MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Hospital 02-05
Medicaid HMOs 02-04

Issued: March 1, 2002

Subject: Rebases Medical/Surgical Hospitals Reimbursed by DRGs
Updates DRG Grouper to Version 19
Implements Area Wage Adjustor
Rebases Rehabilitation Hospitals and Distinct-Part Rehabilitation Units reimbursed by Per Diems
Modifies Schedule for Recalibration of Hospital Prices and Ratios
Information Regarding Executive Order 2001-9 Reductions for FY'02
Addresses Medicaid HMO Payments to Hospitals
Eliminates References to Calculation of Per Diems for Distinct Part Psychiatric Units and Psychiatric Hospitals

Effective: April 1, 2002

Programs Affected: Medicaid, Children's Special Health Care Services (CSHCS)

Hospital Rebasing

Effective April 1, 2002, claims for inpatient hospital admissions reimbursed using the Diagnosis Related Group (DRG) methodology will be processed using the Medicare Grouper Version 19.0. The Department of Community Health (DCH) has established its own relative weights, average lengths of stay, and high and low day outlier thresholds for each DRG based on paid claims data taken from hospital admissions. The relative weights and DRG hospital prices will be rebased with the following changes:

- Four years of paid claims data will be used. The base period for inpatient hospital admissions is from September 1, 1996 through August 31, 2000.

- Three years of hospital cost report data will be used. The data used to calculate the hospital cost to charge ratios and indirect medical education (IME) adjustors will be taken from hospital cost reports ending between September 1, 1997 and August 31, 2000. The wage data will be drawn from Centers for Medicare and Medicaid Services (CMS) audited wage data as published in the Federal Register and includes the three most recent periods available for hospital cost reports ending between September 1, 1996 and August 31, 1999. All hospital cost report and wage data is weighted 60% for the most recent period, 24% for the middle period, and 16% for the oldest period.

- Area wage adjustors will replace hospital specific wage adjustors. Hospitals will be grouped by U.S. Census Metropolitan Statistical Areas (MSAs) as published in the most recent Federal Register for wage data.

Hospital Cost Report Data

Data used to develop the hospital cost to charge ratios and hospital IME adjustors will be taken from filed cost reports submitted to and accepted by DCH. The most recent data available to DCH will be used. For the current rebasing, data will be taken from hospital cost reports for fiscal years ending in the following three periods: 1) September 1, 1997 and August 31, 1998, 2) September 1, 1998 and August 31, 1999, and 3) September 1, 1999 and August 31, 2000.

Inflation and weighting factors are applied to bring all periods up to a common point in time. The following factors, with inflation derived from the 2nd Quarter 2001 Data Resources, Inc. PPS-Type Hospital Market Basket Index, will be used:

FYE	Cost Inflation Factors	Weighting Factors
9/30/97	1.0921	0.16
12/31/97	1.0856	0.16
3/31/98	1.0785	0.16
6/30/98	1.0699	0.16
9/30/98	1.0614	0.24
12/31/98	1.0537	0.24
3/31/99	1.0470	0.24
6/30/99	1.0412	0.24
9/30/99	1.0354	0.60
12/31/99	1.0283	0.60
3/31/00	1.0196	0.60
6/30/00	1.0100	0.60
8/31/00	1.0000	0.60

Audited Wage Data

Salary and wage data used to develop the base and update cost adjustors are taken from the CMS website, public use files. All data were subject to appeal through the hospital's Medicare Fiscal Intermediary. The most recent data available to DCH will be used. This includes hospital cost report data for fiscal years included in the following three periods: 1) September 1, 1996 through August 31, 1997, 2) September 1, 1997 through August 31, 1998, and 3) September 1, 1998 through August 31, 1999.

Inflation and weighting factors are applied to bring all periods to a common point in time. The following factors, with inflation derived from the 2nd quarter 2001 Data Resources, Inc. PPS-Type Hospital Market Basket Index, will be used:

FYE	Cost Inflation Factors	Weighting Factors
9/30/96	1.1351	0.16
12/31/96	1.1277	0.16
3/31/97	1.1210	0.16
6/30/97	1.1141	0.16
9/30/97	1.1065	0.24
12/31/97	1.0980	0.24
3/31/98	1.0890	0.24
6/30/98	1.0799	0.24

FYE	Cost Inflation Factors	Weighting Factors
9/30/98	1.0708	0.60
12/31/98	1.0625	0.60
3/31/99	1.0544	0.60
6/30/99	1.0463	0.60
8/31/99	1.0388	0.60

Cost inflation from August 31, 2000 is set at 1.04 per legislative directive.

Rehabilitation Hospitals and Distinct-Part Rehabilitation Units

Rehabilitation hospitals and distinct-part rehabilitation units will be rebased using the same base period, cost report periods, inflation and weighting factors as used for the medical/surgical hospitals. An area wage adjustor rather than a hospital specific wage adjustor will be used. Hospitals will be grouped by U.S. Census Metropolitan Statistical Areas (MSAs) as published in the most recent Federal Register for wage data.

Schedule for Recalibrating Hospital Prices and Ratios

The Department reserves the right to alter the schedule for recalibrating hospital prices and ratios at any time without further notice.

Executive Order Reduction for FY'02

Executive Order No. 2001-9 directed the Department to reduce hospital payments during FY'02 by $13.7 million. The reduction will be made by a separate adjustor applied to medical/surgical hospitals, rehabilitation hospitals and distinct part rehabilitation units. A separate bulletin detailing the calculations and process the Department will use to implement the reduction will be released in the near future.

Medicaid HMO Payments to Hospitals

Medicaid HMOs are to reimburse out of network medical/surgical hospitals for admissions on and after April 1, 2002 at Medicaid DRG hospital prices effective on April 1, 2002. Medicaid HMOs are to reimburse out of network distinct part rehabilitation units and freestanding rehabilitation hospitals for admissions on and after April 1, 2002 at Medicaid per diem rates effective on April 1, 2002. Medicaid HMOs are to use Medicaid DRG Grouper 19 effective April 1, 2002 to process inpatient hospital claims, assign DRGs, to determine relative weights, outliers and average lengths of stay. The hospital Medicaid operating cost to charge ratios effective on April 1, 2002 are to be used for admissions on and after April 1, 2002.

References to Distinct Part Psychiatric Units and Psychiatric Hospitals Eliminated

All references to the calculation of per diem prices for distinct part psychiatric units and hospitals have been eliminated from Section 2 of Chapter VIII. The Department has not made direct payments to distinct part psychiatric units and psychiatric hospitals since October 1, 1998 and no longer calculates per diem rates for these facilities.

Manual Update

Discard Chapter VIII, Table of Contents and Section 2. Insert the attached Chapter VIII, Table of Contents and Section 2. Insert Appendix – DRG Grouper Version 19.0. The current Appendix – DRG Grouper Version 17.0 should be retained until the hospital has completed processing all its inpatient hospital claims for dates of admission from April 1, 2000 through March 31, 2002.

Retain this bulletin in your manual.

QUESTIONS

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

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DIAGNOSIS RELATED GROUP (DRG) ASSIGNMENT

The Michigan Medicaid Program DRG reimbursement system uses the same Grouper logic that assigns invoices to DRGs as the Medicare Program. However, because the Michigan system uses weights and prices based on Michig an Medicaid claims, Michigan's Medicaid Program may not use the same version of the Grouper program as Medicare is currently using.

Medicaid Date Of Admission	Grouper Version	Medicare Effective Date
2/1/85 -12/31/87	2.0	10/1/84
1/1/88 -4/25/90	5.0	10/1/87
4/26/90 -9/30/90	2.0	10/1/84
10/1/90 -9/30/91	5.0	10/1/87
10/1/91 -9/30/94	8.0	10/1/93
10/1/94 -3/31/98	11.0	10/1/93
4/1/98 -3/31/99	15.0	10/1/97
4/1/99 -3/31/00	16.0	10/1/98
4/1/00 -3/31/02	17.0	10/1/99
4/1/02 -	19.0	

The Michigan Medicaid Program includes "alternate" weights for DRGs 385 through 390. These weights are used for neonatal intensive care services provided in hospitals with specially designated units.

SERVICES INCLUDED IN THE INPATIENT PAYMENT

All routine services (e.g., room and board, nursing) are included in the inpatient payment.

All diagnostic/ancillary services (e.g., radiology, pharmacy, therapists, supplies, pathology) are included in the inpatient payment.

While a patient is in the inpatient setting, the facility charges for any services performed by persons or entities other than the patient's hospital (e.g., an independent lab, a second hospital where no transfer occurs) are covered in the payment to the patient's hospital and must not be billed separately. All charges must be included on the inpatient invoice of the patient's hospital. Any payments due to the second party are the responsibility of the patient's hospital.

All pathology services that are performed by the pathologist but do not directly relate to the specific patient's care are included in the inpatient payment.

All emergency room services provided by the hospital that result in an inpatient admission to that hospital are included in the inpatient payment. All charges must be included on the UB 92 claim.

An orthosis or prosthesis that is required for inpatient treatment, a surgical postoperative procedure, or as a routine service of the hospital, should be included as a supply on the inpatient invoice and is reimbursed under the appropriate DRG.

Examples of items that are included in the inpatient payment are:

> Pacemakers, hip replacements, made to measure braces for compression fractures, compression stockings (TED, Jobst), halos, immediate postsurgical or early fitting of prosthetic devices, etc.

SERVICES EXCLUDED FROM THE INPATIENT PAYMENT

An orthosis or prosthesis that is required for rehabilitation and will be utilized after discharge, and/or is required to address a long term, lifetime, permanent need, is excluded from the DRG payment and must be billed separately to the Medicaid Program by an Orthotist/Prosthetist (provider type 85). Prior authorization must first be obtained for appropriate procedure codes.

Examples of items that are excluded from the inpatient payment are a knee-ankle-foot orthosis or an ankle-foot orthosis.

Except as noted above, outpatient services may not be separately billed while a beneficiary is in the inpatient setting. All charges must be included on the UB 92 claim.

Any services that are covered by Medicaid and excluded from the inpatient payment may be separately billed, if the provider of the service is properly enrolled in the program and a claim is submitted appropriately.

The following are examples of services excluded from the inpatient payment. This list may not be all-inclusive:

- Anatomic pathology services provided directly by a pathologist,
- Orthoses/prostheses required for rehabilitation that will be utilized after discharge, and/or are required to address a long term, lifetime, permanent need,
- Professional services (e.g., practitioner, dental, podiatric, optometric),
- Services provided by a nurse-midwife,
- Services provided by a certified registered nurse anesthetist,
- Ambulance services.

INFLATION

Unless otherwise indicated, inflation rates are computed from the Data Resources, Inc. PPS-Type Hospital Market Basket Index. Wage adjustor inflation rates are derived from the employee cost component of the Data Resources, Inc. PPS-Type Hospital Market Basket Index. Updates are by quarter for the base year and are annual for non-base years. For hospitals with base year cost reporting periods ending other than the end of the quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.

RELATIVE WEIGHTS

A statewide relative weight is assigned to each DRG representing covered services.

DRG assignment is based on the diagnosis and surgical procedure codes included on the billed UB 92 claim. Hospitals should use as many diagnosis and surgical procedure codes as necessary to accurately reflect the patient's condition during the hospitalization.

The average cost for episodes within each DRG is calculated by dividing the sum of the costs of the episodes by the number of episodes within the DRG.

The relative weight for each DRG is calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes.

EPISODE FILE

The statewide relative weights calculated for the Michigan system utilize Medicaid and Children's Special Health Care Services (CSHCS) inpatient claims for admissions during four (4) consecutive state fiscal years and hospital specific cost report data drawn from three (3) consecutive cost report years used to establish the relative weights.

The episode file is assigned DRG values using the appropriate grouper and is adjusted to:

- Combine multiple billings for the same episode of service including:
  - invoices for a single episode of service billed as a transfer from a hospital and an admission to the same hospital caused by a change of ownership and issuance of a new Medicaid ID number, and
  - invoices for a single episode of service billed as a transfer from a hospital and an admission to a new hospital created by the merger of two or more hospitals and the assignment of patient bills from multiple hospitals to a single Medicaid ID number.
- Eliminate episodes with any Medicare charges. (For dual Medicare/Medicaid eligible beneficiaries, only claims paid a full Medicaid DRG are included.)
- Eliminate episodes assigned to DRGs reimbursed by multiplying a hospital's operating cost to charge ratio by charges.
- Eliminate episodes without any charges or days.
- Assign alternate weights for neonatal services. Two sets of weights are calculated for the six (6) DRG classifications representing neonatal services (385-390). One set of weights is identified as "alternative weights" (385.1, 386.1, 387.1, 388.1, 389.1, and 390.1). These alternate weights are calculated from episodes that are assigned to one of these DRGs and include charges for services in an intensive care unit of one of the hospitals designated as having a neonatal intensive care unit (NICU). The remaining claims assigned to these DRGs are used for the other set of weights.
- In order to receive the alternate weights, a hospital must have a Certificate of Need (CON) to operate a NICU or a special newborn nursery unit (SNNU) or the hospital must have previously received alternate weight reimbursement by Medicaid for its SNNU.

  Limit episodes to those from Michigan hospitals, including hospitals that are no longer in operation (provided that hospital cost report data is available).

- Limit episodes to those with a valid patient status (incomplete episodes are excluded as are additional pages of a multiple page bill where there is no initial claim containing a valid patient status).
- Eliminate episodes with a zero dollar Medicaid liability.
- Eliminate episodes where the beneficiary was enrolled in a Michigan Medicaid clinic plan.
- Determine the 3rd and 97th percentile length of stays by DRG, the average length of stay, and the maximum length of stay.
    - Set the low day outlier threshold at the greater of one day or the 3rd percentile length of stay.
    - Set the high day outlier threshold at the lesser of the average length of stay plus 30 days or the 97th percentile length of stay.
    - If the DRG has less than an adequate number of episodes (currently 32), the low day threshold will be set at one day. The high day threshold will be set at the lesser of the average length of stay plus 30 days, the maximum length of stay, or the Medicare DRG 90th percentile length of stay (from the corresponding Grouper as published in the Federal Register). If the Medicare DRG also has an inadequate number of claims, then the threshold is set based upon the expert advice of the Department of Community Health's (DCH) medical staff.
- Eliminate low day outliers (Low day outliers are those episodes whose length of stay is less than the published low day threshold for each DRG. Since low day outliers are paid under a percent of charge method using the hospital's cost to charge ratio times charges, and do not receive a DRG payment, they are excluded from the weight calculations).
- Calculate the arithmetic mean length of stay for each DRG with each episode's length of stay limited to the high day threshold set above. This serves as the final published average length of stay.
- Limit episodes ending in a transfer to another acute setting to those whose length of stay was at least equal to the published average length of stay for the DRG (for DRGs 385 and 385.1 all transfers are included).
- Bring all charges for admissions in the first and second years of the base period up to third year charges through application of inflation and weighting factors.
- Recognize area cost differences by dividing the charges for each hospital by an area cost adjustor. Each area cost adjustor is calculated as follows:
    - Cost Adjustor = 0.9 x Wage Adjustor + 0.1
    - This formula is the algebraic derivation of:
        - 0.75 x Wage Adjustor + 0.25 (0.6 x Wage Adjustor + 0.4)

          The formula is based on the assumption that approximately 75% of a hospital's operating costs are labor costs and that 60% of the remaining 25% of a hospital's operating costs vary with its labor costs.
        - Each area wage adjustor is wage per F.T.E. divided by the statewide average hospital wage per F.T.E. Wage data is collected using the source described in the bulletin for the rate setting period in question. Contract labor costs, as defined by Medicare, are included in determining a hospital's wage costs.

- Each hospital's wage costs are adjusted for different fiscal year ends by multiplying the hospital's costs by inflation and weighting factors. All wages are brought to a common point in time.

  For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.

- If two or more hospitals merge and are operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data is inflated to a common point in time.

- Indirect medical education (IME) charges are removed by dividing each hospital's adjusted charges by an IME adjustor. Each hospital's IME adjustor is calculated as follows:

$$1+([(1+\frac{Interns\ \&\ Residents}{Beds}).5795-1]\times 0.715)$$

  - The number of beds for each hospital is the average number of available beds for the hospital. Available licensed beds are limited to beds in the medical/surgical portion of the hospital. Interns and residents are only those allocated to the medical/surgical portion of the hospital.
  - Data taken from the hospital's cost report for the three fiscal years is weighted as follows: 60% for the most recent year, 24% for the middle year, and 16% for the oldest year.
  - If two or more hospitals merge and are operating as a single hospital, indirect medical education data is computed using the combined cost report data from all hospitals involved in the merger.

- Adjust charges for high day and/or cost outliers to approximate the charges for the non-outlier portion of the stay.
  - If an episode's length of stay is greater than the high day outlier threshold for the DRG, then it is considered a high day outlier claim. Adjusted charges representing an estimate of the non-outlier portion of charges for high day outliers are used for the relative weight and price calculations as follows:

$$Adj\ Chrg = \frac{Charges \times High\ Day\ Threshold}{High\ Day\ Threshold + [.6 \times (LOS - High\ Day\ Threshold)]}$$

  - An episode is a cost outlier if its costs (i.e., charges times hospital's operating cost to charge ratio) are greater than the cost threshold for that DRG (the threshold is set at the larger of twice the DRG payment or $50,000).
    - The cost to charge ratio is each hospital's inpatient operating cost to charge ratio, not to exceed 1.0.
    - The adjusted charges for cost outliers use a cost threshold estimate the greater of:

Cost Threshold = 2 x Avg. Cost for DRG

Or $50,000.

    - Adjusted charges are calculated as follows:

$$Adj\ Chrg = Charges - \frac{[(Charges \times Cost\ Ratio) - Cost\ Threshold] \times .85}{Cost\ Ratio}$$

  - If an episode is both a high day and a cost outlier, the lesser of the two adjusted charges is used in computing the relative weights and DRG prices.

- The adjusted cost for each episode is calculated by multiplying the adjusted charges for the episode by the inpatient operating cost to charge ratio.
  - Each hospital's Title XIX inpatient hospital cost to charge ratio is obtained from the hospital's filed cost report for the fiscal year ending in the second year of the base period. If the cost to charge ratio is greater than 1.0, then 1.0 is used.
  - If two or more hospitals merge, and are operating as a single hospital, a cost to charge ratio for the period is computed using the combined cost report data from all hospitals involved in the merger. Cost and charge data is inflated to a common point in time.
- The average cost for episodes within each DRG is calculated by dividing the sum of the costs for the episodes by the number of episodes within the DRG.
- The relative weight for each DRG is calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes. A table showing the relative weights, average lengths of stay, and outlier thresholds for each DRG is included in the Appendix – DRG Grouper Version 19.0.

DRG PRICE

The episode file used for DRG price calculations is the same as the file used to set relative weights with the following exceptions:

- The episode file is limited to those hospitals enrolled as of a specified date.
- The case mix is calculated using the sum of all relative weights assigned to each hospital's claims during the base period, divided by the total number of episodes for the hospital during the same period.
- The adjusted cost for each hospital is summed.
- The hospital specific base price (cost per discharge for a case mix of 1.00) is computed.
  - Divide total adjusted costs by the total number of episodes.
  - Divide average costs by the case mix.
  - Multiply the result by the applicable inflation factor. Costs are inflated through the rate period. Inflation factors are obtained from the Data Resources, Inc. PPS-Type Hospital Market Basket Index.

Determine the DRG base price by:

- Calculate each hospital's limited base price. This is the lesser of the hospital specific base price or the mean of all base prices, plus one standard deviation.
- Calculate the statewide operating cost limit. This is a truncated, weighted mean of all hospitals' limited base prices divided by base period discharges.
- The lesser of the truncated mean or the hospital specific base price then becomes the DRG base price (before the cost adjustor and incentives are added) for each hospital.

Calculate any incentive. For hospitals with base DRG prices below the operating limit (truncated mean), the hospital's base DRG price is increased by adding 10% of the difference between the hospital specific base price and the limit.

Adjust each hospital's DRG base price, plus any incentive, by the updated cost adjustor. The updated cost adjustor is calculated, to reflect the most current data available, in the same manner as the base cost adjustor, except that:

- Wage data is collected using the source described within the bulletin for the rate setting period.
- The wage and benefit inflation factors are derived from the employee cost component of the Data Resources, Inc., PPS-Type Hospital Market Basket Index, relative to the period.
- In the event that changes in federal regulations result in incompatible data between the base and update periods, adjustments are made either to the base or the update period to render the data comparable.

To summarize the above, the DRG price for each hospital is calculated using the following steps:

1. Hospital's adjusted charges.
2. Inpatient cost to charge ratio.
3. Hospital's adjusted costs (line 1 * line 2).
4. Hospital's episodes.
5. Cost per discharge (line 3/line 4)
6. Hospital's casemix
7. Weighted inflation.
8. Hospital's base price (line 5 * line 7/line 6)
9. Establish the statewide base limit (mean plus one standard deviation).
10. Hospital's limited base price (lesser of lines 8 or 9).
11. Establish the statewide operating cost limit (truncated, weighted mean of line 10).
12. Hospital's DRG base price (lesser of lines 8 or 11).
13. Calculate the hospital's incentive (if line 12 < line 11, 10% of line 12 - line 11, otherwise 0).
14. Hospital's DRG base price plus any incentive (line 12 plus line 13).
15. Hospital's Area Cost Adjustor.
16. Hospital's final DRG price (line 14 x line 15). The DRG price is rounded to the nearest whole dollar amount.

SPECIAL CIRCUMSTANCES UNDER DRG REIMBURSEMENT

In some special circumstances, reimbursement for operating costs uses a DRG daily rate. The DRG daily rate is:

$$\frac{\textit{DRG Price} \times \textit{Relative Weight}}{\textit{Avg. LOS for the DRG}}$$

The average length of stay for each DRG is listed in the Appendix – DRG Grouper Version 19.0

High Day Outliers

High day thresholds are set at the lesser of the 97th percentile of length of stay or 30 days beyond the mean length of stay.

Reimbursement for high day outliers is:

$$DRG\ Price \times Rel\ Wt + (Outlier\ Days \times \frac{DRG\ Price \times Rel\ Wt.}{Avg.\ LOS\ for\ the\ DRG} \times 60\%)$$

The multiplier for the daily rate is 60% for all services, including those provided in children's hospitals and children's distinct part units of at least 150 beds.

If an episode is both a high day and a cost outlier, reimbursement is the greater of the two amounts.

Low Day Outliers

For services where the length of stay is less than the published low day threshold, reimbursement is actual charges multiplied by the individual hospital's cost to charge ratio net of IME, not to exceed the full DRG payment rate. The specific low day outlier thresholds for each DRG are listed in the Appendix – DRG Grouper Version19.0.

Less than Acute Care

If a claim is a high day outlier and review shows that the beneficiary required less than acute continuous medical care during the outlier day period, Medicaid payment is made at the statewide nursing facility per diem rate for the continuous sub-acute outlier days, if nursing care was medically necessary.

Cost Outliers

An episode is a cost outlier when costs (charges x the hospital's operating ratio excluding IME) exceed the computed cost threshold. Claims paid a percent of charge cannot be cost outliers.

Reimbursement for cost outliers is dependent upon the cost threshold.

(DRG Price x Rel Wt) + ([(Charges x Operating Cost to Charge Ratio) - (Cost Threshold)] x 85%)

The Cost Threshold is the larger of:

- 2 x DRG Price x Rel Wt (twice the regular payment for a transfer paid on a per day basis for episodes getting less than a full DRG), or
- $50,000

If an episode is both a high day and a cost outlier, reimbursement is the greater of the two amounts.

Transfers to a Hospital

Payment to a hospital that receives a patient as a transfer from another inpatient hospital differs depending on whether the patient is discharged or is subsequently transferred again.

If the beneficiary is subsequently discharged, the receiving hospital is paid the full DRG payment, plus an outlier payment if appropriate.

Reimbursement is based on discharge in the following situations. If the patient:

- is formally released from the hospital, or

- is transferred to home health services, or
- dies while hospitalized, or
- leaves the hospital against medical advice, or
- is transferred to a long term care facility.

If the beneficiary is subsequently transferred again, the hospital is paid a DRG daily rate for each day of the beneficiary's stay. The payment will not exceed the appropriate full DRG payment plus an outlier payment, if appropriate.

Transfers From a Hospital

Except in cases where the DRG is defined as a transfer of a patient (for which a full DRG payment is made, plus an outlier payment, if appropriate) the transferring hospital is paid a DRG daily rate for each day of the beneficiary's stay, not to exceed the appropriate full DRG payment, plus an outlier payment if appropriate. If the transferring hospital is a specialty hospital (e.g., burn, neonatal) depending on the documentation attached and a request for review (Condition Code - 88), or the actual number of days of stay, payment may be a full DRG payment, plus an outlier payment if appropriate.

Readmissions

Readmissions within 15 days for a related condition, whether to the same or a different hospital, are considered a part of a single case/episode for payment purposes.

If the readmission is to a different hospital, full payment is made to the second hospital. The first hospital's payment is reduced by the amount paid to the second hospital. The first hospital's payment is never less than zero for the episode.

Readmissions within 15 days for unrelated conditions, whether to the same or a different hospital, are considered new admissions for payment purposes.

Percent of Charge Reimbursement

The payment amount for pancreas transplants (surgical procedures 52.80 through 52.83) and for claims that fall into DRGs 103, 468, 480, 481 or 495 is hospital charges times the hospital's cost to charge ratio excluding IME.

Hospitals Outside of Michigan

Medical/surgical hospitals not located in Michigan are reimbursed under the DRG system. The DRG price is the statewide operating cost limit (truncated mean of base prices for hospitals located in Michigan).

Hospitals that have charges which exceed $250,000 during a single fiscal year (using the State of Michigan fiscal year-October 1st through September 30th) may be reimbursed the hospital's cost to charge ratio for those Michigan Medicaid DRGs reimbursed by percentage of charge. The hospital's chief financial officer must submit and the DCH must accept documentation stating the hospital's Medicaid cost to charge ratio in the state that the hospital is located. Once accepted, the hospital's actual cost to charge ratio is applied prospectively to those DRGs and claims subject to percentage of charge reimbursement using the Michigan DRG payment system.

New DRG Hospitals

A new hospital or unit is one for which no Michigan Medicaid Program cost or paid claims data exists during the period used to establish hospital specific base rates or one which was not enrolled in the Medicaid Program when hospital specific base prices/rates were last established. Hospitals that experience a change of ownership or that are created as the result of a merger are not considered new hospitals.

The DRG base price for new general hospitals is the statewide operating limit until new DRG base prices are calculated for all hospitals using data from time periods during which the new hospital provided services to Medicaid patients.

HOSPITALS AND UNITS EXEMPT FROM DRG REIMBURSEMENT

Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units

The per diem prices calculated for the Michigan Medicaid system utilize Medicaid and Children's Special Health Care Services inpatient claims for admissions during four (4) consecutive state fiscal years. Hospital specific cost report data is drawn from three consecutive cost report years.

The claim file is limited to those hospitals enrolled as of the specified date.

The claim file is adjusted to:

- Eliminate episodes with any Medicare charges. (For dual Medicare/Medicaid eligible beneficiaries, only claims paid a full Medicaid payment are included).
- Eliminate episodes without any charges or days.
- Limit episodes to those from Michigan hospitals (provided that hospital cost report data is available for three (3) consecutive fiscal years used for the base period, including hospitals that are no longer in operation).
- Limit episodes to those with a valid patient status (incomplete episodes are excluded as are additional pages of multiple page bills where there is no initial claim containing a valid patient status).
- Eliminate episodes with a zero dollar Medicaid liability.

Total charges and days paid are summed by hospital.

The cost for each hospital is calculated by multiplying the charges for the hospital by the cost to charge ratio for the hospital.

- Each hospital's operating cost to total charge ratio is obtained from weighted filed cost reports for fiscal years ending in the second year of the base period. If the cost to charge ratio is greater than 1.00, then 1.00 is used. For distinct part rehabilitation units, this ratio is unique to the unit.
- If two or more hospitals merge and are operating as a single hospital, a cost to charge ratio for the period is computed using the combined cost report data from all hospitals involved in the merger. Cost and charge data is inflated to a common point in time.

The cost per day by hospital is calculated by dividing the sum of the costs by the number of days for the hospital.

To determine a hospital specific Per Diem base rate:

- Multiply the cost per day by the applicable inflation factor. Each hospital's costs are inflated to a common point in time. Inflation factors are obtained from the Data Resources, Inc. PPS-Type Hospital Market Basket Index. The inflation update for the quarter in which the hospital's fiscal year ends is used.
- Recognize area cost differences by dividing the cost per day for each hospital by an area cost adjustor factor. Each area cost adjustor is calculated as follows:
  - Cost Adjustor = 0.9 x Wage Adjustor + 0.1
  - This formula is the algebraic derivation of:

    0.75 x Wage Adjustor + 0.25 x (0.6 x Wage Adjustor + 0.4)

    The formula is based on the assumption that approximately 75% of a hospital's operating costs are labor costs and that 60% of the remaining 25% of a hospital's operating costs vary with its labor costs.
  - Each area wage adjustor is wage per full-time equivalent (F.T.E.) divided by the statewide average hospital wage per F.T.E. Contract labor costs, as defined by Medicare, are included in determining a hospital's wage costs.
  - Each hospital's wage costs are adjusted for different fiscal year end dates by multiplying the hospital's wage costs by inflation and weighting factors. All wages are brought to a common point in time.
  - For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.
  - The wage data for distinct part rehabilitation units is the same as for the inpatient medical/surgical area of the hospital. The cost reports do not differentiate salaries/hours by unit type.
  - If two or more hospitals merge and are operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data is inflated to a common point in time.
- Remove indirect medical education (IME) costs by dividing by an adjustor for indirect education. Each hospital's IME adjustor is calculated as follows:
  - $IME\ Adjustor = 1 + 0.715 \times [(1 + Interns\&\ Residents/Beds)^{0.5795} - 1]$
  - Distinct part rehabilitation units report this data separately. The IME adjustor is unique to the unit.
  - Data taken from the hospital's cost report for the three fiscal is weighted as follows: 60% for the most recent year, 24% for the middle year, and 16% for the oldest year.
  - If two or more hospitals merge and are operating as a single hospital, indirect medical education data is computed using the combined cost report data from all hospitals involved in the merger.

To determine the per diem rate:

- Calculate the statewide operating cost limit (by provider type). This is a weighted mean of all hospitals' specific base prices weighted by base period days (truncated mean), multiplied by the appropriate percentage.

- For freestanding rehabilitation hospitals the percentage is 150%.

  The 50th percentile is determined by calculating a standardized rate for each unit. The standardized rate for all enrolled Michigan units are sorted in ascending order. The standardized rate of the first unit after the 50% of the units listed becomes the statewide 50th percentile.

- For distinct part rehabilitation units the percentage is 200%.

- Calculate the statewide operating cost minimum (by provider type). This is a truncated, weighted mean of all hospitals' specific base prices divided by base period days multiplied by 70%.
- The per diem base rate is the lesser of:
  - The greater of the hospital specific base price or the statewide operating cost minimum, or
  - The statewide operating cost limit.

Adjust each hospital's per diem base rate by the updated cost adjustor (to reflect a hospital specific per diem rate). The updated cost adjustor is calculated, to reflect the most current data available, in the same manner as the base cost adjustor, except that:

- The updated year data is the most recent completed Medicare audited wage data.
- The wage and benefit inflation factors are derived from the employee cost component of the Data Resources, Inc. PPS-Type Hospital Market Basket Index.
- In the event that changes in federal regulations result in incompatible data between the base and update periods, adjustments will be made either to the base or the update period (whichever is more practical) to render the data comparable.

Calculate the final per diem rate by rounding to the nearest whole dollar.

Hospitals Outside of Michigan

Freestanding rehabilitation hospitals and distinct part rehabilitation units are reimbursed using a per diem rate. The per diem rate is the statewide weighted average per diem (truncated mean) for this provider type.

New Freestanding Hospitals and Distinct Part Units

If a hospital at least doubles the number of licensed beds in its distinct part unit and the number of licensed beds in the unit increases by at least 20, the entire unit is treated as a new distinct part unit for determining the per diem rate. In order for this provision to apply, the hospital must request in writing that the unit is treated as a new unit. The new unit per diem rate will become effective on the date that the number of licensed beds doubles and the increase is at least 20 beds, or the date on which the request is received by DCH, whichever is later.

New freestanding hospitals and distinct part units are reimbursed using the statewide average (weighted by days during the base period) per diem rate for the provider type.

A hospital/unit specific per diem rate is established when new rates are calculated using data from time periods during which the new hospital/unit provided services to Medicaid patients.

FREQUENCY OF RECALIBRATION

The Department will normally recalibrate hospital prices and ratios according to the following schedule. (However, the Department reserves the right to alter the schedule at anytime without further notice to hospitals.)

- Relative weights are recalibrated annually.
- DRG prices will be rebased every three years and updated annually.
- Per Diem rates will be rebased every two years and updated annually.
- Cost to charge operating ratios are recalculated with each DRG/Per Diem rebasing.

MERGERS

General Hospitals

In the event of a merger between two or more hospitals between DRG rebasing periods, the DRG price for the surviving hospital will be computed as follows:

- Cost to charge ratio, indirect medical education (IME), and wage data will be inflated to a common point in time (for the surviving entity).
- No changes will be made to the relative weights.
- The DRG price will be computed with the same methodology as described in the section covering the computation of the DRG price, with the following exceptions:
  - No change will be made to the statewide operating cost limitation.
  - No change will be made to the statewide average used to compute the update base wage adjustor.
  - No change will be made with respect to the statewide average used to compute the update wage adjustor.
- As part of recalibration or rebasing, all data is combined prior to adjusting the invoice file, as discussed in the section covering the recalibration/rebasing.

Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units

In the event of a merger between two or more hospitals between per diem rebasing periods, the resulting per diem rate for the surviving hospital will be computed as follows:

- Cost to charge ratio, indirect medical education (IME), and wage data will be inflated to a common point in time (for the surviving entity).
- The per diem rate will be computed using the same methodology as described in the section covering the computation of the DRG rates, with the following exceptions:
  - No change will be made to the statewide operating cost limit.
  - No change will be made to the statewide operating cost minimum.
  - No change will be made to the statewide average used to compute the base wage adjustor.
  - No change will be made to the statewide average used to compute the update wage adjustor.

- As part of recalibration or rebasing, all data is combined prior to adjusting the invoice file, as discussed in the section covering the recalibration/rebasing.

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
1	1	SURG	Craniotomy Age >17 Except For Trauma	4.5023	10.27	1	40
2	1	SURG	Craniotomy For Trauma Age >17	5.1215	11.20	1	36
3	1	SURG	Craniotomy Age 0-17	2.5217	7.11	1	37
4	1	SURG	Spinal Procedures	3.0718	8.26	1	38
5	1	SURG	Extracranial Vascular Procedures	1.9583	4.00	1	17
6	1	SURG	Carpal Tunnel Release	1.0308	3.90	1	6
7	1	SURG	Periph & Cranial Nerve & Other Nerv Syst Proc W Cc	2.7458	9.28	1	35
8	1	SURG	Periph & Cranial Nerve & Other Nerv Syst Proc W/O Cc	1.7008	2.99	1	10
9	1	MED	Spinal Disorders & Injuries	1.4006	4.70	1	12
10	1	MED	Nervous System Neoplasms W Cc	1.5952	6.24	1	24
11	1	MED	Nervous System Neoplasms W/O Cc	1.0187	3.90	1	12
12	1	MED	Degenerative Nervous System Disorders	1.3789	6.40	1	22
13	1	MED	Multiple Sclerosis & Cerebellar Ataxia	1.1579	5.90	1	18
14	1	MED	Specific Cerebrovascular Disorders Except Tia	1.8149	6.46	1	22
15	1	MED	Transient Ischemic Attack & Precerebral Occlusions	0.9138	3.37	1	9
16	1	MED	Nonspecific Cerebrovascular Disorders W Cc	1.8682	7.33	1	23
17	1	MED	Nonspecific Cerebrovascular Disorders W/O Cc	0.9452	3.38	1	16
18	1	MED	Cranial & Peripheral Nerve Disorders W Cc	1.2297	5.73	1	23
19	1	MED	Cranial & Peripheral Nerve Disorders W/O Cc	0.8534	3.70	1	12
20	1	MED	Nervous System Infection Except Viral Meningitis	2.4592	9.04	1	30
21	1	MED	Viral Meningitis	0.6532	3.13	1	8
22	1	MED	Hypertensive Encephalopathy	1.6498	5.50	1	18
23	1	MED	Nontraumatic Stupor & Coma	0.8355	3.23	1	15
24	1	MED	Seizure & Headache Age >17 W Cc	1.0665	4.16	1	15
25	1	MED	Seizure & Headache Age >17 W/O Cc	0.6839	2.87	1	9
26	1	MED	Seizure & Headache Age 0-17	0.5825	2.48	1	8
27	1	MED	Traumatic Stupor & Coma, Coma >1 Hr	1.5733	4.20	1	17
28	1	MED	Traumatic Stupor & Coma, Coma <1 Hr Age >17 W Cc	1.3351	4.55	1	23
29	1	MED	Traumatic Stupor & Coma, Coma <1 Hr Age >17 W/O Cc	0.7442	2.76	1	8
30	1	MED	Traumatic Stupor & Coma, Coma <1 Hr Age 0-17	0.5756	1.96	1	7

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
31	1	MED	Concussion Age >17 W Cc	0.8173	2.48	1	8
32	1	MED	Concussion Age >17 W/O Cc	0.6270	1.73	1	5
33	1	MED	Concussion Age 0-17	0.4156	1.27	1	3
34	1	MED	Other Disorders Of Nervous System W Cc	1.3607	5.09	1	23
35	1	MED	Other Disorders Of Nervous System W/O Cc	0.6381	2.77	1	10
36	2	SURG	Retinal Procedures	1.1878	1.69	1	11
37	2	SURG	Orbital Procedures	1.1549	3.07	1	9
38	2	SURG	Primary Iris Procedures	0.6193	1.67	1	5
39	2	SURG	Lens Procedures With Or Without Vitrectomy	0.9422	2.00	1	5
40	2	SURG	Extraocular Procedures Except Orbit Age >17	1.4287	3.89	1	14
41	2	SURG	Extraocular Procedures Except Orbit Age 0-17	2.3751	6.68	1	36
42	2	SURG	Intraocular Procedures Except Retina, Iris & Lens	1.2150	3.58	1	30
43	2	MED	Hyphema	0.4639	3.59	1	10
44	2	MED	Acute Major Eye Infections	0.5361	3.42	1	10
45	2	MED	Neurological Eye Disorders	0.7756	2.96	1	8
46	2	MED	Other Disorders Of The Eye Age >17 W Cc	0.7675	3.56	1	10
47	2	MED	Other Disorders Of The Eye Age >17 W/O Cc	0.5747	2.78	1	14
48	2	MED	Other Disorders Of The Eye Age 0-17	0.7624	3.58	1	17
49	3	SURG	Major Head & Neck Procedures	3.0112	3.11	1	16
50	3	SURG	Sialoadenectomy	0.8976	1.60	1	4
51	3	SURG	Salivary Gland Procedures Except Sialoadenectomy	1.2600	4.00	1	13
52	3	SURG	Cleft Lip & Palate Repair	0.7541	1.49	1	4
53	3	SURG	Sinus & Mastoid Procedures Age >17	1.4771	3.95	1	17
54	3	SURG	Sinus & Mastoid Procedures Age 0-17	1.3688	3.49	1	15
55	3	SURG	Miscellaneous Ear, Nose, Mouth & Throat Procedures	1.9681	5.09	1	27
56	3	SURG	Rhinoplasty	0.9942	2.17	1	9
57	3	SURG	T&A Proc, Except Tonsillectomy &/Or Adenoidectomy Only, Age >17	0.7904	3.10	1	13
58	3	SURG	T&A Proc, Except Tonsillectomy &/Or Adenoidectomy Only, Age 0-17	0.8798	2.90	1	9
59	3	SURG	Tonsillectomy &/Or Adenoidectomy Only, Age >17	0.9219	2.50	1	9
60	3	SURG	Tonsillectomy &/Or Adenoidectomy Only, Age 0-17	0.8194	2.46	1	10

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
61	3	SURG	Myringotomy W Tube Insertion Age >17	2.2255	6.00	1	14
62	3	SURG	Myringotomy W Tube Insertion Age 0-17	0.9458	2.71	1	14
63	3	SURG	Other Ear, Nose, Mouth & Throat O.R. Procedures	1.6221	3.15	1	11
64	3	MED	Ear, Nose, Mouth & Throat Malignancy	1.7943	7.38	1	22
65	3	MED	Dysequilibrium	0.6183	2.67	1	7
66	3	MED	Epistaxis	0.7128	2.93	1	9
67	3	MED	Epiglottitis	0.8780	3.00	1	8
68	3	MED	Otitis Media & Uri Age >17 W Cc	0.6566	2.89	1	9
69	3	MED	Otitis Media & Uri Age >17 W/O Cc	0.4567	2.28	1	6
70	3	MED	Otitis Media & Uri Age 0-17	0.4361	2.41	1	7
71	3	MED	Laryngotracheitis	0.3743	1.80	1	5
72	3	MED	Nasal Trauma & Deformity	0.7545	2.60	1	6
73	3	MED	Other Ear, Nose, Mouth & Throat Diagnoses Age >17	0.7525	3.28	1	9
74	3	MED	Other Ear, Nose, Mouth & Throat Diagnoses Age 0-17	0.7119	2.87	1	11
75	4	SURG	Major Chest Procedures	4.0545	11.60	1	42
76	4	SURG	Other Resp System O.R. Procedures W Cc	3.8016	12.52	1	43
77	4	SURG	Other Resp System O.R. Procedures W/O Cc	1.2691	4.63	1	18
78	4	MED	Pulmonary Embolism	1.5460	6.46	1	16
79	4	MED	Respiratory Infections & Inflammations Age >17 W Cc	2.1360	8.92	2	27
80	4	MED	Respiratory Infections & Inflammations Age >17 W/O Cc	1.1407	5.51	1	18
81	4	MED	Respiratory Infections & Inflammations Age 0-17	1.6955	7.14	1	21
82	4	MED	Respiratory Neoplasms	1.9019	7.47	1	25
83	4	MED	Major Chest Trauma W Cc	0.9865	3.35	1	9
84	4	MED	Major Chest Trauma W/O Cc	0.5476	3.00	1	7
85	4	MED	Pleural Effusion W Cc	1.4468	5.78	1	18
86	4	MED	Pleural Effusion W/O Cc	0.6421	2.89	1	7
87	4	MED	Pulmonary Edema & Respiratory Failure	2.3281	7.06	1	29
88	4	MED	Chronic Obstructive Pulmonary Disease	1.0680	4.48	1	12
89	4	MED	Simple Pneumonia & Pleurisy Age >17 W Cc	1.2245	5.22	1	14
90	4	MED	Simple Pneumonia & Pleurisy Age >17 W/O Cc	0.7462	3.45	1	8

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
91	4	MED	Simple Pneumonia & Pleurisy Age 0-17	0.6256	3.07	1	8
92	4	MED	Interstitial Lung Disease W Cc	1.6598	7.06	1	28
93	4	MED	Interstitial Lung Disease W/O Cc	0.9159	4.30	1	15
94	4	MED	Pneumothorax W Cc	1.2154	5.33	1	20
95	4	MED	Pneumothorax W/O Cc	0.6574	3.46	1	9
96	4	MED	Bronchitis & Asthma Age >17 W Cc	0.8446	3.67	1	10
97	4	MED	Bronchitis & Asthma Age >17 W/O Cc	0.5973	2.72	1	7
98	4	MED	Bronchitis & Asthma Age 0-17	0.5226	2.60	1	7
99	4	MED	Respiratory Signs & Symptoms W Cc	0.8469	3.12	1	11
100	4	MED	Respiratory Signs & Symptoms W/O Cc	0.5023	2.11	1	6
101	4	MED	Other Respiratory System Diagnoses W Cc	0.9738	3.66	1	13
102	4	MED	Other Respiratory System Diagnoses W/O Cc	0.5390	2.14	1	7
103	PRE	SURG	Heart Transplant		***Paid Percentage of Charge***		
104	5	SURG	Cardiac Valve & Oth Major Cardiothoracic Proc W Card Cath.	9.9059	18.61	1	50
105	5	SURG	Cardiac Valve & Oth Major Cardiothoracic Proc W/O Card Cath.	6.4377	10.71	3	35
106	5	SURG	Coronary Bypass W Ptca	7.1904	11.73	3	35
107	5	SURG	Coronary Bypass W Cardiac Cath	5.8368	10.60	4	25
108	5	SURG	Other Cardiothoracic Procedures	5.5541	9.94	1	40
109	5	SURG	Coronary Bypass W/O Ptca Or Cardiac Cath	3.9677	7.16	3	21
110	5	SURG	Major Cardiovascular Procedures W Cc	5.3040	10.76	1	41
111	5	SURG	Major Cardiovascular Procedures W/O Cc	2.4898	4.52	1	11
112	5	SURG	No Longer Valid				
113	5	SURG	Amputation For Circ System Disorders Except Upper Limb & Toe	4.4285	16.53	3	45
114	5	SURG	Upper Limb & Toe Amputation For Circ System Disorders	2.4295	9.96	1	34
115	5	SURG	Prm Card Pacem Impl W Ami,Hrt Fail Or Shk,Or Aicd Lead Or Gn	4.8036	8.55	1	30
116	5	SURG	Other Permanent Cardiac Pacemaker Implant	3.1712	4.92	1	17
117	5	SURG	Cardiac Pacemaker Revision Except Device Replacement	1.8212	5.00	1	31
118	5	SURG	Cardiac Pacemaker Device Replacement	2.2607	4.46	1	22
119	5	SURG	Vein Ligation & Stripping	1.0340	5.17	1	15
120	5	SURG	Other Circulatory System O.R. Procedures	3.1331	10.29	1	35

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
121	5	MED	Circulatory Disorders W Ami & Major Comp, Discharged Alive	2.5137	6.18	1	20
122	5	MED	Circulatory Disorders W Ami W/O Major Comp, Discharged Alive	1.5720	3.48	1	9
123	5	MED	Circulatory Disorders W Ami, Expired	2.1513	4.08	1	20
124	5	MED	Circulatory Disorders Except Ami, W Card Cath & Complex Diag	1.7588	4.65	1	14
125	5	MED	Circulatory Disorders Except Ami, W Card Cath W/O Complex Diag.	1.2636	2.86	1	9
126	5	MED	Acute & Subacute Endocarditis	4.0214	16.06	1	46
127	5	MED	Heart Failure & Shock	1.2385	4.86	1	15
128	5	MED	Deep Vein Thrombophlebitis	0.9727	5.28	1	11
129	5	MED	Cardiac Arrest, Unexplained	1.2665	2.07	1	10
130	5	MED	Peripheral Vascular Disorders W Cc	1.2610	6.35	1	19
131	5	MED	Peripheral Vascular Disorders W/O Cc	0.8232	4.81	1	10
132	5	MED	Atherosclerosis W Cc	0.8472	2.72	1	8
133	5	MED	Atherosclerosis W/O Cc	0.7878	2.29	1	6
134	5	MED	Hypertension	0.7900	3.14	1	9
135	5	MED	Cardiac Congenital & Valvular Disorders Age >17 W Cc	1.4176	4.70	1	28
136	5	MED	Cardiac Congenital & Valvular Disorders Age >17 W/O Cc	0.6178	2.40	1	7
137	5	MED	Cardiac Congenital & Valvular Disorders Age 0-17	1.7650	5.31	1	33
138	5	MED	Cardiac Arrhythmia & Conduction Disorders W Cc	1.0615	3.70	1	12
139	5	MED	Cardiac Arrhythmia & Conduction Disorders W/O Cc	0.6203	2.13	1	7
140	5	MED	Angina Pectoris	0.7762	2.37	1	6
141	5	MED	Syncope & Collapse W Cc	0.8260	3.23	1	10
142	5	MED	Syncope & Collapse W/O Cc	0.6357	2.28	1	6
143	5	MED	Chest Pain	0.6687	2.03	1	6
144	5	MED	Other Circulatory System Diagnoses W Cc	1.6791	6.56	1	24
145	5	MED	Other Circulatory System Diagnoses W/O Cc	0.8739	3.13	1	10
146	6	SURG	Rectal Resection W Cc	3.0182	10.54	4	42
147	6	SURG	Rectal Resection W/O Cc	2.2634	7.00	1	17
148	6	SURG	Major Small & Large Bowel Procedures W Cc	4.2900	13.69	3	44
149	6	SURG	Major Small & Large Bowel Procedures W/O Cc	1.8820	6.70	2	15
150	6	SURG	Peritoneal Adhesiolysis W Cc	3.0143	10.97	2	40

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
151	6	SURG	Peritoneal Adhesiolysis W/O Cc	1.4757	4.95	1	14
152	6	SURG	Minor Small & Large Bowel Procedures W Cc	2.3832	8.86	2	39
153	6	SURG	Minor Small & Large Bowel Procedures W/O Cc	1.4318	5.61	2	12
154	6	SURG	Stomach, Esophageal & Duodenal Procedures Age >17 W Cc	4.3057	12.39	2	43
155	6	SURG	Stomach, Esophageal & Duodenal Procedures Age >17 W/O Cc	1.5877	4.50	1	11
156	6	SURG	Stomach, Esophageal & Duodenal Procedures Age 0-17	1.5955	4.98	1	28
157	6	SURG	Anal & Stomal Procedures W Cc	1.5850	5.84	1	36
158	6	SURG	Anal & Stomal Procedures W/O Cc	0.8342	2.97	1	9
159	6	SURG	Hernia Procedures Except Inguinal & Femoral Age >17 W Cc	1.5626	4.39	1	11
160	6	SURG	Hernia Procedures Except Inguinal & Femoral Age >17 W/O Cc	0.9876	2.45	1	6
161	6	SURG	Inguinal & Femoral Hernia Procedures Age >17 W Cc	1.4895	4.57	1	20
162	6	SURG	Inguinal & Femoral Hernia Procedures Age >17 W/O Cc	0.8382	2.31	1	6
163	6	SURG	Hernia Procedures Age 0-17	1.2336	3.22	1	30
164	6	SURG	Appendectomy W Complicated Principal Diag W Cc	2.1144	7.61	2	19
165	6	SURG	Appendectomy W Complicated Principal Diag W/O Cc	1.2686	4.29	1	9
166	6	SURG	Appendectomy W/O Complicated Principal Diag W Cc	1.1975	3.14	1	9
167	6	SURG	Appendectomy W/O Complicated Principal Diag W/O Cc	0.8386	1.95	1	5
168	3	SURG	Mouth Procedures W Cc	1.4097	4.02	1	20
169	3	SURG	Mouth Procedures W/O Cc	0.8660	2.40	1	9
170	6	SURG	Other Digestive System O.R. Procedures W Cc	3.3629	10.95	1	42
171	6	SURG	Other Digestive System O.R. Procedures W/O Cc	1.2728	3.89	1	11
172	6	MED	Digestive Malignancy W Cc	2.0768	8.47	1	28
173	6	MED	Digestive Malignancy W/O Cc	1.2247	5.36	1	15
174	6	MED	G.I. Hemorrhage W Cc	1.2860	4.56	1	16
175	6	MED	G.I. Hemorrhage W/O Cc	0.6600	2.77	1	9
176	6	MED	Complicated Peptic Ulcer	1.3180	5.68	1	22
177	6	MED	Uncomplicated Peptic Ulcer W Cc	0.8341	3.54	1	7
178	6	MED	Uncomplicated Peptic Ulcer W/O Cc	0.7093	2.64	1	8
179	6	MED	Inflammatory Bowel Disease	1.1145	5.86	1	19
180	6	MED	G.I. Obstruction W Cc	0.9711	4.62	1	14

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
181	6	MED	G.I. Obstruction W/O Cc	0.6039	3.30	1	9
182	6	MED	Esophagitis, Gastroent & Misc Digest Disorders Age >17 W Cc	0.8489	3.71	1	12
183	6	MED	Esophagitis, Gastroent & Misc Digest Disorders Age >17 W/O Cc	0.6174	2.54	1	7
184	6	MED	Esophagitis, Gastroent & Misc Digest Disorders Age 0-17	0.4110	2.40	1	7
185	3	MED	Dental & Oral Dis Except Extractions & Restorations, Age >17	0.7686	2.82	1	9
186	3	MED	Dental & Oral Dis Except Extractions & Restorations, Age 0-17	0.6753	3.51	1	11
187	3	MED	Dental Extractions & Restorations	0.8539	2.95	1	8
188	6	MED	Other Digestive System Diagnoses Age >17 W Cc	1.3512	5.70	1	20
189	6	MED	Other Digestive System Diagnoses Age >17 W/O Cc	0.6204	2.84	1	10
190	6	MED	Other Digestive System Diagnoses Age 0-17	0.9275	3.64	1	15
191	7	SURG	Pancreas, Liver & Shunt Procedures W Cc	5.6808	16.07	1	47
192	7	SURG	Pancreas, Liver & Shunt Procedures W/O Cc	2.1858	6.54	1	15
193	7	SURG	Biliary Tract Proc Except Only Cholecyst W Or W/O C.D.E. W Cc	3.6518	11.21	3	42
194	7	SURG	Biliary Tract Proc Except Only Cholecyst W Or W/O C.D.E. W/O Cc	2.1837	6.07	1	14
195	7	SURG	Cholecystectomy W C.D.E. W Cc	2.5741	7.21	2	16
196	7	SURG	Cholecystectomy W C.D.E. W/O Cc	1.8745	4.98	1	10
197	7	SURG	Cholecystectomy Except By Laparoscope W/O C.D.E. W Cc	2.3501	7.02	2	21
198	7	SURG	Cholecystectomy Except By Laparoscope W/O C.D.E. W/O Cc	1.4051	3.60	1	8
199	7	SURG	Hepatobiliary Diagnostic Procedure For Malignancy	5.3129	17.14	1	42
200	7	SURG	Hepatobiliary Diagnostic Procedure For Non-Malignancy	3.5036	10.26	1	43
201	7	SURG	Other Hepatobiliary Or Pancreas O.R. Procedures	4.8797	15.08	2	47
202	7	MED	Cirrhosis & Alcoholic Hepatitis	1.8026	6.70	1	24
203	7	MED	Malignancy Of Hepatobiliary System Or Pancreas	1.8326	7.76	1	27
204	7	MED	Disorders Of Pancreas Except Malignancy	1.1867	5.59	1	17
205	7	MED	Disorders Of Liver Except Malig,Cirr,Alc Hepa W Cc	1.5002	5.65	1	21
206	7	MED	Disorders Of Liver Except Malig,Cirr,Alc Hepa W/O Cc	0.6657	3.32	1	9
207	7	MED	Disorders Of The Biliary Tract W Cc	1.1093	4.42	1	14
208	7	MED	Disorders Of The Biliary Tract W/O Cc	0.6412	2.49	1	8
209	8	SURG	Major Joint & Limb Reattachment Procedures Of Lower Extremity	2.8584	5.18	2	12

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
210	8	SURG	Hip & Femur Procedures Except Major Joint Age >17 W Cc	2.7205	8.54	2	29
211	8	SURG	Hip & Femur Procedures Except Major Joint Age >17 W/O Cc	1.7401	3.95	1	10
212	8	SURG	Hip & Femur Procedures Except Major Joint Age 0-17	1.3634	3.92	1	21
213	8	SURG	Amputation For Musculoskeletal System & Conn Tissue Disorders	2.2255	8.84	1	33
214	8	SURG	No Longer Valid				
215	8	SURG	No Longer Valid				
216	8	SURG	Biopsies Of Musculoskeletal System & Connective Tissue	2.4834	10.57	1	42
217	8	SURG	Wnd Debrid & Skn Grft Except Hand,For Muscskelet & Conn Tiss Dis	3.8961	13.84	1	45
218	8	SURG	Lower Extrem & Humer Proc Except Hip,Foot,Femur Age >17 W Cc	1.9875	5.18	1	20
219	8	SURG	Lower Extrem & Humer Proc Except Hip,Foot,Femur Age >17 W/O Cc	1.3548	2.76	1	9
220	8	SURG	Lower Extrem & Humer Proc Except Hip,Foot,Femur Age 0-17	0.9345	2.01	1	6
221	8	SURG	No Longer Valid				
222	8	SURG	No Longer Valid				
223	8	SURG	Major Shoulder/Elbow Proc, Or Other Upper Extremity Proc W Cc	1.1456	2.82	1	13
224	8	SURG	Shoulder,Elbow Or Forearm Proc,Exc Major Joint Proc, W/O Cc	0.9886	1.79	1	5
225	8	SURG	Foot Procedures	1.0966	2.71	1	14
226	8	SURG	Soft Tissue Procedures W Cc	1.7643	5.73	1	25
227	8	SURG	Soft Tissue Procedures W/O Cc	0.9227	2.11	1	9
228	8	SURG	Major Thumb Or Joint Proc,Or Oth Hand Or Wrist Proc W Cc	1.4073	4.38	1	17
229	8	SURG	Hand Or Wrist Proc, Except Major Joint Proc, W/O Cc	0.7880	2.03	1	10
230	8	SURG	Local Excision & Removal Of Int Fix Devices Of Hip & Femur	1.4610	5.07	1	29
231	8	SURG	Local Excision & Removal Of Int Fix Devices Except Hip & Femur	1.6830	4.71	1	23
232	8	SURG	Arthroscopy	1.1614	5.00	1	20
233	8	SURG	Other Musculoskelet Sys & Conn Tiss O.R. Proc W Cc	3.1993	8.47	1	38
234	8	SURG	Other Musculoskelet Sys & Conn Tiss O.R. Proc W/O Cc	1.8277	3.27	1	10
235	8	MED	Fractures Of Femur	1.0813	7.85	1	28
236	8	MED	Fractures Of Hip & Pelvis	1.0408	4.72	1	19
237	8	MED	Sprains, Strains, & Dislocations Of Hip, Pelvis & Thigh	0.8933	3.09	1	8
238	8	MED	Osteomyelitis	1.6677	9.49	1	40

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
239	8	MED	Pathological Fractures & Musculoskeletal & Conn Tiss Malignancy	1.8270	7.54	1	26
240	8	MED	Connective Tissue Disorders W Cc	1.6870	6.52	1	24
241	8	MED	Connective Tissue Disorders W/O Cc	0.6103	2.81	1	10
242	8	MED	Septic Arthritis	1.1281	5.26	1	21
243	8	MED	Medical Back Problems	0.7520	3.68	1	12
244	8	MED	Bone Diseases & Specific Arthropathies W Cc	1.2552	5.34	1	17
245	8	MED	Bone Diseases & Specific Arthropathies W/O Cc	0.5832	3.00	1	7
246	8	MED	Non-Specific Arthropathies	1.0272	5.14	1	20
247	8	MED	Signs & Symptoms Of Musculoskeletal System & Conn Tissue	0.6251	2.67	1	8
248	8	MED	Tendonitis, Myositis & Bursitis	1.0092	4.35	1	19
249	8	MED	Aftercare, Musculoskeletal System & Connective Tissue	1.1357	4.96	1	33
250	8	MED	Fx, Sprn, Strn & Disl Of Forearm, Hand, Foot Age >17 W Cc	0.6290	2.50	1	13
251	8	MED	Fx, Sprn, Strn & Disl Of Forearm, Hand, Foot Age >17 W/O Cc	0.4464	1.94	1	15
252	8	MED	Fx, Sprn, Strn & Disl Of Forearm, Hand, Foot Age 0-17	0.3953	1.45	1	4
253	8	MED	Fx, Sprn, Strn & Disl Of Uparm,Lowleg Ex Foot Age >17 W Cc	0.9299	4.26	1	12
254	8	MED	Fx, Sprn, Strn & Disl Of Uparm,Lowleg Ex Foot Age >17 W/O Cc	0.5460	2.12	1	11
255	8	MED	Fx, Sprn, Strn & Disl Of Uparm,Lowleg Ex Foot Age 0-17	0.4434	1.76	1	5
256	8	MED	Other Musculoskeletal System & Connective Tissue Diagnoses	0.9371	4.39	1	28
257	9	SURG	Total Mastectomy For Malignancy W Cc	1.2122	2.94	1	10
258	9	SURG	Total Mastectomy For Malignancy W/O Cc	1.0239	2.12	1	5
259	9	SURG	Subtotal Mastectomy For Malignancy W Cc	1.3711	4.80	1	25
260	9	SURG	Subtotal Mastectomy For Malignancy W/O Cc	0.8835	1.66	1	7
261	9	SURG	Breast Proc For Non-Malignancy Except Biopsy & Local Excision	1.2862	3.06	1	11
262	9	SURG	Breast Biopsy & Local Excision For Non-Malignancy	0.8271	3.11	1	9
263	9	SURG	Skin Graft &/Or Debrid For Skn Ulcer Or Cellulitis W Cc	2.8600	14.23	2	45
264	9	SURG	Skin Graft &/Or Debrid For Skn Ulcer Or Cellulitis W/O Cc	1.4354	7.42	1	29
265	9	SURG	Skin Graft &/Or Debrid Except For Skin Ulcer Or Cellulitis W Cc	2.7935	8.33	1	40
266	9	SURG	Skin Graft &/Or Debrid Except For Skin Ulcer Or Cellulitis W/O Cc	1.2561	3.63	1	19
267	9	SURG	Perianal & Pilonidal Procedures	0.8470	2.85	1	15

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
268	9	SURG	Skin, Subcutaneous Tissue & Breast Plastic Procedures	1.5540	4.50	1	24
269	9	SURG	Other Skin, Subcut Tiss & Breast Proc W Cc	1.7891	7.26	1	29
270	9	SURG	Other Skin, Subcut Tiss & Breast Proc W/O Cc	0.8730	3.15	1	11
271	9	MED	Skin Ulcers	1.2608	7.55	1	25
272	9	MED	Major Skin Disorders W Cc	1.2203	6.71	1	24
273	9	MED	Major Skin Disorders W/O Cc	0.5741	4.43	1	11
274	9	MED	Malignant Breast Disorders W Cc	1.5787	6.53	1	37
275	9	MED	Malignant Breast Disorders W/O Cc	1.1892	4.57	1	9
276	9	MED	Non-Maligant Breast Disorders	0.6437	3.65	1	12
277	9	MED	Cellulitis Age >17 W Cc	0.9514	5.11	1	16
278	9	MED	Cellulitis Age >17 W/O Cc	0.6140	3.61	1	11
279	9	MED	Cellulitis Age 0-17	0.4963	3.04	1	8
280	9	MED	Trauma To The Skin, Subcut Tiss & Breast Age >17 W Cc	0.6235	2.09	1	8
281	9	MED	Trauma To The Skin, Subcut Tiss & Breast Age >17 W/O Cc	0.5146	1.74	1	6
282	9	MED	Trauma To The Skin, Subcut Tiss & Breast Age 0-17	0.5093	1.58	1	4
283	9	MED	Minor Skin Disorders W Cc	0.7158	3.88	1	13
284	9	MED	Minor Skin Disorders W/O Cc	0.4526	3.17	1	12
285	10	SURG	Amputat Of Lower Limb For Endocrine,Nutrit,& Metabol Disorders	3.2324	13.57	2	44
286	10	SURG	Adrenal & Pituitary Procedures	2.5105	6.64	3	20
287	10	SURG	Skin Grafts & Wound Debrid For Endoc, Nutrit & Metab Disorders	2.1937	9.74	1	40
288	10	SURG	O.R. Procedures For Obesity	2.4153	7.38	1	32
289	10	SURG	Parathyroid Procedures	1.0834	2.65	1	13
290	10	SURG	Thyroid Procedures	0.9184	1.77	1	5
291	10	SURG	Thyroglossal Procedures	0.5378	1.40	1	3
292	10	SURG	Other Endocrine, Nutrit & Metab O.R. Proc W Cc	4.1313	14.16	1	45
293	10	SURG	Other Endocrine, Nutrit & Metab O.R. Proc W/O Cc	2.0138	7.78	1	17
294	10	MED	Diabetes Age >35	1.0150	4.32	1	14
295	10	MED	Diabetes Age 0-35	0.6892	2.87	1	8
296	10	MED	Nutritional & Misc Metabolic Disorders Age >17 W Cc	1.0913	4.88	1	18
297	10	MED	Nutritional & Misc Metabolic Disorders Age >17 W/O Cc	0.6690	3.16	1	11

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
298	10	MED	Nutritional & Misc Metabolic Disorders Age 0-17	0.5259	3.08	1	12
299	10	MED	Inborn Errors Of Metabolism	1.1719	5.20	1	24
300	10	MED	Endocrine Disorders W Cc	1.2682	5.41	1	23
301	10	MED	Endocrine Disorders W/O Cc	0.5785	2.77	1	9
302	11	SURG	Kidney Transplant	9.2146	11.86	1	42
303	11	SURG	Kidney,Ureter & Major Bladder Procedures For Neoplasm	2.8956	7.94	3	19
304	11	SURG	Kidney,Ureter & Major Bladder Proc For Non-Neopl W Cc	2.5533	7.78	1	28
305	11	SURG	Kidney,Ureter & Major Bladder Proc For Non-Neopl W/O Cc	1.1548	3.00	1	7
306	11	SURG	Prostatectomy W Cc	1.0470	4.88	1	17
307	11	SURG	Prostatectomy W/O Cc	0.8488	1.83	1	5
308	11	SURG	Minor Bladder Procedures W Cc	2.4822	8.13	1	39
309	11	SURG	Minor Bladder Procedures W/O Cc	1.3837	4.69	1	19
310	11	SURG	Transurethral Procedures W Cc	1.4973	4.58	1	18
311	11	SURG	Transurethral Procedures W/O Cc	0.8525	2.12	1	5
312	11	SURG	Urethral Procedures, Age >17 W Cc	2.1059	7.26	1	21
313	11	SURG	Urethral Procedures, Age >17 W/O Cc	0.5761	1.00	1	5
314	11	SURG	Urethral Procedures, Age 0-17	1.1670	3.89	1	10
315	11	SURG	Other Kidney & Urinary Tract O.R. Procedures	2.9448	10.04	1	34
316	11	MED	Renal Failure	1.6178	6.11	1	20
317	11	MED	Admit For Renal Dialysis	0.9549	3.22	1	10
318	11	MED	Kidney & Urinary Tract Neoplasms W Cc	1.7412	7.03	1	25
319	11	MED	Kidney & Urinary Tract Neoplasms W/O Cc	0.5978	2.50	1	6
320	11	MED	Kidney & Urinary Tract Infections Age >17 W Cc	0.9678	4.71	1	14
321	11	MED	Kidney & Urinary Tract Infections Age >17 W/O Cc	0.5857	2.93	1	6
322	11	MED	Kidney & Urinary Tract Infections Age 0-17	0.5662	3.20	1	8
323	11	MED	Urinary Stones W Cc, &/Or Esw Lithotripsy	0.7828	2.74	1	9
324	11	MED	Urinary Stones W/O Cc	0.4937	1.81	1	5
325	11	MED	Kidney & Urinary Tract Signs & Symptoms Age >17 W Cc	0.8696	4.05	1	17
326	11	MED	Kidney & Urinary Tract Signs & Symptoms Age >17 W/O Cc	0.6227	2.56	1	9
327	11	MED	Kidney & Urinary Tract Signs & Symptoms Age 0-17	0.4599	2.42	1	6

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
328	11	MED	Urethral Stricture Age >17 W Cc	0.7579	2.86	1	8
329	11	MED	Urethral Stricture Age >17 W/O Cc	0.3919	2.00	1	4
330	11	MED	Urethral Stricture Age 0-17	0.7780	5.00	1	5
331	11	MED	Other Kidney & Urinary Tract Diagnoses Age >17 W Cc	1.3122	5.73	1	17
332	11	MED	Other Kidney & Urinary Tract Diagnoses Age >17 W/O Cc	0.7803	3.58	1	13
333	11	MED	Other Kidney & Urinary Tract Diagnoses Age 0-17	0.8785	3.95	1	14
334	12	SURG	Major Male Pelvic Procedures W Cc	1.9316	4.54	2	11
335	12	SURG	Major Male Pelvic Procedures W/O Cc	1.5064	3.56	1	5
336	12	SURG	Transurethral Prostatectomy W Cc	0.8961	3.12	1	14
337	12	SURG	Transurethral Prostatectomy W/O Cc	0.6889	2.07	1	6
338	12	SURG	Testes Procedures, For Malignancy	3.2241	10.72	1	41
339	12	SURG	Testes Procedures, Non-Malignancy Age >17	1.4212	4.65	1	29
340	12	SURG	Testes Procedures, Non-Malignancy Age 0-17	0.7260	1.52	1	5
341	12	SURG	Penis Procedures	1.3211	2.87	1	14
342	12	SURG	Circumcision Age >17	0.7005	4.00	1	6
343	12	SURG	Circumcision Age 0-17	0.5728	2.00	1	3
344	12	SURG	Other Male Reproductive System O.R. Procedures For Malignancy	1.3129	4.00	1	6
345	12	SURG	Other Male Reproductive System O.R. Proc Except For Malignancy	0.7555	2.33	1	8
346	12	MED	Malignancy, Male Reproductive System, W Cc	2.3014	8.00	1	26
347	12	MED	Malignancy, Male Reproductive System, W/O Cc	0.9828	2.00	1	6
348	12	MED	Benign Prostatic Hypertrophy W Cc	0.9009	4.36	1	12
349	12	MED	Benign Prostatic Hypertrophy W/O Cc	0.8463	2.00	1	5
350	12	MED	Inflammation Of The Male Reproductive System	0.7800	3.89	1	9
351	12	MED	Sterilization, Male	0.3333	1.90	1	5
352	12	MED	Other Male Reproductive System Diagnoses	0.6084	2.59	1	12
353	13	SURG	Pelvic Evisceration, Radical Hysterectomy & Radical Vulvectomy	2.3262	7.19	1	23
354	13	SURG	Uterine,Adnexa Proc For Non-Ovarian/Adnexal Malig W Cc	1.9867	5.79	1	27
355	13	SURG	Uterine,Adnexa Proc For Non-Ovarian/Adnexal Malig W/O Cc	1.0040	2.51	1	6
356	13	SURG	Female Reproductive System Reconstructive Procedures	0.9419	2.35	1	4
357	13	SURG	Uterine & Adnexa Proc For Ovarian Or Adnexal Malignancy	2.6908	7.82	2	31

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
358	13	SURG	Uterine & Adnexa Proc For Non-Malignancy W Cc	1.3746	3.96	1	11
359	13	SURG	Uterine & Adnexa Proc For Non-Malignancy W/O Cc	0.9975	2.56	1	5
360	13	SURG	Vagina, Cervix & Vulva Procedures	1.2438	4.11	1	16
361	13	SURG	Laparoscopy & Incisional Tubal Interruption	1.1325	2.93	1	8
362	13	SURG	Endoscopic Tubal Interruption	0.8617	2.75	1	5
363	13	SURG	D&C, Conization & Radio-Implant, For Malignancy	1.0504	3.10	1	14
364	13	SURG	D&C, Conization Except For Malignancy	0.8461	2.48	1	10
365	13	SURG	Other Female Reproductive System O.R. Procedures	1.4738	4.19	1	14
366	13	MED	Malignancy, Female Reproductive System W Cc	1.6458	6.14	1	19
367	13	MED	Malignancy, Female Reproductive System W/O Cc	0.6859	3.57	1	15
368	13	MED	Infections, Female Reproductive System	0.6162	2.94	1	8
369	13	MED	Menstrual & Other Female Reproductive System Disorders	0.4678	2.03	1	6
370	14	SURG	Cesarean Section W Cc	1.0952	4.30	2	14
371	14	SURG	Cesarean Section W/O Cc	0.8443	3.11	2	6
372	14	MED	Vaginal Delivery W Complicating Diagnoses	0.6003	2.35	1	7
373	14	MED	Vaginal Delivery W/O Complicating Diagnoses	0.4561	1.71	1	3
374	14	SURG	Vaginal Delivery W Sterilization &/Or D&C	0.7527	2.01	1	4
375	14	SURG	Vaginal Delivery W O.R. Proc Except Steril &/Or D&C	1.4386	3.86	1	26
376	14	MED	Postpartum & Post Abortion Diagnoses W/O O.R. Procedure	0.4990	2.44	1	7
377	14	SURG	Postpartum & Post Abortion Diagnoses W O.R. Procedure	1.3260	3.81	1	15
378	14	MED	Ectopic Pregnancy	0.9824	2.33	1	5
379	14	MED	Threatened Abortion	0.4937	3.02	1	12
380	14	MED	Abortion W/O D&C	0.4680	1.56	1	4
381	14	SURG	Abortion W D&C, Aspiration Curettage Or Hysterotomy	0.7428	1.78	1	6
382	14	MED	False Labor	0.4435	2.56	1	15
383	14	MED	Other Antepartum Diagnoses W Medical Complications	0.5202	2.93	1	9
384	14	MED	Other Antepartum Diagnoses W/O Medical Complications	0.5343	2.91	1	12
385	15	MED	Neonates, Died Or Transferred To Another Acute Care Facility	0.3236	1.33	1	4
385.1	15	MED	Neonates, Died Or Transferred To Another Acute Care Facility	3.9769	10.61	1	42
386	15	MED	Extreme Immaturity Or Respiratory Distress Syndrome, Neonate	3.4665	14.54	1	40

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
386.1	15	MED	Extreme Immaturity Or Respiratory Distress Syndrome, Neonate	11.2262	42.28	5	76
387	15	MED	Prematurity W Major Problems	1.2974	9.30	1	28
387.1	15	MED	Prematurity W Major Problems	3.6165	18.58	2	48
388	15	MED	Prematurity W/O Major Problems	0.3572	3.66	1	15
388.1	15	MED	Prematurity W/O Major Problems	1.6386	9.71	1	22
389	15	MED	Full Term Neonate W Major Problems	0.4418	3.35	1	10
389.1	15	MED	Full Term Neonate W Major Problems	1.9301	7.47	1	23
390	15	MED	Neonate W Other Significant Problems	0.2187	2.31	1	5
390.1	15	MED	Neonate W Other Significant Problems	0.8747	4.35	1	9
391	15	MED	Normal Newborn	0.1288	1.71	1	3
392	16	SURG	Splenectomy Age >17	2.7668	6.94	2	23
393	16	SURG	Splenectomy Age 0-17	1.4636	3.78	1	10
394	16	SURG	Other O.R. Procedures Of The Blood And Blood Forming Organs	1.9364	6.71	1	32
395	16	MED	Red Blood Cell Disorders Age >17	1.1324	6.77	1	21
396	16	MED	Red Blood Cell Disorders Age 0-17	0.6215	3.68	1	10
397	16	MED	Coagulation Disorders	1.4914	4.08	1	15
398	16	MED	Reticuloendothelial & Immunity Disorders W Cc	1.4212	5.50	1	19
399	16	MED	Reticuloendothelial & Immunity Disorders W/O Cc	0.6706	3.42	1	8
400	17	SURG	Lymphoma & Leukemia W Major O.R. Procedure	3.8253	11.37	1	42
401	17	SURG	Lymphoma & Non-Acute Leukemia W Other O.R. Proc W Cc	3.9686	12.99	1	43
402	17	SURG	Lymphoma & Non-Acute Leukemia W Other O.R. Proc W/O Cc	1.4705	5.56	1	19
403	17	MED	Lymphoma & Non-Acute Leukemia W Cc	2.8803	10.47	1	40
404	17	MED	Lymphoma & Non-Acute Leukemia W/O Cc	1.2448	4.45	1	15
405	17	MED	Acute Leukemia W/O Major O.R. Procedure Age 0-17	2.8335	8.75	1	38
406	17	SURG	Myeloprolif Disord Or Poorly Diff Neopl W Maj O.R.Proc W Cc	4.0098	11.93	3	31
407	17	SURG	Myeloprolif Disord Or Poorly Diff Neopl W Maj O.R.Proc W/O Cc	1.3944	3.23	1	8
408	17	SURG	Myeloprolif Disord Or Poorly Diff Neopl W Other O.R.Proc	2.4914	7.64	1	25
409	17	MED	Radiotherapy	1.4197	5.18	1	24
410	17	MED	Chemotherapy W/O Acute Leukemia As Secondary Diagnosis	0.9158	2.98	1	8

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
411	17	MED	History Of Malignancy W/O Endoscopy	0.7692	1.00	1	7
412	17	MED	History Of Malignancy W Endoscopy	1.2061	6.00	1	7
413	17	MED	Other Myeloprolif Dis Or Poorly Diff Neopl Diag W Cc	1.6789	6.63	1	34
414	17	MED	Other Myeloprolif Dis Or Poorly Diff Neopl Diag W/O C	1.0445	4.27	1	12
415	18	SURG	O.R. Procedure For Infectious & Parasitic Diseases	4.3867	16.15	2	47
416	18	MED	Septicemia Age >17	2.3266	8.69	1	30
417	18	MED	Septicemia Age 0-17	1.1259	5.05	1	17
418	18	MED	Postoperative & Post-Traumatic Infections	0.9923	5.08	1	16
419	18	MED	Fever Of Unknown Origin Age >17 W Cc	0.9585	4.12	1	13
420	18	MED	Fever Of Unknown Origin Age >17 W/O Cc	0.6162	3.10	1	13
421	18	MED	Viral Illness Age >17	0.6806	2.98	1	11
422	18	MED	Viral Illness & Fever Of Unknown Origin Age 0-17	0.4261	2.41	1	5
423	18	MED	Other Infectious & Parasitic Diseases Diagnoses	1.8693	7.57	1	34
424	19	SURG	O.R. Procedure W Principal Diagnoses Of Mental Illness	2.8214	11.60	1	27
425	19	MED	Acute Adjustment Reaction & Psychosocial Dysfunction	0.7131	2.92	1	11
426	19	MED	Depressive Neuroses	0.4770	2.06	1	7
427	19	MED	Neuroses Except Depressive	0.6976	3.89	1	10
428	19	MED	Disorders Of Personality & Impulse Control	0.9321	4.76	1	17
429	19	MED	Organic Disturbances & Mental Retardation	1.4960	9.23	1	40
430	19	MED	Psychoses	0.7825	4.48	1	15
431	19	MED	Childhood Mental Disorders	0.4049	2.47	1	12
432	19	MED	Other Mental Disorder Diagnoses	1.0656	5.54	1	31
433	20	MED	Alcohol/Drug Abuse Or Dependence, Left Ama	0.3878	1.76	1	6
434	20	MED	No Longer Valid				
435	20	MED	No Longer Valid				
436	20	MED	No Longer Valid				
437	20	MED	No Longer Valid				
438	20		No Longer Valid				
439	21	SURG	Skin Grafts For Injuries	2.3853	9.98	1	40
440	21	SURG	Wound Debridements For Injuries	2.6744	9.87	1	40

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
441	21	SURG	Hand Procedures For Injuries	0.9799	2.87	1	11
442	21	SURG	Other O.R. Procedures For Injuries W Cc	2.9492	8.52	1	32
443	21	SURG	Other O.R. Procedures For Injuries W/O Cc	1.1557	3.24	1	12
444	21	MED	Traumatic Injury Age >17 W Cc	0.8242	3.37	1	14
445	21	MED	Traumatic Injury Age >17 W/O Cc	0.5187	1.82	1	6
446	21	MED	Traumatic Injury Age 0-17	0.5306	2.01	1	7
447	21	MED	Allergic Reactions Age >17	0.5896	2.38	1	9
448	21	MED	Allergic Reactions Age 0-17	0.3726	1.57	1	5
449	21	MED	Poisoning & Toxic Effects Of Drugs Age >17 W Cc	0.9443	2.75	1	11
450	21	MED	Poisoning & Toxic Effects Of Drugs Age >17 W/O Cc	0.4775	1.54	1	4
451	21	MED	Poisoning & Toxic Effects Of Drugs Age 0-17	0.4742	1.93	1	6
452	21	MED	Complications Of Treatment W Cc	0.9883	4.37	1	18
453	21	MED	Complications Of Treatment W/O Cc	0.6584	3.00	1	8
454	21	MED	Other Injury, Poisoning & Toxic Effect Diag W Cc	1.4470	4.74	1	20
455	21	MED	Other Injury, Poisoning & Toxic Effect Diag W/O Cc	0.4858	2.37	1	7
456	22		No Longer Valid				
457	22	MED	No Longer Valid				
458	22	SURG	No Longer Valid				
459	22	SURG	No Longer Valid				
460	22	MED	No Longer Valid				
461	23	SURG	O.R. Proc W Diagnoses Of Other Contact W Health Services	1.5154	5.36	1	39
462	23	MED	Rehabilitation	2.8509	15.44	3	49
463	23	MED	Signs & Symptoms W Cc	0.8598	3.94	1	17
464	23	MED	Signs & Symptoms W/O Cc	0.5247	2.54	1	7
465	23	MED	Aftercare W History Of Malignancy As Secondary Diagnosis	0.9933	1.00	1	7
466	23	MED	Aftercare W/O History Of Malignancy As Secondary Diagnosis	2.6004	9.44	1	42
467	23	MED	Other Factors Influencing Health Status	0.4423	2.16	1	7
468			Extensive O.R. Procedure Unrelated To Principal Diagnosis		***Paid Percentage of Charge***		
469			Principal Diagnosis Invalid As Discharge Diagnosis				
470			Ungroupable				

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
471	8	SURG	Bilateral Or Multiple Major Joint Procs Of Lower Extremity	4.2747	6.38	1	18
472	22	SURG	No Longer Valid				
473	17	SURG	Acute Leukemia W/O Major O.R. Procedure Age >17	6.7352	19.66	1	50
474	4	SURG	No Longer Valid				
475	4	MED	Respiratory System Diagnosis With Ventilator Support	4.7449	12.00	1	44
476		SURG	Prostatic O.R. Procedure Unrelated To Principal Diagnosis	4.5247	18.50	1	25
477		SURG	Non-Extensive O.R. Procedure Unrelated To Principal Diagnosis	2.3211	8.29	1	29
478	5	SURG	Other Vascular Procedures W Cc	2.9711	7.80	1	26
479	5	SURG	Other Vascular Procedures W/O Cc	1.8128	3.95	1	14
480	PRE	SURG	Liver Transplant	***Paid Percentage of Charge***			
481	PRE	SURG	Bone Marrow Transplant	***Paid Percentage of Charge***			
482	PRE	SURG	Tracheostomy For Face,Mouth & Neck Diagnoses	4.3931	12.39	2	41
483	PRE	SURG	Tracheostomy Except For Face,Mouth & Neck Diagnoses	20.2741	42.54	6	78
484	24	SURG	Craniotomy For Multiple Significant Trauma	7.0265	12.87	1	43
485	24	SURG	Limb Reattachment, Hip And Femur Proc For Multiple Significant Tra	5.5101	11.47	2	34
486	24	SURG	Other O.R. Procedures For Multiple Significant Trauma	5.1645	11.35	1	40
487	24	MED	Other Multiple Significant Trauma	2.1928	5.61	1	21
488	25	SURG	Hiv W Extensive O.R. Procedure	5.9653	20.24	3	50
489	25	MED	Hiv W Major Related Condition	2.1540	8.82	1	30
490	25	MED	Hiv W Or W/O Other Related Condition	1.3435	5.63	1	18
491	8	SURG	Major Joint & Limb Reattachment Procedures Of Upper Extremity	1.9699	3.98	1	33
492	17	MED	Chemotherapy W Acute Leukemia As Secondary Diagnosis	1.2471	4.40	1	24
493	7	SURG	Laparoscopic Cholecystectomy W/O C.D.E. W Cc	1.6839	4.18	1	13
494	7	SURG	Laparoscopic Cholecystectomy W/O C.D.E. W/O Cc	1.1507	2.08	1	5
495	PRE	SURG	Lung Transplant	***Paid Percentage of Charge***			
496	8	SURG	Combined Anterior/Posterior Spinal Fusion	7.0473	12.74	3	43
497	8	SURG	Spinal Fusion Except Cervical W Cc	3.7855	7.11	3	19
498	8	SURG	Spinal Fusion Except Cervical W/O Cc	2.7007	4.14	1	8
499	8	SURG	Back & Neck Procedures Except Spinal Fusion W Cc	1.8462	4.79	1	22
500	8	SURG	Back & Neck Procedures Except Spinal Fusion W/O Cc	0.9456	1.97	1	7

DRG	MDC	Med/ Surg		Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
501	8	SURG	Knee Procedures W Pdx Of Infection W Cc	2.7355	14.24	1	43
502	8	SURG	Knee Procedures W Pdx Of Infection W/O Cc	1.5050	5.50	1	11
503	8	SURG	Knee Procedures W/O Pdx Of Infection	1.4526	2.50	1	10
504	22	SURG	Extensive 3Rd Degree Burns W Skin Graft	16.6005	28.19	1	64
505	22	MED	Extensive 3Rd Degree Burns W/O Skin Graft	2.8026	5.52	1	40
506	22	SURG	Full Thickness Burn W Skin Graft Or Inhal Inj W Cc Or Sig Trauma	6.3409	17.73	1	46
507	22	SURG	Full Thickness Burn W Skin Grft Or Inhal Inj W/O Cc Or Sig Trauma	2.6360	9.72	1	26
508	22	MED	Full Thickness Burn W/O Skin Grft Or Inhal Inj W Cc Or Sig Trauma	2.7997	9.37	1	38
509	22	MED	Full Thickness Burn W/O Skin Grft Or Inh Inj W/O Cc Or Sig Trauma	0.6601	2.66	1	10
510	22	MED	Non-Extensive Burns W Cc Or Significant Trauma	2.2730	8.25	1	38
511	22	MED	Non-Extensive Burns W/O Cc Or Significant Trauma	0.7357	3.04	1	11
512	PRE	SURG	Simultaneous Pancreas/Kidney Transplant	6.2655	7.17	1	25
513	PRE	SURG	Pancreas Transplant	4.9228	5.33	1	19
514	5	SURG	Cardiac Defibrillator Implant W Cardiac Cath	8.0591	9.83	1	33
515	5	SURG	Cardiac Defibrillator Implant W/O Cardiac Cath	6.4551	7.86	1	40
516	5	SURG	Percutaneous Cardiovasc Proc W Ami	2.8742	4.18	1	13
517	5	SURG	Perc Cardio Proc W Coronary Artery Stent W/O Ami	2.3180	2.54	1	9
518	5	SURG	Perc Cardio Proc W/O Coronary Artery Stent Or Ami	1.8853	2.95	1	11
519	8	SURG	Cervical Spinal Fusion W Cc	2.3665	5.25	1	23
520	8	SURG	Cervical Spinal Fusion W/O Cc	1.4357	2.25	1	7
521	20	MED	Alcohol/Drug Abuse Or Dependence W Cc	0.8904	4.13	1	14
522	20	MED	No Longer Valid				
523	20	MED	Alc/Drug Abuse Or Depend W/O Rehabilitation Therapy W/O Cc	0.4582	2.30	1	7