \$53,883 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, 35.2 days at LTAC hospitals, 6.2 days at psychiatric hospitals, 12.7 days at rehabilitation hospitals, and 33.4 days at the state-operated mental health institutes (see Table 2 for details).
- In 2025, there were 52,831 obstetrical hospitalizations and 58,173 neonatal hospitalizations. There were also 79,948 cardiovascular, 42,653 orthopedic, 37,374 psychiatric, and 13,632 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 Blood Infection/Septicemia (APR-DRG 720). 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 48,329 hospitalizations (83 percent of all neonatal hospitalizations) with an average charge of \$6,156 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 39,679 hospitalizations at an average charge of \$17,807. 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, 6,440 patients had open-heart surgery at 33 GMS hospitals, with an average length of stay of 7.8 days and an average charge of \$227,069.
- Four GMS hospitals performed a total of 69 heart transplants (APR-DRG 002; MDC 05), with an average charge of \$2,025,7700 and an average length of stay of 66.7 days.
- The most expensive APR-DRGs were Neonate with External Heart and Lung Oxygen Support (APR-DRG 583), at an average charge of \$1,987,193 and Heart and/or Lung Transplant (APR-DRG 002), at an average charge of \$1,797,614.

Combined, they accounted for only 175 hospitalizations, yet their complexity and length of stay resulted in \$318 million total charges and 9,630 patient days.

- The APR-DRGs generating the most total charges were Blood Infection/Septicemia (APR-DRG 720), at \$2.2 billion, and Heart Failure (APR-DRG 194), at \$806.8 million.
- Females accounted for 54 percent of all hospitalizations. Sixteen percent of hospitalizations among females were obstetric-related.
- During 2025, injury-related hospitalizations and ambulatory surgeries accounted for \$8.5 billion in charges at hospitals and FASCs.

Ambulatory Surgery Data

- Ambulatory surgery procedures were performed at 130 Wisconsin GMS hospitals and 85 FASCs in 2025. Data for 1,158,289 cases were collected: 859,297 from hospitals and 298,992 from FASCs.
- Lesion Removal Colonoscopy by Snare was the most frequently reported principal ambulatory procedure in 2025, with 109,657 cases.
- The principal procedure producing the highest average charge among the 20 common principal procedures was Total Hip Arthroplasty (CPT 27130), at \$55,078. The least expensive among the top 20 most common principal procedures was Drain/Inject- Joint/Bursa (CPT 20610) with an average charge of \$3,147.

Emergency Department Data

- In 2025, Wisconsin hospitals reported over 2.0 million visits to hospital emergency departments.
- The most common primary diagnoses associated with emergency department visits was symptoms and signs involving the circulatory and respiratory systems, representing about eight percent of all visits.
- Included in the 2025 emergency department visits were 367,073 visits (approximately 18 percent of the overall total) related to all types of injury and poisoning.
- Injury-related emergency department visits accounted for \$1.9 billion in charges (approximately 22 percent of the overall total).

Comparison to 2024 Data

- Compared to 2024, the number of hospitalizations in 2025 increased by 3.4 percent while the number of patient days increased by 3.1 percent. The average length of stay decreased by 0.2 percent (see Table 1 for details).
- Statewide, the average charge per hospitalization rose from \$52,851 to \$55,879 (5.7 percent) between 2024 and 2025 (see Table 1 for details).
- The average charge per hospitalization increased from \$53,666 to \$56,731 (5.7 percent) at GMS hospitals, from \$417,685 to \$510,565 (22.2 percent) at LTAC hospitals, from \$19,286 to \$19,827 (2.8 percent) at psychiatric hospitals, and from \$44,537 to \$53,883 (21.0 percent) at the state-operated mental health institutes.
- The average charge per hospitalization decreased from \$50,532 to \$49,064 (2.9 percent) at the rehabilitation hospitals (see Table 3 for details).
- The average length of stay increased from 33.7 days to 36.3 days (4.6 percent) at the LTAC hospitals, and from 30.2 days to 33.4 days (10.8 percent) at the state-operated mental health institutes.
- The average length of stay decreased from 4.5 days to 4.5 days (0.4 percent) at GMS hospitals, from 6.2 days to 6.2 days (0.3 percent) at the psychiatric hospitals, and from 13.1 days to 12.7 days (2.7 percent) at the rehabilitation hospitals.
- The 40 most frequently performed ambulatory surgery procedures comprised 60 percent of all reported cases. Charges for the top 40 procedures combined increased 8 percent from 2024. Some fluctuations in utilization may be observed compared to previous years.
- The number of reported emergency department visits decreased by 0.3 percent, from 1.98 million in 2024 to 1.96 million in 2025.

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 2025 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:

$$\begin{array}{r} \$6,216 \\ 5,425 \\ 4,984 \\ 5,733 \\ 7,002 \\ 6,558 \\ + 5,193 \\ \hline \$41,111 \end{array} \qquad \$41,111 / 7 = \$5,873$$

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-4² 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**

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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 2025 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 2025, 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 \$53,666 in 2024 to \$56,731 in 2025. 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 22.2 percent from 2024 to 2025. The number of hospitalizations decreased 3.6 percent, patient days increased 0.8 percent, and average length of stay increased 4.6 percent.

The average charge per stay at psychiatric hospitals increased 2.8 percent from 2024 to 2025. The number of hospitalizations increased 5.3 percent, patient days increased 5.0 percent, and average length of stay decreased 0.3 percent.

The average charge per stay at rehabilitation facilities decreased 2.9 percent from 2024 to 2025. The number of hospitalizations increased 24.6 percent, patient days increased 21.3 percent, and average length of stay decreased 2.9 percent.

The average charge per stay at the state-operated mental health institutes increased 21.0 percent from 2024 to 2025. The number of hospitalizations decreased 14.3 percent, patient days decreased 5.0 percent, and average length of stay increased 10.8 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, 2024 and 2025

	2025	2024	% Difference
Number of Hospitalizations	593,688	574,287	3.4%
Total Patient Days	2,926,950	2,838,114	3.1%
Average Stay (days)	4.9	4.9	-0.2%
Hospitalizations per 1,000 population	99.6	96.4	3.3%
Patient Days per 1,000 population	491.1	476.2	3.1%
Total Charges	\$33,174,630,308	\$30,351,821,766	9.3%
Average Charge per Hospitalization	\$55,879	\$52,851	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 2025 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, 2025

Type	Number of Hospitals	Number of Hospitalizations	Patient Days	Average Stay (days)	Average Charge per Day	Average Charge per Stay
GMS	143	555,361	2,512,346	4.5	\$12,541	\$56,731
LTAC	4	1,140	40,137	35.2	\$14,501	\$510,565
PSYCH	15	25,806	160,083	6.2	\$3,196	\$19,827
REHAB	10	8,011	101,817	12.7	\$3,860	\$49,064
STATE	2	3,370	112,567	33.4	\$1,613	\$53,883
TOTAL	174	593,688	2,926,950	4.9	\$11,334	\$55,879

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 2025 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, 2024 to 2025

Type	Number of Hospitalizations	Patient Days	Average Length of Stay	Average Charge per Stay
GMS	3.2%	2.8%	-0.4%	5.7%
LTAC	-3.6%	0.8%	4.6%	22.2%
PSYCH	5.3%	5.0%	-0.3%	2.8%
REHAB	24.6%	21.3%	-2.7%	-2.9%
STATE	-14.3%	-5.0%	10.8%	21.0%
TOTAL	3.4%	3.1%	-0.2%	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 2025 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 98.1 percent of all Wisconsin hospitalizations in 2025.

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 2025, 52,831 women delivered babies (single and multiple births) in Wisconsin hospitals, up from 52,576 in 2024.

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 4.8 percent of childbirths.

Statewide, the rate for Cesarean sections, also called C-sections (APR-DRG 540) decreased to 24.9 percent of childbirths compared to 25.0 percent in 2024.

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 34.2 percent of all childbirths, Froedtert South – Froedtert Pleasant Prairie Hospital had a rate of 31.1 percent, and SSM Health St Mary's Hospital - Madison had a rate of 29.5 percent.

Table 4. Childbirths in Wisconsin, 2025

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
540	Cesarean Delivery	13,152	3.5	\$33,658	\$29,439
541	Vaginal Delivery with Sterilization	652	2.2	\$29,064	\$26,989
542	Vaginal Delivery with Proc Except Sterilization	1,918	2.7	\$28,779	\$22,760
560	Vaginal Delivery	37,109	2.1	\$17,042	\$15,474
Total Childbirths		52,831	2.5	\$21,753	\$18,382

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 increased to 58,173 in 2025 from 57,776 in 2024.

Table 5. Neonatal Hospitalizations (MDC 15) in Wisconsin, 2025

APR- DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
580	Neonate, Transferred <5 Days Old, Not Born Here	206	1.2	\$13,696	\$12,394
581	Neonate, Transferred <5 Days Old, Born Here	1,726	1.1	\$5,446	\$2,392
583	Neonate with External Heart and Lung Oxygen Support	18	67.1	\$1,987,193	\$1,174,306
588	Neonate Birthwt <1500g with Major Procedure	19	128.6	\$1,633,023	\$1,558,813
589	Neonate Birthwt <500g or Gestational Age <24 weeks	57	43.8	\$531,712	\$177,331
591	Neonate Birthwt 500-749g without Major Procedure	62	82.9	\$836,564	\$840,726
593	Neonate Birthwt 750-999g without Major Procedure	105	71.6	\$616,183	\$616,501
602	Neonate Birthwt 1000-1249g with Respiratory Distress Syndrome	129	63.5	\$484,103	\$467,290
603	Other Neonate Birthwt 1000-1249g	3	39.7	\$312,919	\$381,670
607	Neonate Birthwt 1250-1499g with Respiratory Distress Syndrome	170	51.3	\$399,351	\$334,336
608	Other Neonate Birthwt 1250-1499g	23	26.1	\$167,533	\$133,351
609	Neonate Birthwt 1500-2499g with Major Procedure	27	60.9	\$827,453	\$718,838
611	Neonate Birthwt 1500-1999g with Major Anomaly	71	32.5	\$249,480	\$174,642
612	Neonate Birthwt 1500-1999g with Respiratory Distress Syndrome	388	32.0	\$211,866	\$183,923
613	Neonate Birthwt 1500-1999g with Congenital Or Perinatal Infections	6	20.3	\$108,958	\$104,014
614	Other Neonate Birthwt 1500-1999g	268	14.7	\$84,584	\$69,290
621	Neonate Birthwt 2000-2499g with Major Anomaly	153	19.0	\$176,090	\$105,409
622	Neonate Birthwt 2000-2499g with Respiratory Distress Syndrome	482	19.5	\$124,796	\$101,590
623	Neonate Birthwt 2000-2499g with Congenital Or Perinatal Infections	7	17.1	\$124,214	\$94,772
625	Neonate Birthwt 2000-2499g with Other Significant Condition	194	13.1	\$71,344	\$59,458
626	Normal Newborn Birthweight 2000g - 2499g	1,581	4.0	\$17,703	\$8,083
630	Neonate Birthwt >2499g with Major Cardiovascular Procedure	50	41.2	\$893,539	\$622,216
631	Neonate Birthwt >2499g with Other Major Procedure	52	35.1	\$587,800	\$298,853
633	Neonate Birthwt >2499g with Major Anomaly	937	6.7	\$60,297	\$11,011
634	Neonate Birthwt >2499g with Respiratory Distress Syndrome	1,708	8.9	\$65,663	\$39,066
636	Neonate Birthwt >2499g with Congenital or Perinatal Infections	102	7.8	\$48,632	\$28,589
639	Neonate Birthwt >2499g with Other Significant Condition	1,300	5.2	\$27,792	\$11,534
640	Normal Newborn, Birthweight 2500g+	48,329	1.9	\$6,156	\$5,155
Total Neonatal Hospitalizations		58,173	3.5	\$20,953	\$5,453

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 2025, cardiovascular diagnoses accounted for 79,948 hospitalizations (up from 75,396 in 2024) (not including patients treated at rehabilitation hospitals or state-operated mental health institutes). These patients represented 13.5 percent of all hospitalizations and 21.5 percent of all inpatient charges, compared to 13.1 percent and 20.8 percent, respectively, the year before. Charges for cardiovascular-related hospitalizations in 2025 totaled \$7.1 billion, up from \$6.3 billion the previous year.

Thirty-three GMS hospitals performed open-heart surgery (APR-DRGs 162-163, and 165-167) on 6,440 patients, an 8.0 percent increase from 2024.

The largest number of open-heart surgeries (1,256) was performed by Aurora St. Luke's Medical Center in Milwaukee.

Four hospitals performed a total of 76 heart transplants in 2025. These four urban teaching hospitals performed all heart transplants in 2025. UW Hospital and Clinics Authority, Madison, performed 26, Froedtert Hospital, Milwaukee, performed 23 transplants, Aurora St. Luke's Medical Center, Milwaukee, performed 20 transplants, and Children's Wisconsin-Milwaukee Hospital performed 7.

Table 6. Cardiovascular Hospitalizations (MDC 05) in Wisconsin, 2025

APR- DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
002	Heart Transplant	76	66.7	\$2,025,770	\$1,559,900
161	Defibrillator and Heart Assist Implant	34	42.5	\$1,500,518	\$1,396,246
162	Cardiac valve procedures w AML or complex PDX	319	12.7	\$368,929	\$305,434
163	Cardiac valve procedures w/o AML or complex PDX	1,935	7.1	\$232,120	\$201,256
165	Coronary bypass w AML or complex PDX	1,135	9.9	\$240,291	\$210,308
166	Coronary bypass w/o AML or complex PDX	2,303	6.8	\$187,482	\$165,647
167	Other cardiothoracic & thoracic vascular procedures	748	7.5	\$255,324	\$180,143
170	Pacemaker Implant with Heart Attack, Heart Failure or Shock	16	7.2	\$126,844	\$106,673
171	Pacemaker Implant without Heart Attack, Heart Failure or Shock	2,196	4.0	\$89,990	\$74,201
174	Percutaneous coronary intervention w AML	5,040	3.0	\$98,840	\$83,384
175	Percutaneous coronary intervention w/o AML	5,405	2.4	\$123,803	\$103,921
176	Pacemaker/Defibrillator Replacement	106	5.8	\$128,627	\$105,522
177	Pacemaker/Defibrillator Revision Except Replacement	95	5.1	\$98,758	\$71,328
190	Circulatory Disorders with Heart Attack	4,007	3.1	\$44,884	\$37,409
191	Cardiac catheterization for coronary artery disease	1,198	2.0	\$45,079	\$41,118
192	Cardiac catheterization for other non-coronary conditions	4,424	5.2	\$76,937	\$58,666
194	Heart Failure	20,291	4.6	\$39,760	\$30,786
196	Cardiac arrest & shock	460	4.4	\$66,538	\$45,120
198	Chest Pain with Angina Pectoris or Coronary Atherosclerosis	951	1.9	\$25,654	\$23,118
199	Hypertension	2,054	3.1	\$34,630	\$27,996
200	Heart Structural and Valve Disorders	328	4.7	\$47,484	\$31,782
201	Heart Abnormal Rhythm and Conduction Disorders	8,468	2.8	\$28,012	\$22,100
203	Chest Pain	398	1.8	\$26,710	\$24,082
204	Fainting and Collapse	1,958	3.1	\$33,257	\$28,489
206	Malfunction/ Reaction/Complication of Heart Device or Procedure	943	5.1	\$58,546	\$40,735
	All Other Cardiovascular Hospitalizations	15,060	5.3	\$145,031	\$104,856
	Total Cardiovascular Hospitalizations	79,948	4.4	\$89,212	\$50,905
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 42,653 hospitalizations in 2025 (not including patients treated at rehabilitation hospitals or state-operated mental health institutes). Orthopedic patients accounted for 7.2 percent of all hospitalizations and 10.4 percent of total inpatient charges.

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

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
303	Dorsal and Lumbar Fusion with Principal Diagnosis of Back Curvature	220	5.5	\$218,246	\$188,784
304	Dorsal and Lumbar Fusion Without Principal Diagnosis of Back Curvature	1,927	4.3	\$147,387	\$121,720
305	Amputation of Lower Limb Except Toes	1,573	9.5	\$102,156	\$73,771
308	Hip & femur fracture repair	4,624	5.6	\$80,322	\$68,125
309	Other significant hip & femur surgery	643	6.1	\$117,313	\$88,550
310	Back/Neck Procedures Except Dorsal and Lumbar Fusion	885	4.4	\$76,493	\$61,207
313	Other Knee/Lower Leg Surgery	2,627	5.3	\$93,610	\$73,983
314	Foot/Toe Surgery	1,456	5.6	\$65,400	\$50,275
315	Shoulder, upper arm & forearm procedures except joint replacement	964	5.0	\$94,269	\$78,174
316	Hand/Wrist Surgery	402	4.3	\$59,964	\$44,582
321	Upper Spinal Fusion	1,907	4.2	\$104,529	\$89,845
323	Non-elective or complex hip joint replacement	3,492	5.2	\$88,500	\$76,560
324	Elective hip joint replacement	1,045	2.5	\$76,631	\$69,363
325	Non-elective or complex knee joint replacement	1,524	3.4	\$100,907	\$90,105
326	Elective knee joint replacement	1,297	2.1	\$70,331	\$64,226
340	Thigh Fracture	768	3.9	\$29,247	\$21,775
341	Pelvis Fracture/Hip Dislocation	597	4.4	\$31,448	\$25,735
342	Fracture or Dislocation Except Thigh, Pelvis, Back	1,905	4.3	\$34,593	\$28,209
343	Musculoskeletal Malignancy	512	7.4	\$72,837	\$50,883
347	Other Back/Neck Disorders, Fractures, Injuries	4,066	4.4	\$38,849	\$31,536
351	Other Musculoskeletal System and Connective Tissue Diagnoses	3,290	4.2	\$34,130	\$26,535
	All Other Orthopedic Hospitalizations	6,929	5.5	\$108,007	\$75,148
	Total Orthopedic Hospitalizations	42,653	5.0	\$81,117	\$62,275

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

Psychiatric Hospitalizations

GMS, and psychiatric hospitals treated 34,306 psychiatric inpatients in 2025 (up from 33,784 in 2024). They represented 5.8 percent of all hospitalizations and 2.2 percent of total inpatient charges.

The number of psychiatric hospitalizations increased by 1.5 percent from 2024, and patient days increased by 1.2 percent.

The average charge for psychiatric hospitalizations increased by 2.6 percent in 2025 to \$21,242, from \$20,704 the year before.

Table 8. Psychiatric Hospitalizations (MDC 19) in Wisconsin, 2025

APR- DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
740	Mental Illness Diagnosis with O.R. Procedure	30	9.6	\$89,492	\$49,996
750	Schizophrenia	6,168	8.0	\$25,810	\$20,150
751	Psychoses	16,101	5.2	\$17,947	\$15,549
752	Personality and Impulse Control Disorders	425	4.4	\$16,332	\$13,150
753	Bipolar Disorders	3,288	5.8	\$18,669	\$15,000
755	Neuroses Other Than Depression	1,210	3.6	\$11,819	\$9,674
756	Acute Adjust React Psychosocial Dysfunction	1,954	4.6	\$23,487	\$18,704
757	Organic Disturbances and Mental Retardation	171	6.7	\$29,637	\$17,631
758	Behavioral disorders	1,549	6.0	\$21,111	\$20,562
759	Eating Disorders	768	15.7	\$60,280	\$45,565
760	Other Mental Disorders	58	4.6	\$35,795	\$22,687
	All Other Psychiatric Hospitalizations	2,584	8.2	\$24,461	\$17,760
	Total Psychiatric Hospitalizations	34,306	6.2	\$21,242	\$17,260

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 13,427 hospitalizations in 2025 in GMS and psychiatric facilities, up from 13,307 in 2024.

Table 9. AODA Hospitalizations (MDC 20) in Wisconsin, 2025					
APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
770	Substance Abuse/Dependence, Left Against Medical Advice	1,166	2.0	\$15,642	\$11,008
772	Substance Abuse/Dependence with Rehab and/or Detox	1,087	3.7	\$20,579	\$15,099
773	Opioid Abuse/Dependence	1,484	4.3	\$21,484	\$17,525
774	Cocaine Abuse/Dependence	920	4.2	\$21,231	\$16,860
775	Alcohol Abuse/Dependence	8,349	3.7	\$23,812	\$17,525
776	Other Substance Abuse/Dependence	371	4.2	\$19,507	\$14,578
	All Other AODA Hospitalizations	50	9.5	\$120,617	\$88,626
	Total AODA Hospitalizations	13,427	3.7	\$22,648	\$16,977
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 18.5 percent of all inpatient charges at GMS, LTAC, and psychiatric facilities in 2025.

Birth-related hospitalizations (APR-DRGs 540, 541, 542, and 560 and MDC 15) accounted for 19.1 percent of all hospitalizations at these facilities, but only 7.1 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 (\$29,364) compared to the average charge for all inpatients at GMS, LTAC, and psychiatric facilities (\$57,327).

Table 10. Most Common Hospitalizations in Wisconsin, 2025

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
640	Normal Newborn, Birthweight 2500g+	48,329	1.9	\$6,156	\$5,155
720	Blood Infection/Septicemia	37,867	5.6	\$59,409	\$40,534
560	Vaginal Delivery	37,109	2.1	\$17,042	\$15,474
194	Heart Failure	20,291	4.6	\$39,760	\$30,786
751	Psychoses	16,101	5.2	\$17,947	\$15,549
540	Cesarean Delivery	13,152	3.5	\$33,658	\$29,439
133	Respiratory failure	10,605	4.6	\$49,925	\$29,108
139	Pneumonia	10,141	3.9	\$34,265	\$26,801
469	Acute kidney injury	8,703	4.8	\$40,989	\$28,516
201	Heart Abnormal Rhythm and Conduction Disorders	8,468	2.8	\$28,012	\$22,100
Above Hospitalizations Total		210,766	3.6	\$29,364	\$19,130
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 2025 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 2025 (see Table 11).

These APR-DRGs required specialized treatment and long hospital stays. Together, they represented only 920 hospitalizations.

Table 11. Top 10 Hospitalizations by Average Charge in Wisconsin, 2025					
APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Median Charge
583	Neonate with External Heart and Lung Oxygen Support	18	67.1	\$1,987,193	\$1,174,306
002	Heart and/or Lung Transplant	157	53.6	\$1,797,614	\$1,332,710
841	Burns, 3rd Degree with Skin Graft	8	68.5	\$1,780,433	\$1,422,787
588	Neonate Birthwt <1500g with Major Procedure	19	128.6	\$1,633,023	\$1,558,813
161	Defibrillator and Heart Assist Implant	34	42.5	\$1,500,518	\$1,396,246
011	Chimeric antigen receptor (CAR) T-cell and other immunotherapies	94	14.1	\$1,285,080	\$984,053
004	Tracheostomy w MV 96+ hours w extensive procedure	451	50.5	\$1,019,544	\$754,016
630	Neonate Birthwt >2499g with Major Cardiovascular Procedure	50	41.2	\$893,539	\$622,216
591	Neonate Birthwt 500-749g without Major Procedure	62	82.9	\$836,564	\$840,726
609	Neonate Birthwt 1500-2499g with Major Procedure	27	60.9	\$827,453	\$718,838
Above Hospitalizations Total		920	51.1	\$1,210,631	\$916,749
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 21.5 percent of all hospitalizations and 23.4 percent of total charges among GMS, LTAC, and psychiatric hospitals in 2025 (see Table 12). They included a mixture of high-cost conditions (e.g., Respiratory 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).

APR-DRG	Description	Number of Hospitalizations	Average Stay (days)	Average Charge	Total Charges
720	Blood Infection/Septicemia	37,867	5.6	\$59,409	\$2,249,658,292
194	Heart Failure	20,291	4.6	\$39,760	\$806,763,448
710	Infectious & parasitic diseases including HIV w O.R. procedure	4,883	11.1	\$155,885	\$761,188,751
175	Percutaneous coronary intervention w/o AMI	5,405	2.4	\$123,803	\$669,156,893
183	Percutaneous structural cardiac procedures	3,273	3.0	\$200,690	\$656,858,222
560	Vaginal Delivery	37,109	2.1	\$17,042	\$632,421,969
133	Respiratory failure	10,605	4.6	\$49,925	\$529,451,570
130	Respiratory System DX w/ Vent Support 96+ Hrs	887	24.3	\$584,463	\$518,418,452
174	Percutaneous coronary intervention w AMI	5,040	3.0	\$98,840	\$498,151,490
021	Craniotomy Except For Trauma	2,369	7.9	\$207,546	\$491,676,381
Above Hospitalizations Total		127,729	4.4	\$61,174	

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 cause 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 2025 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, 2025

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	2,028	34.0	\$67,244,536
Accidental	1,389	23.3	\$38,913,286
Self-Inflicted	550	9.2	\$20,000,906
Assault	82	1.4	\$8,169,310
Undetermined	7	0.1	\$161,034
Drown/Submersion	24	0.4	\$1,264,795
Accidental	17	0.3	\$795,103
Self-Inflicted/Assault/Undetermined	7	0.1	\$469,692
Falls	47,427	794.1	\$2,984,208,351
Accidental	47,401	793.6	\$2,982,016,108
Self-Inflicted/Assault/Undetermined	26	0.4	\$2,192,243
Fire/Flames	319	5.3	\$50,446,923
Accidental	294	4.9	\$40,675,815
Self-Inflicted/Assault/Undetermined	25	0.4	\$9,771,107
Firearms	587	9.8	\$103,222,295
Accidental	193	3.2	\$22,550,056
Self-Inflicted	48	0.8	\$5,824,504
Assault	295	4.9	\$66,828,041
Undetermined	51	0.9	\$8,019,694
Hot Objects/Scalds	622	10.4	\$35,049,350
Accidental	364	6.1	\$20,468,290
Self-Inflicted/Assault/Undetermined	258	4.3	\$14,581,061
Machinery	489	8.2	\$19,356,159
Motor Veh Traffic	4,039	67.6	\$473,278,900
Accidental	4,009	67.1	\$469,633,522
Self-Inflicted/Assault/Undetermined	30	0.5	\$3,645,379
Oth Pedal Cycle	600	10.0	\$37,800,390
Oth Mot Veh Nontraffic	991	16.6	\$76,250,789
Oth Transport	189	3.2	\$11,429,488
Natural/Environmental	40,562	679.1	\$1,745,502,989
Overexertion	4,878	81.7	\$148,035,791
Poisoning	36,257	607.0	\$2,544,816,988
Accidental	730	12.2	\$34,531,654
Self-Inflicted	926	15.5	\$24,280,081
Assault	0	N/A	N/A
Undetermined	34,601	579.3	\$2,486,005,253
Striking/Struck By	3,307	55.4	\$147,384,806
Accidental	2,818	47.2	\$118,446,732
Assault	489	8.2	\$28,938,074
Other Injury	783	13.1	\$30,461,193
Accidental	715	12.0	\$25,887,136
Self-Inflicted	17	0.3	\$2,205,587
Assault	41	0.7	\$2,107,147
Undetermined	3	0.1	\$70,586
Others	7	0.1	\$190,737
Total Injuries	143,102	2,395.9	\$8,475,753,741
Total Self-Inflicted	1,804	30.2	\$72,724,891
Total Assaults	929	15.6	\$107,575,283

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, 2025

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	312	25.9	\$11,766,384
Accidental	216	17.9	\$7,404,385
Self-Inflicted	83	6.9	\$3,820,339
Assault	10	0.8	\$452,329
Undetermined	3	0.2	\$89,331
Drown/Submersion	4	0.3	\$184,175
Accidental	3	0.2	\$112,387
Self-Inflicted/Assault/Undetermined	1	0.1	\$71,789
Falls	8,016	665.0	\$612,986,945
Accidental	8,012	664.7	\$612,706,791
Self-Inflicted/Assault/Undetermined	4	0.3	\$280,154
Fire/Flames	107	8.9	\$22,097,974
Accidental	102	8.5	\$21,118,042
Self-Inflicted/Assault/Undetermined	5	0.4	\$979,932
Firearms	65	5.4	\$19,508,180
Accidental	40	3.3	\$9,309,311
Self-Inflicted	5	0.4	\$825,343
Assault	17	1.4	\$9,287,230
Undetermined	3	0.2	\$86,296
Hot Objects/Scalds	140	11.6	\$7,755,511
Accidental	83	6.9	\$4,782,046
Self-Inflicted/Assault/Undetermined	57	4.7	\$2,973,465
Machinery	90	7.5	\$3,323,248
Motor Veh Traffic	693	57.5	\$111,730,811
Accidental	684	56.7	\$109,582,628
Self-Inflicted/Assault/Undetermined	9	0.7	\$2,148,182
Oth Pedal Cycle	120	10.0	\$9,589,885
Oth Mot Veh Nontraffic	193	16.0	\$21,890,799
Oth Transport	40	3.3	\$3,775,733
Natural/Environmental	8,602	713.6	\$372,810,650
Overexertion	718	59.6	\$20,023,925
Poisoning	6,415	532.2	\$623,161,294
Accidental	125	10.4	\$7,514,032
Self-Inflicted	190	15.8	\$7,915,543
Assault	0	N/A	N/A
Undetermined	6,100	506.1	\$607,731,719
Striking/Struck By	507	42.1	\$28,307,744
Accidental	438	36.3	\$22,975,991
Assault	69	5.7	\$5,331,753
Other Injury	133	11.0	\$6,104,851
Accidental	125	10.4	\$5,906,476
Self-Inflicted	2	0.2	\$58,189
Assault	5	0.4	\$83,115
Undetermined	0	N/A	N/A
Others	1	0.1	\$57,072
Total Injuries	26,155	2,169.9	\$1,875,018,110
Total Self-Inflicted	333	27.6	\$17,877,508
Total Assaults	106	8.8	\$15,390,827

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, 2025

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	271	24.1	\$8,586,471
Accidental	216	19.2	\$6,162,078
Self-Inflicted	51	4.5	\$2,138,043
Assault	4	0.4	\$286,350
Undetermined	0	N/A	N/A
Drown/Submersion	3	0.3	\$73,001
Accidental	2	0.2	\$41,219
Self-Inflicted/Assault/Undetermined	1	0.1	\$31,782
Falls	9,475	842.8	\$552,640,801
Accidental	9,473	842.6	\$552,596,377
Self-Inflicted/Assault/Undetermined	2	0.2	\$44,424
Fire/Flames	25	2.2	\$1,524,152
Accidental	21	1.9	\$1,158,012
Self-Inflicted/Assault/Undetermined	4	0.4	\$366,140
Firearms	17	1.5	\$651,210
Accidental	8	0.7	\$236,779
Self-Inflicted	3	0.3	\$68,513
Assault	5	0.4	\$289,853
Undetermined	1	0.1	\$56,066
Hot Objects/Scalds	72	6.4	\$6,224,243
Accidental	26	2.3	\$1,568,288
Self-Inflicted/Assault/Undetermined	46	4.1	\$4,655,955
Machinery	39	3.5	\$1,189,738
Motor Veh Traffic	474	42.2	\$37,099,753
Accidental	473	42.1	\$37,025,490
Self-Inflicted/Assault/Undetermined	1	0.1	\$74,262
Oth Pedal Cycle	79	7.0	\$3,992,191
Oth Mot Veh Nontraffic	94	8.4	\$4,935,910
Oth Transport	27	2.4	\$1,248,992
Natural/Environmental	8,074	718.1	\$333,574,795
Overexertion	523	46.5	\$22,622,708
Poisoning	6,054	538.5	\$306,400,990
Accidental	117	10.4	\$6,220,176
Self-Inflicted	72	6.4	\$2,159,420
Assault	0	N/A	N/A
Undetermined	5,865	521.7	\$298,021,394
Striking/Struck By	505	44.9	\$21,874,798
Accidental	446	39.7	\$18,305,283
Assault	59	5.2	\$3,569,516
Other Injury	92	8.2	\$2,678,379
Accidental	90	8.0	\$2,336,989
Self-Inflicted	1	0.1	\$217,310
Assault	1	0.1	\$124,080
Undetermined	0	N/A	N/A
Others	0	N/A	N/A
Total Injuries	25,824	2,296.9	\$1,305,318,131
Total Self-Inflicted	177	15.7	\$9,701,616
Total Assaults	69	6.1	\$4,269,799

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, 2025

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	459	49.7	\$24,393,625
Accidental	278	30.1	\$12,578,033
Self-Inflicted	133	14.4	\$6,073,311
Assault	45	4.9	\$5,682,000
Undetermined	3	0.3	\$60,281
Drown/Submersion	4	0.4	\$247,931
Accidental	4	0.4	\$247,931
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Falls	9,560	1,034.4	\$904,492,920
Accidental	9,548	1,033.1	\$903,114,353
Self-Inflicted/Assault/Undetermined	12	1.3	\$1,378,566
Fire/Flames	127	13.7	\$25,135,611
Accidental	118	12.8	\$16,850,403
Self-Inflicted/Assault/Undetermined	9	1.0	\$8,285,208
Firearms	401	43.4	\$74,500,321
Accidental	86	9.3	\$10,273,143
Self-Inflicted	18	1.9	\$2,955,492
Assault	262	28.3	\$54,033,645
Undetermined	35	3.8	\$7,238,042
Hot Objects/Scalds	246	26.6	\$15,812,760
Accidental	184	19.9	\$11,444,625
Self-Inflicted/Assault/Undetermined	62	6.7	\$4,368,135
Machinery	80	8.7	\$6,000,987
Motor Veh Traffic	1,282	138.7	\$208,194,654
Accidental	1,272	137.6	\$207,313,586
Self-Inflicted/Assault/Undetermined	10	1.1	\$881,068
Oth Pedal Cycle	114	12.3	\$11,692,334
Oth Mot Veh Nontraffic	142	15.4	\$16,395,701
Oth Transport	22	2.4	\$1,643,947
Natural/Environmental	7,547	816.6	\$482,445,119
Overexertion	599	64.8	\$25,017,422
Poisoning	11,589	1,253.9	\$1,120,094,855
Accidental	205	22.2	\$11,921,920
Self-Inflicted	229	24.8	\$5,802,514
Assault	0	N/A	N/A
Undetermined	11,155	1,207.0	\$1,102,370,421
Striking/Struck By	817	88.4	\$47,782,602
Accidental	604	65.4	\$33,076,703
Assault	213	23.0	\$14,705,899
Other Injury	176	19.0	\$13,737,558
Accidental	142	15.4	\$10,462,499
Self-Inflicted	7	0.8	\$1,564,298
Assault	26	2.8	\$1,679,581
Undetermined	1	0.1	\$31,180
Others	0	N/A	N/A
Total Injuries	33,165	3,588.4	\$2,977,588,345
Total Self-Inflicted	441	47.7	\$22,844,226
Total Assaults	555	60.1	\$77,133,861

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, 2025

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	268	41.8	\$5,348,358
Accidental	154	24.0	\$2,326,343
Self-Inflicted	108	16.9	\$2,575,633
Assault	6	0.9	\$446,381
Undetermined	0	N/A	N/A
Drown/Submersion	5	0.8	\$202,308
Accidental	2	0.3	\$140,183
Self-Inflicted/Assault/Undetermined	3	0.5	\$62,125
Falls	4,847	756.5	\$190,639,111
Accidental	4,844	756.1	\$190,524,757
Self-Inflicted/Assault/Undetermined	3	0.5	\$114,354
Fire/Flames	12	1.9	\$343,504
Accidental	11	1.7	\$319,110
Self-Inflicted/Assault/Undetermined	1	0.2	\$24,394
Firearms	16	2.5	\$781,604
Accidental	9	1.4	\$428,926
Self-Inflicted	3	0.5	\$177,200
Assault	0	N/A	N/A
Undetermined	4	0.6	\$175,479
Hot Objects/Scalds	47	7.3	\$836,612
Accidental	12	1.9	\$242,412
Self-Inflicted/Assault/Undetermined	35	5.5	\$594,200
Machinery	64	10.0	\$1,374,048
Motor Veh Traffic	316	49.3	\$19,665,817
Accidental	315	49.2	\$19,625,283
Self-Inflicted/Assault/Undetermined	1	0.2	\$40,534
Oth Pedal Cycle	70	10.9	\$2,332,546
Oth Mot Veh Nontraffic	69	10.8	\$4,249,906
Oth Transport	13	2.0	\$669,911
Natural/Environmental	3,929	613.3	\$110,956,009
Overexertion	551	86.0	\$16,767,312
Poisoning	2,293	357.9	\$83,924,091
Accidental	51	8.0	\$1,219,492
Self-Inflicted	112	17.5	\$1,875,738
Assault	0	N/A	N/A
Undetermined	2,130	332.5	\$80,828,861
Striking/Struck By	304	47.4	\$9,304,887
Accidental	266	41.5	\$8,272,837
Assault	38	5.9	\$1,032,050
Other Injury	121	18.9	\$1,859,785
Accidental	111	17.3	\$1,669,148
Self-Inflicted	3	0.5	\$77,660
Assault	2	0.3	\$12,065
Undetermined	2	0.3	\$39,406
Others	3	0.5	\$61,507
Total Injuries	12,925	2,017.4	\$449,255,811
Total Self-Inflicted	263	41.1	\$5,369,993
Total Assaults	49	7.6	\$1,552,003

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, 2025

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	202	30.8	\$5,240,248
Accidental	163	24.9	\$3,465,755
Self-Inflicted	33	5.0	\$1,141,406
Assault	6	0.9	\$633,088
Undetermined	0	N/A	N/A
Drown/Submersion	3	0.5	\$127,994
Accidental	3	0.5	\$127,994
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Falls	5,231	798.1	\$266,416,890
Accidental	5,230	797.9	\$266,356,088
Self-Inflicted/Assault/Undetermined	1	0.2	\$60,802
Fire/Flames	10	1.5	\$200,724
Accidental	9	1.4	\$190,426
Self-Inflicted/Assault/Undetermined	1	0.2	\$10,298
Firearms	31	4.7	\$1,447,692
Accidental	18	2.7	\$657,707
Self-Inflicted	6	0.9	\$589,214
Assault	1	0.2	\$35,998
Undetermined	6	0.9	\$164,773
Hot Objects/Scalds	37	5.6	\$1,614,448
Accidental	19	2.9	\$939,748
Self-Inflicted/Assault/Undetermined	18	2.7	\$674,699
Machinery	79	12.1	\$2,337,231
Motor Veh Traffic	391	59.7	\$29,958,266
Accidental	390	59.5	\$29,905,066
Self-Inflicted/Assault/Undetermined	1	0.2	\$53,200
Oth Pedal Cycle	92	14.0	\$4,103,932
Oth Mot Veh Nontraffic	113	17.2	\$6,928,883
Oth Transport	27	4.1	\$1,146,294
Natural/Environmental	6,547	998.8	\$257,647,118
Overexertion	1,242	189.5	\$31,713,970
Poisoning	3,209	489.6	\$156,292,200
Accidental	69	10.5	\$3,039,816
Self-Inflicted	62	9.5	\$1,725,928
Assault	0	N/A	N/A
Undetermined	3,078	469.6	\$151,526,456
Striking/Struck By	427	65.1	\$13,279,251
Accidental	388	59.2	\$12,016,698
Assault	39	6.0	\$1,262,553
Other Injury	111	16.9	\$2,800,847
Accidental	106	16.2	\$2,692,984
Self-Inflicted	1	0.2	\$11,601
Assault	3	0.5	\$70,347
Undetermined	0	N/A	N/A
Others	1	0.2	\$25,916
Total Injuries	17,752	2,708.3	\$781,255,988
Total Self-Inflicted	118	18.0	\$4,024,410
Total Assaults	51	7.8	\$2,088,703

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, 2025

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	208	40.5	\$4,126,949
Accidental	141	27.4	\$2,546,910
Self-Inflicted	65	12.7	\$1,548,273
Assault	1	0.2	\$20,344
Undetermined	1	0.2	\$11,422
Drown/Submersion	1	0.2	\$290,289
Accidental	0	N/A	N/A
Self-Inflicted/Assault/Undetermined	1	0.2	\$290,289
Falls	3,300	642.4	\$123,223,477
Accidental	3,299	642.2	\$123,218,341
Self-Inflicted/Assault/Undetermined	1	0.2	\$5,137
Fire/Flames	12	2.3	\$279,381
Accidental	9	1.8	\$204,058
Self-Inflicted/Assault/Undetermined	3	0.6	\$75,323
Firearms	10	1.9	\$855,620
Accidental	6	1.2	\$230,233
Self-Inflicted	3	0.6	\$349,695
Assault	0	N/A	N/A
Undetermined	1	0.2	\$275,692
Hot Objects/Scalds	25	4.9	\$660,817
Accidental	12	2.3	\$380,968
Self-Inflicted/Assault/Undetermined	13	2.5	\$279,848
Machinery	38	7.4	\$861,614
Motor Veh Traffic	228	44.4	\$14,007,540
Accidental	225	43.8	\$13,801,809
Self-Inflicted/Assault/Undetermined	3	0.6	\$205,732
Oth Pedal Cycle	24	4.7	\$1,052,141
Oth Mot Veh Nontraffic	87	16.9	\$3,486,476
Oth Transport	27	5.3	\$1,074,763
Natural/Environmental	2,330	453.6	\$58,726,547
Overexertion	503	97.9	\$12,424,168
Poisoning	1,910	371.8	\$60,534,691
Accidental	47	9.1	\$1,234,730
Self-Inflicted	95	18.5	\$1,550,394
Assault	0	N/A	N/A
Undetermined	1,768	344.2	\$57,749,568
Striking/Struck By	236	45.9	\$6,904,314
Accidental	212	41.3	\$6,092,307
Assault	24	4.7	\$812,007
Other Injury	58	11.3	\$1,160,309
Accidental	53	10.3	\$806,108
Self-Inflicted	2	0.4	\$255,402
Assault	2	0.4	\$88,620
Undetermined	0	N/A	N/A
Others	1	0.2	\$10,179
Total Injuries	8,997	1,751.5	\$289,669,097
Total Self-Inflicted	184	35.8	\$4,528,674
Total Assaults	28	5.5	\$947,253

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, 2025

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	118	42.0	\$3,130,189
Accidental	85	30.3	\$1,708,762
Self-Inflicted	30	10.7	\$1,302,917
Assault	3	1.1	\$118,510
Undetermined	0	N/A	N/A
Drown/Submersion	2	0.7	\$42,871
Accidental	1	0.4	\$29,164
Self-Inflicted/Assault/Undetermined	1	0.4	\$13,708
Falls	1,854	660.4	\$76,541,914
Accidental	1,851	659.3	\$76,233,108
Self-Inflicted/Assault/Undetermined	3	1.1	\$308,807
Fire/Flames	4	1.4	\$105,545
Accidental	4	1.4	\$105,545
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Firearms	18	6.4	\$1,666,043
Accidental	9	3.2	\$410,322
Self-Inflicted	3	1.1	\$386,026
Assault	6	2.1	\$869,695
Undetermined	0	N/A	N/A
Hot Objects/Scalds	11	3.9	\$359,538
Accidental	5	1.8	\$168,812
Self-Inflicted/Assault/Undetermined	6	2.1	\$190,726
Machinery	40	14.2	\$1,971,973
Motor Veh Traffic	192	68.4	\$13,321,293
Accidental	189	67.3	\$13,170,946
Self-Inflicted/Assault/Undetermined	3	1.1	\$150,347
Oth Pedal Cycle	35	12.5	\$1,449,414
Oth Mot Veh Nontraffic	64	22.8	\$5,233,524
Oth Transport	19	6.8	\$1,090,487
Natural/Environmental	1,214	432.4	\$39,947,016
Overexertion	264	94.0	\$8,967,579
Poisoning	1,533	546.0	\$54,529,203
Accidental	36	12.8	\$941,612
Self-Inflicted	107	38.1	\$1,646,201
Assault	0	N/A	N/A
Undetermined	1,390	495.1	\$51,941,389
Striking/Struck By	199	70.9	\$7,770,812
Accidental	180	64.1	\$6,915,638
Assault	19	6.8	\$855,174
Other Injury	36	12.8	\$980,468
Accidental	33	11.8	\$911,537
Self-Inflicted	1	0.4	\$21,128
Assault	1	0.4	\$11,740
Undetermined	0	N/A	N/A
Others	1	0.4	\$36,063
Total Injuries	5,603	1,995.7	\$217,107,869
Total Self-Inflicted	154	54.9	\$4,019,859
Total Assaults	30	10.7	\$1,891,183

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, 2025

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	175	36.6	\$4,436,438
Accidental	130	27.2	\$2,644,478
Self-Inflicted	38	7.9	\$1,261,653
Assault	7	1.5	\$530,307
Undetermined	0	N/A	N/A
Drown/Submersion	2	0.4	\$96,226
Accidental	2	0.4	\$96,226
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Falls	4,741	991.6	\$248,101,695
Accidental	4,741	991.6	\$248,101,695
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Fire/Flames	20	4.2	\$741,277
Accidental	19	4.0	\$726,531
Self-Inflicted/Assault/Undetermined	1	0.2	\$14,746
Firearms	28	5.9	\$3,808,538
Accidental	16	3.3	\$1,000,549
Self-Inflicted	7	1.5	\$473,022
Assault	4	0.8	\$2,311,621
Undetermined	1	0.2	\$23,346
Hot Objects/Scalds	36	7.5	\$1,634,977
Accidental	17	3.6	\$822,905
Self-Inflicted/Assault/Undetermined	19	4.0	\$812,072
Machinery	58	12.1	\$2,287,993
Motor Veh Traffic	450	94.1	\$38,932,511
Accidental	448	93.7	\$38,840,458
Self-Inflicted/Assault/Undetermined	2	0.4	\$92,053
Oth Pedal Cycle	59	12.3	\$3,421,993
Oth Mot Veh Nontraffic	218	45.6	\$12,872,071
Oth Transport	14	2.9	\$779,361
Natural/Environmental	1,993	416.9	\$82,138,945
Overexertion	428	89.5	\$9,456,710
Poisoning	3,008	629.2	\$135,136,301
Accidental	75	15.7	\$2,359,931
Self-Inflicted	49	10.2	\$1,457,643
Assault	0	N/A	N/A
Undetermined	2,884	603.2	\$131,318,726
Striking/Struck By	285	59.6	\$11,588,299
Accidental	259	54.2	\$10,254,201
Assault	26	5.4	\$1,334,098
Other Injury	53	11.1	\$1,084,522
Accidental	52	10.9	\$1,046,922
Self-Inflicted	0	N/A	N/A
Assault	1	0.2	\$37,600
Undetermined	0	N/A	N/A
Others	0	N/A	N/A
Total Injuries	11,568	2,419.6	\$556,517,860
Total Self-Inflicted	112	23.4	\$4,025,548
Total Assaults	39	8.2	\$4,266,632

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, 2025

Injury Category	Number of Cases	Rate per 100,000 population	Total Charges
Cut/Pierce	15	10.0	\$215,873
Accidental	6	4.0	\$76,541
Self-Inflicted	9	6.0	\$139,332
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	403	268.2	\$9,164,599
Accidental	403	268.2	\$9,164,599
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Fire/Flames	2	1.3	\$18,754
Accidental	1	0.7	\$3,689
Self-Inflicted/Assault/Undetermined	1	0.7	\$15,065
Firearms	1	0.7	\$3,088
Accidental	1	0.7	\$3,088
Self-Inflicted	0	N/A	N/A
Assault	0	N/A	N/A
Undetermined	0	N/A	N/A
Hot Objects/Scalds	8	5.3	\$150,445
Accidental	6	4.0	\$118,484
Self-Inflicted/Assault/Undetermined	2	1.3	\$31,960
Machinery	1	0.7	\$9,326
Motor Veh Traffic	13	8.7	\$368,255
Accidental	13	8.7	\$368,255
Self-Inflicted/Assault/Undetermined	0	N/A	N/A
Oth Pedal Cycle	7	4.7	\$165,953
Oth Mot Veh Nontraffic	11	7.3	\$257,519
Oth Transport	0	N/A	N/A
Natural/Environmental	326	217.0	\$7,256,790
Overexertion	50	33.3	\$1,041,997
Poisoning	246	163.7	\$4,743,364
Accidental	5	3.3	\$79,945
Self-Inflicted	10	6.7	\$146,701
Assault	0	N/A	N/A
Undetermined	231	153.7	\$4,516,718
Striking/Struck By	27	18.0	\$572,096
Accidental	25	16.6	\$537,074
Assault	2	1.3	\$35,022
Other Injury	3	2.0	\$54,472
Accidental	3	2.0	\$54,472
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	1,113	740.8	\$24,022,530
Total Self-Inflicted	22	14.6	\$333,058
Total Assaults	2	1.3	\$35,022

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), 2025

Injury Category	Number of Cases		Total Cases
	Male	Female	
Cutting/Piercing	220	330	550
Drowning/Submersion	2	5	7
Firearms And Explosives	41	7	48
Jumping From A High Place	8	6	14
Other Self-Inflicted Injuries	112	145	259
Poisoning	320	606	926
Total Self-Inflicted Injuries	703	1,099	1,804

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), 2025

Injury Category	Number of Cases		Total Cases
	Male	Female	
Bite Of Human Being	14	5	19
Cutting/Piercing	60	22	82
Firearms And Explosives	237	46	283
Other Assaultive Injuries	48	22	70
Striking By Blunt Or Thrown Object	40	7	47
Unarmed Fight Or Brawl	269	159	428
Total Self-Inflicted Injuries	668	261	929

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, 2025, and December 31, 2025. 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 2025.

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 medical advice, 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
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
042	Degenerative nervous system disorders exc mult sclerosis
044	Intracranial Hemorrhage
045	Stroke and Precerebral Occlusion with Infarct
049	Bacterial & tuberculous infections of nervous system
053	Seizure
055	Head trauma w coma >1 hr or hemorrhage
113	Epiglottitis, Ear Infection, URI and Laryngotracheitis
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

APR-DRG	Description
183	Percutaneous structural cardiac procedures
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
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
380	Skin Ulcers

APR-DRG	Description
383	Cellulitis & other skin infections
420	Diabetes
426	Non-hypovolemic sodium disorders
463	Kidney/Urinary Tract Infection
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
720	Blood Infection/Septicemia

APR-DRG	Description
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
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
930	Multiple significant trauma w/o O.R. procedure

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: Births 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™ 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.