MEDICAID BULLETIN

BT199902 APRIL 1, 1999

To: **All Indiana Medicaid Acute Care Hospitals, Freestanding Psychiatric Hospitals, Rehabilitation Hospitals, Distinct Part Unit Psychiatric Facilities, and Ambulatory Surgical Centers**

Subject: **Changes in Diagnostic-Related Groups/Level-of-Care Inpatient and Outpatient Reimbursement Methodologies**

Table of Contents

Overview

In accordance with *IC 12-15-13-6*, this bulletin is to notify providers of NEW RATES for reimbursing Indiana Medicaid inpatient and outpatient services. Public notice of the intent to change the methods and standards for setting payment rates for inpatient services was provided in the September 1, 1998, and October 1, 1998, versions of the *Indiana Register*. Notice of the final rates, weights, methodologies, and justifications was provided in the April 1, 1999, version of the *Indiana Register*. The new rates should be used for billing purposes for

both services with admissions made on or after May 15, 1999. Billing procedures for both inpatient and outpatient hospital services have not changed. Please refer to the *Indiana Medical Assistance Programs Provider Manual* and *Indiana Medicaid Provider Update* bulletins for specific billing instructions.

Overall Fiscal Impact

With respect to outpatient hospital services, current rates are based on state fiscal year (SFY) 1992 claims data and cost reporting periods in accordance with *405 IAC 1-8-2, 3*. The Office of Medicaid Policy and Planning (OMPP) adjusted the rates of reimbursement for most outpatient services in two ways. Rates that have been in effect since March 1994 have been adjusted to reflect inflation. The Health Care Financing Administration Hospital Market Basket Index was utilized as the inflation index when applying the inflation adjustment to the outpatient rates. The rates have been adjusted to the midpoint of (SFY) 1999.

In addition to the inflationary increase, the OMPP adjusted rates for certain essential outpatient services to reflect changes in cost for providing the service due to advances in technology and other resources. These rates were adjusted upward to reflect 100 percent aggregate cost coverage based on SFY 1996 Medicaid utilization data.

Essential outpatient services are designated with a @ in the Notes section of Appendices C-F. These essential outpatient services have been adjusted or are currently being reimbursed at or above 100 percent of adjusted aggregate provider cost. If no increase in a particular service is reflected in the exhibit, it is because the service was already being reimbursed at 100 percent aggregate cost coverage.

In addition, the OMPP did not adjust the fees for laboratory services because these rates are limited by the Medicare lab fee schedule.

As a result of these rate increases, the aggregate fiscal impact produced an increase in payments for outpatient services of approximately $20 million. Furthermore, from the outset, a budget neutral approach was pursued by the OMPP. That is, when taking into account both the outpatient and inpatient rate adjustments, it was the OMPP’s intent to produce an overall hospital fiscal impact of approximately zero, while not reducing aggregate payment levels below current spending levels. Therefore, after reviewing the reimbursement for outpatient services, it was the OMPP’s intent to

adjust reimbursement levels to inpatient services only to the extent that it would be offset by an increase in payments for outpatient services.

Claims data and cost reports from SFY 1996 were used as the basis for the rebasing of the DRG rates and recalibration of the weights for inpatient services in accordance with *405 IAC 1-10.5*. The rates were then inflated to the midpoint of SFY 1999. Due to the OMPP's desire to avoid such significant reductions in inpatient payments at this time, the OMPP decided to reduce inpatient payments only to the extent that they would be offset by an increase in payments for outpatient services. In order to obtain an approximate $20 million decrease in payments for inpatient services the OMPP used 93.9 percent of the weighted median for the DRG base and LOC rates. This results in an average cost coverage of 112 percent (hospital care for the indigent payments and disproportionate share payments net of the intergovernmental transfers have been included in determining payments) for inpatient services. A list of the inpatient rates and weights that were adjusted are discussed throughout the bulletin or shown in Appendices A and B of this bulletin.

The remainder of this bulletin will describe in more detail the methodologies used to calculate or update the rates of reimbursement. Both inpatient and outpatient services are presented in the following information.

Inpatient and Outpatient Reimbursement Systems

The State of Indiana has a LOC/DRG inpatient hybrid reimbursement system and an outpatient reimbursement system for providers that participate in the Indiana Medical Assistance Programs.

Inpatient Reimbursement System

With respect to the hybrid reimbursement system, this system consists of two distinct reimbursement methodologies:

- A DRG system, which reimburses a per case rate according to diagnoses and procedures performed
- A LOC system, which reimburses select cases on a *per diem* basis.

Reimbursement for inpatient hospital services under the hybrid system comprises the following components:

- DRG rate per case or LOC *per diem* rate
- Outlier payment, if applicable

- Capital rate
- Medical education rate, if applicable

DRG Reimbursement Methodology

DRGs are the basis for payments to hospitals under a prospective payment system. DRGs are intended to represent groups of hospital inpatient cases that are clinically similar to one another and relatively homogeneous with respect to resource utilization. Indiana Medicaid claims data were used to base the DRG system on Indiana's experience.

The DRG reimbursement rates are intended to cover all inpatient hospital costs, including the costs of inpatient routine care and ancillary services. Additional payments to hospitals will be provided for the following:

- Capital related costs
- Direct medical education costs, if applicable

Hospitals may not bill Indiana Medical Assistance Program patients for the difference between payments and actual charges, except for those conditions as stated on page 4-4-1 of the *Indiana Medical Assistance Programs Provider Manual*. Refer to *Indiana Medical Assistance Programs Provider Manual* for more information.

The critical components of a DRG inpatient reimbursement system are the classification system (also known as the grouper), the base rates, relative weights, outlier payments (which utilize facility-specific cost-to-charge ratios), capital rates, and medical education rates, if applicable.

Grouper

Groupers classify inpatient cases into categories that represent similar resource consumption during treatment. These categories are termed Diagnosis-Related Groups, or DRGs.

Each discharge will be assigned to only one DRG regardless of the number of services furnished or the number of days of care provided. DRG assignment is based on the physician's recording of the patient's principal diagnosis, of any additional diagnoses and of any procedures performed. This information is expressed using ICD-9-CM codes with the highest level of specificity possible. Providers must use a fourth or fifth digit whenever one is identified in the *ICD-9-CM Manual*. Failure

to properly specify this data may result in inaccurate payment for a submitted claim or result in a suspended claim which will also delay payment. The *Indiana Medical Assistance Programs Provider Manual* contains general billing procedures and coding instructions.

The All-Patient (A-P) DRG Grouper is currently being used as the Grouper for the DRG system in Indiana because the A-P DRG Grouper most appropriately addresses the resource consumption of the Indiana Medical Assistance Programs (for example, non-Medicare) population.

As with the Medicare Grouper, new versions of the A-P DRG Grouper are issued periodically. Revised versions of the grouper software are not adopted by the State until the DRG system is rebased or providers are notified by the State. At that time, the State upgrades to a more current version of the Grouper.

Therefore, as a result of rebasing the DRG system, the State will upgrade to a more current version of the Grouper. Indiana Medicaid will use Version 14.1 of the A-P DRG Grouper. If providers are interested in ordering a copy of the Grouper, contact 3M at 1-800-458-4797 or HSS at 1-800-999-3747 to obtain information about Version 14.1 of the A-P DRG Grouper.

DRG Base Rate

The DRG rate is the payment rate used in reimbursing hospitals for both routine and ancillary costs associated with inpatient care. This rate is determined by the statewide base payment amount, which is the rate per Medicaid stay, which is multiplied by the relative weight to determine the inpatient payment. A “Medicaid stay” is a period of inpatient care that includes at least one night in the hospital, and is reimbursable under the Indiana Medical Assistance Programs.

The rebased DRG base rate is calculated using the following methodology. The cost per discharge amount is determined for each hospital by dividing each hospital’s total reported (or adjusted, if audited) Medicaid operating costs by each hospital’s total Medicaid discharges, which is then divided by the each hospital’s case mix index to arrive at the case mix adjusted cost per discharge. Each hospital’s adjusted cost per discharge is arrayed from low to high and a median is determined, which is then weighted by the number of Medicaid discharges. The new DRG base rate is 93.9 percent of the weighted median. The weighted median adjustment percent serves to maintain budget neutrality, with the corresponding cost increases reflected in the outpatient services reimbursement rates.

The DRG base rate effective May 15, 1999, is $2,961.80.

DRG Base Rate for Children's Hospitals

405 IAC 1-10.5-3 allows the OMPP to establish separate base rate amounts for children's hospitals to the extent necessary to reflect significant differences in cost. By definition, a children's hospital means an inpatient hospital facility whose primary specialty is providing short-term acute care medical services for children and newborns.

Children's hospitals have been identified based upon incurring significantly higher Medicaid costs than other hospitals, even after accounting for differences in the case mix of patients. At this time, it has been determined that the children's hospitals are:

- Clarian Health Partners/Riley Hospital For Children
- Children's Memorial Hospital of Chicago, Illinois

Based on the review of costs for facilities meeting this definition, the DRG base rate for children's hospitals is 120 percent of the standard DRG base rate.

Therefore, effective May 15, 1999, the DRG base rate for children's hospitals is $3,554.16.

Relative Weights

Recalibration of DRG relative weights re-establishes the relative relationship among services to reflect the current costs of care within each DRG. Historical claims and cost reports have been used to compute claim specific estimates of cost and these, in turn, have been aggregated to derive average cost per discharge for each DRG. The DRG relative weights are then computed by taking the ratio of average estimated cost for each DRG to the average cost for all cases in all DRG's combined. A complete list of new relative weights and average lengths of stay can be found in Appendix B of this bulletin. DRG numbers 424-432 (excluding diagnosis code 317.XX-319.XX), 430-432, 456-459, 462 and 472 are processed under the LOC payment methodology.

These new relative weights and average lengths of stay are effective May 15, 1999.

DRG Outlier Payments

Under a DRG hybrid reimbursement system, the need for an outlier policy is significantly reduced, as cases that traditionally are classified as outliers (such as burn and psychiatric care) are reimbursed under the LOC component. Outlier payments are available for all qualifying cases reimbursed under the DRG system.

The State of Indiana defines a DRG outlier case as a Medicaid stay that exceeds a predetermined threshold, defined as the greater of twice the DRG rate or $25,000. Day outliers will not be reimbursed under the DRG outlier payment policy.

To determine the outlier payment amounts, costs per Medicaid stay are calculated by multiplying a hospital-specific, cost-to-charge ratio by allowed charges. The payment is then a percentage of the difference between this prospective cost per stay and the outlier threshold indicated above. The percentage (or marginal cost factor) has been determined at 60 percent.

The total payment is the sum of the DRG rate, outlier payment, capital rate and medical payment rate payment, if applicable.

Hospital-specific, cost-to-charge ratios have been adjusted based on claims data utilized for the DRG and LOC rebasing and recalibration project. Myers and Stauffer LC, the OMPP's hospital rate-setting contractor, has notified hospitals individually of their new global cost-to-charge ratio, which will be used to calculate DRG outlier payments. Cost-to-charge ratios are calculated only during rebasing and recalibration periods, except for new providers.

The notification letters were mailed to providers on October 20, 1998, and March 3, 1999. Providers who did not receive a notification letter will receive the statewide average.

LOC Reimbursement Methodology

Due to wide variances in length of stay and severity, certain cases have been excluded from the DRG rate methodology. A hybrid system, however, incorporates a distinct reimbursement mechanism to accommodate these cases. This reimbursement mechanism is known as a LOC system and it reimburses hospitals on a *per diem* basis. Three types of cases are reimbursed under the LOC system:

- Certain burn cases
- Psychiatric cases

- Rehabilitation cases

The LOC reimbursement rates represent all payments (excluding any applicable disproportionate share payments) to a hospital for all inpatient costs, costs of inpatient routine care and ancillary services. Additional payments to hospital will be provided for:

- Capital related costs
- Direct medical education costs, if applicable

Although there are three LOC types, there are four LOC payment rates.

- Psychiatric
- Burn/1
- Burn/2
- Rehabilitation

LOC rates are established using costs derived from cost-to-charge ratio adjusted claims data for cases having the following DRG numbers 424-432 (excluding diagnosis code 317.XX-319.XX), 430-432, 456-459, 462 and 472. The cost *per diem* is calculated for each hospital in each of the four LOC groups. These *per diem* payments are based upon the weighted median *per diem* cost, calculated based on the number of discharges.

Claims classified into the following DRGs are excluded from the DRG system, and reimbursed under the LOC system:

- DRGs excluded for Burn cases
  - 456 through 459, 472
- DRGs excluded for Psychiatric cases
  - 424 through 432 (DRG 429 excludes diagnoses 317-319)
- DRGs excluded for Rehabilitation cases
  - 462

Burn cases are divided into two groups (Burn/1 and Burn/2) based on the facility, equipment and resources utilized by hospitals to treat burn patients. These rates have been developed to handle severe burn cases that call for specialized facilities and procedures.

Burn/1 facilities have been identified based upon the burn services provided in certified burn care facilities and the costs of burn services they provide. The certified Burn/1 facilities are:

- Wishard Memorial Hospital

- Clarian Health Partners
- Saint Joseph's Hospital of Fort Wayne
- University Medical Center (Louisville)

These three facilities are eligible to bill and receive reimbursement at the Burn/1 rate. The definition of Burn/1 hospitals is re-evaluated when the DRG inpatient reimbursement system is rebased.

All other hospitals will receive the Burn/2 rate.

Hospitals may not bill Medicaid patients for the difference between payments and actual charges except for those conditions as stated on page 4-4-1 of the *Indiana Medical Assistance Programs Provider Manual*. Refer to the *Indiana Medical Assistance Program Provider Manual* for more information.

The new LOC *per diem* rates have been calculated using Medicaid costs from facilities' SFY 1996 cost reports, adjusted for inflation. The cost *per diem* is calculated for each facility in the four LOC groups and arrayed with the weighted median cost selected. The rates were established using 93.9 percent of the weighted median *per diem* cost.

The new LOC *per diems* effective May 15, 1999, are shown in Table 1.1.

Table 1.1 – New LOC *Per Diems*

Level-of-Care	***Per Diem***
Psychiatric—Acute	$429.79
Psychiatric—Freestanding/DPU	$399.75
Rehabilitation	$599.75
Burn/1	$1,671.75
Burn/2	$500.07

Claims will be run through the A-P DRG Grouper to be classified into appropriate DRGs. Some claims will be classified by specialty type, such as freestanding and distinct part unit psychiatric and rehabilitation facilities.

Payment for inpatient rehabilitation services will be paid under LOC, regardless of setting.

Inpatient burn treatment services will also be paid under LOC, regardless of setting. Two LOCs have been established for burn care.

LOC Outlier Payments

Under the LOC system, outlier payments are made for burn cases that exceed established thresholds. The State of Indiana defines a LOC cost outlier as a Medicaid day whose cost per days exceeds twice the burn rate of $1,671.75 for Burn/1 care or $500.07 for Burn/2 care.

To determine the outlier payment amounts, costs per Medicaid stay will be calculated by multiplying a hospital-specific, cost-to-charge ratio by allowed charges. The outlier is a percentage of the difference between the prospective cost per day and the outlier threshold for each covered day of care. The percentage (or marginal cost factor) has been determined at 60 percent. The total payment is the sum of LOC rate, outlier payment, if applicable, capital rate, and medical education, if applicable, for each covered day of care.

Capital (Per Diem) Rate Reimbursement

Inpatient hospital stays are reimbursed using the DRG or LOC rate, the outlier payment, if applicable, the capital rate, and the medical education rate, if applicable. A capital (*per diem)* rate is reimbursed under both the DRG and LOC reimbursement systems.

Facilities are reimbursed a flat, statewide (*per diem)* rate for capital costs. This payment rate is calculated by inflating the SFY 1997 capital rate to the midpoint of the SFY 1999 using the DRI-McGraw Hill Hospital Market Basket Index. The SFY 1999 capital rate was established according to the following steps:

1. Each facility's routine and ancillary capital costs, less nursery costs, were extracted from SFY 1996 cost report.
2. Each facility's total beds, total days of care and total Medicaid days were extracted from SFY 1996 cost reports.
3. Available days were determined by multiplying total beds, less nursery beds, by 365.
4. Medicaid days were adjusted in order to reflect a minimum occupancy rate of 80 percent. For example, if a facility had an occupancy rate of 60 percent and provided two hundred days of care covered by Medicaid, Medicaid days were adjusted using the formula below:

   200 x .80/.60 = 267

5. The sum of each facility's routine and ancillary capital costs were divided by adjusted Medicaid days in order to calculate each facility's occupancy-adjusted capital cost (*per diem)*.

6. Each facility's capital costs (*per diem)* were inflated using the DRI-McGraw Hill Market Basket Index.
7. All facilities' inflated capital costs (*per diem)* were arrayed from high to low.
8. The weighted median capital costs per day was established according to the median of all Medicaid days of care provided; the weighted median is the capital cost per day associated with the median of all Medicaid days.
9. The weighted median capital cost (*per diem)* rate was inflated using the DRI-McGraw Hill Market Basket Index to create the SFY 1999 capital (*per diem)* rate.
10. There will be capital payments for normal newborn cases (DRGs 620 and 629). Previously, no capital payments were made on normal newborn cases.

The capital payment rate for inpatient care reimbursed under the DRG methodology is the capital rate, multiplied by the average length of stay for all cases within the particular DRG. For cases reimbursed under the LOC system, facilities are reimbursed the capital *per diem* rate for each covered day of care.

The capital (*per diem)* rates, shown in Table 1.2, are effective May 15, 1999.

Table 1.2–Capital (*Per Diem)* Rates

Type of Capital (*Per Diem)* Rate	***(Per Diem)* Rate**
Acute Care DRG System Capital Payment Rate	$65.60
Freestanding Psychiatric and Acute Care Distinct Part Unit LOC Capital *Per Diem* Rate	$42.00

While there are two types of capital (*per diem*) rates, Acute Care Capital Rate and Freestanding Psychiatric, and Acute Care Distinct Part Unit Capital *Per Diem* Rate, the Indiana*Aim* System can only store a single capital (*per diem)* rate, which is the Acute Care Capital Rate. To accommodate this requirement, the Acute Care Capital Rate of $65.60 will be loaded for each facility. For those facilities that qualify for the Freestanding Psychiatric and Acute Care Distinct Part Unit Capital *Per Diem* Rate, your LOC rate will be reduced by the difference between the Acute Care Capital Rate of $65.60 and the Freestanding Psychiatric and Acute Care Distinct Part Unit Capital *Per Diem* Rate of $42.00 or, $23.60 ($65.50 - $42.00 = $23.60). This does

not represent a departure from our current reimbursement methodology.

Medical Education Rate Reimbursement

Medical education costs are reimbursed based upon a hospital-specific *per diem*, which has been calculated using each facility's SFY 1996 cost report. Total graduate medical education and paramedical education costs were utilized from the cost reports, along with total inpatient days and total Medicaid days to arrive at the facility specific medical education cost per day. Medical education rates are calculated only during rebasing and recalibration periods, except for new providers. The SFY 1999 medical education rate was established using the following criteria:

1. Each facility's intern and resident medical education and paramedical education costs were extracted from SFY 1996 cost reports.
2. Each facility's total inpatient days and total Medicaid days were extracted from SFY 1996 cost reports.
3. Each facility's intern and resident full-time equivalent (FTE) counts were extracted from SFY 1996 audited cost reports, or the most current audited cost report available.
4. Updated FTE counts for facilities that reported medical education in SFY 1996 were derived from the most current, audited cost reports.
5. The intern and resident costs were adjusted based on the change in FTE count.
6. The intern and resident costs plus paramedical costs were multiplied by the percent of Medicaid days.
7. The total Medicaid costs were divided by Medicaid days.
8. The Medicaid costs per day were inflated to the midpoint of SFY 1999

Under the DRG system, medical education payments for Medicaid stays are equal to the medical education *per diem* rate multiplied by the average length of stay for the DRG.

Under the LOC system, Medicaid stays are reimbursed the medical education *per diem* rate for each covered day of care.

Each facility that qualifies for medical education reimbursement will be notified by Myers and Stauffer LC of its new medical education *per diem*. The notification letters were mailed to providers on October 20, 1998.

Qualification for Medical Education Payments

Institutional providers must continue to submit current HCFA-2552-96 cost reports. Adjustments in the payment rate are made based on changes in the FTE count of interns and residents. For hospitals with paramedical programs only, the payment rate is not adjusted for FTE count. Payment for medical education is provided only to those hospitals that operate medical education programs. Hospitals that discontinue or downsize their medical education programs must promptly notify the State of this change.

A complete list of all inpatient DRG, LOC, and capital (*per diem)* rates may be found in Appendix A of this bulletin.

Outpatient Reimbursement System

As previously stated with respect to outpatient hospital services, current rates are based on SFY 1992 claims data and cost reporting periods in accordance with *405 IAC 1-8-2, 3*. The OMPP adjusted the rates of reimbursement for most outpatient services in two ways. Rates that have been in effect since March 1994 have been adjusted to reflect inflation. This inflationary adjustment applies to both essential and nonessential services. The Health Care Financing Administration Hospital Market Basket Index was used as the inflation index when applying the inflation adjustment to the outpatient rates. The rates have been adjusted to the midpoint of SFY 1999.

In addition to the inflationary increase, the OMPP adjusted rates for certain essential outpatient services to reflect changes in cost for providing the service due to advances in technology and other resources. These rates were adjusted upward to reflect 100 percent aggregate cost coverage based on SFY 1996 Medicaid utilization data.

Essential outpatient services include those services that cannot be routinely or safely performed in another delivery setting, such as a physician’s office. These services require the more sophisticated environment often found in an acute care facility. Essential outpatient services have been identified with the assistance of the OMPP and include the following:

- Emergency room and clinic visits for emergent diagnoses
- Labor and delivery services
- Chemotherapy services
- Most surgical procedures

- Maximum fees and radiology services

Essential outpatient services are designated with a @ in the Notes section of Appendices C - F. These essential outpatient services have been adjusted or are currently being reimbursed at or above 100 percent of adjusted aggregate provider cost. Please note that if no increase in a particular service is reflected in the appendix, it is because the service was already being reimbursed at 100 percent aggregate cost coverage.

In addition, the OMPP did not adjust the fees for laboratory services because these rates are limited by the Medicare lab fee schedule. Payment is 100 percent of the fee schedule, which is updated annually. Hospitals should continue to bill the technical component on the UB92 form or, in some instances, the global component, where applicable. Appendix C of this bulletin lists those services for which CPT codes are required for billing along with the applicable revenue code. Please refer to Section IIL of the *Indiana Medical Assistance Programs Provider Manual* for more information.

Table 1.3 displays an example of the cost adjustment for a particular Medicaid service.

Table 1.3 – Cost Adjustment Example

Revenue Code	Description	SFY 1996 Units	SFY 1996 Inflated and Adjusted Costs	SFY 1996 Rate	SFY 1999 Rate	Cost Adjustment	Final Rate
387	Blood	18	$892.62	$32	$35.97	$13.62	$49.59

1. The SFY 1996 Rate is inflated to the midpoint of SFY 1999 to get the SFY 1999 rate.
2. A cost adjustment amount is added to the SFY 1999 rate to get the final rate. The final rate is equal to the SFY 1996 inflated and adjusted costs divided by the number of units.

Appendices C-F contains the current outpatient reimbursement rates and the new rates which reflect the adjustments noted above. Please begin using those rates for services with admissions made on or after May 15, 1999.

Questions

For questions regarding the information contained in this bulletin, please contact EDS Provider Assistance at (317) 655-3240 or 1-800-577-1278.

Appendix A: DRG and LOC Rates

DRG and LOC Rates	Prior to 5/15/99	On or After 5/15/99
DRG Base Rate	$2,606.85	$2,961.80
Children's Hospital DRG Base Rate	NA	$3,554.16
Psychiatric-Acute LOC Rate	$434.13	$429.79
Psychiatric-Freestanding / DPU LOC Rate	$374.78	$399.75
Rehabilitation LOC Rate	$702.56	$599.75
Burn/1 LOC Rate	$1,555.20	$1,671.15
Burn/2 LOC Rate	$491.15	$500.07
Acute Care Capital Rate	$55.18	$65.60
Freestanding / DPU Capital Rate	$91.78	$42.00

Please refer to Appendix B for a listing of the updated DRG relative weights. Rates for the period prior to 5/15/99 may vary by time period. Please refer to Indiana Medical Assistance Program Updates for the appropriate rate and time period.

Appendix B: DRG Weight Table

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
001	Craniotomy age >17 except for trauma	5.8954	14.0	3.7862	7.4
002	Craniotomy for trauma age >17	7.9451	18.2	4.5163	17.3
004	Spinal procedures	3.4865	11.1	2.8348	6.3
005	Extracranial vascular procedures	2.2894	5.6	1.5265	2.9
006	Carpal tunnel release	0.6309	2.1	1.0386	1.0
007	Periph & cranial nerve & other nerv syst proc w cc	2.6275	7.9	3.1942	5.7
008	Periph & cranial nerve & other nerv syst proc w/o cc	1.6920	4.5	1.6274	3.1
009	Spinal disorders & injuries	2.0691	11.5	1.3891	6.2
010	Nervous system neoplasms w cc	2.2101	8.7	1.4271	6.1
011	Nervous system neoplasms w/o cc	1.2598	4.4	1.2357	4.4
012	Degenerative nervous system disorders	1.8444	9.0	0.9468	4.7
013	Multiple sclerosis & cerebellar ataxia	1.2751	6.1	1.0043	4.8
014	Specific cerebrovascular disorders except TIA	2.1671	8.5	1.7005	6.5
015	Transient ischemic attack & precerebral occlusions	1.5098	6.4	1.0263	4.2
016	Nonspecific cerebrovascular disorders w cc	1.5410	6.6	1.3919	5.9
017	Nonspecific cerebrovascular disorders w/o cc	1.1931	6.1	0.8978	3.8
018	Cranial & peripheral nerve disorders w cc	1.3691	6.2	1.1573	5.4
019	Cranial & peripheral nerve disorders w/o cc	1.1264	5.6	0.9427	5.1
020	Nervous system infection except viral meningitis	2.2124	9.9	2.4548	7.5
021	Viral meningitis	0.8207	4.1	0.7514	3.3
022	Hypertensive encephalopathy	1.1510	4.9	0.9684	4.5
023	Nontraumatic stupor & coma	1.1914	5.2	1.1372	3.6
024	Seizure & headache age >17 w cc	1.1393	5.3	0.8949	3.5
025	Seizure & headache age >17 w/o cc	0.8047	3.8	0.6753	2.8
034	Other disorders of nervous system w cc	1.4882	6.3	1.1300	4.7
035	Other disorders of nervous system w/o cc	0.9690	4.1	0.8340	3.8
036	Retinal procedures	1.0612	1.5	1.0986	1.6

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
037	Orbital procedures	1.1023	3.4	1.7948	3.7
038	Primary iris procedures	0.6494	2.9	0.7317	2.0
039	Lens procedures with or without vitrectomy	0.7691	1.9	1.2789	3.2
040	Extraocular procedures except orbit age >17	0.8180	2.0	1.2627	5.0
041	Extraocular procedures except orbit age <18	0.7255	1.9	1.0206	1.8
042	Intraocular procedures except retina, iris & lens	1.0888	2.4	1.3598	3.5
043	Hyphema	0.4941	3.2	0.5275	4.0
044	Acute major eye infections	0.5863	3.5	0.7573	3.6
045	Neurological eye disorders	0.9439	3.2	0.6384	2.9
046	Other disorders of the eye age >17 w cc	0.8205	4.8	1.0695	5.9
047	Other disorders of the eye age >17 w/o cc	0.7238	3.9	0.5907	2.5
048	Other disorders of the eye age <18	0.7332	3.9	0.4711	2.4
049	Major head & neck procedures except for malignancy	2.2282	3.6	3.3041	6.0
050	Sialoadenectomy	0.8559	2.1	1.2295	4.1
051	Salivary gland procedures except sialoadenectomy	0.7205	2.7	1.2200	2.1
052	Cleft lip & palate repair	1.0343	2.1	1.0312	2.3
053	Sinus & mastoid procedures age >17	1.0547	2.7	1.0957	2.6
054	Sinus & mastoid procedures age <18	0.8993	2.0	0.8563	2.0
055	Miscellaneous ear, nose, mouth & throat procedures	1.3008	3.4	1.2603	4.3
056	Rhinoplasty	0.8317	2.2	1.2815	1.0
057	T&A proc,except tonsillectomy &/or adenoidect only,age >17	0.6623	2.9	0.9430	4.8
058	T&A proc,except tonsillectomy &/or adenoidect only,age <18	0.7703	2.0	1.1619	3.7
059	Tonsillectomy &/or adenoidectomy only, age >17	0.4837	1.5	0.7801	2.0
060	Tonsillectomy &/or adenoidectomy only, age <18	0.5515	1.6	0.7108	3.9
061	Myringotomy w tube insertion age >17	0.5538	0.9	0.7628	8.0
062	Myringotomy w tube insertion age <18	0.6675	1.9	1.0275	2.8

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
063	Other ear, nose, mouth & throat O.R. procedures	1.4762	4.1	1.4900	3.4
064	Ear, nose, mouth & throat malignancy	1.2827	5.2	1.4258	6.0
065	Dysequilibrium	0.6537	3.3	0.6659	2.8
066	Epistaxis	0.8717	3.7	0.7480	2.9
067	Epiglottitis	1.0662	3.9	0.4297	1.8
068	Otitis media & uri age >17 w cc	0.8727	4.2	1.0021	3.6
069	Otitis media & uri age >17 w/o cc	0.7303	3.7	0.6245	2.5
070	Otitis media & uri age <18	0.5130	2.9	0.4489	2.3
071	Laryngotracheitis	0.4686	2.5	0.3884	1.9
072	Nasal trauma & deformity	0.4264	1.8	0.8245	4.3
073	Other ear, nose, mouth & throat diagnoses age >17	0.7474	3.4	0.6578	2.7
074	Other ear, nose, mouth & throat diagnoses age <18	0.8568	3.7	0.6842	2.9
075	Major chest procedures	5.1342	13.9	3.5999	9.1
076	Other resp system O.R. procedures w cc	3.9669	13.3	2.4781	8.6
077	Other resp system O.R. procedures w/o cc	2.8655	8.9	1.4694	4.8
078	Pulmonary embolism	2.0394	8.0	1.6916	6.5
079	Respiratory infections & inflammations age >17 w cc	2.4306	9.5	1.5346	6.1
080	Respiratory infections & inflammations age >17 w/o cc	2.2926	10.4	1.4078	5.7
082	Respiratory neoplasms	1.7730	7.7	1.5920	6.7
083	Major chest trauma w cc	1.2382	5.3	1.2245	5.0
084	Major chest trauma w/o cc	0.9235	4.4	0.8098	4.0
085	Pleural effusion w cc	1.6305	5.8	1.4678	6.9
086	Pleural effusion w/o cc	1.1384	5.0	1.2684	6.3
087	Pulmonary edema & respiratory failure	1.9984	7.1	1.6474	5.6
088	Chronic obstructive pulmonary disease	1.2639	5.5	1.0412	4.4
089	Simple pneumonia & pleurisy age >17 w cc	1.4778	6.8	1.2399	5.2
090	Simple pneumonia & pleurisy age >17 w/o cc	1.1595	5.6	0.7928	3.4
092	Interstitial lung disease w cc	1.5146	5.3	1.6620	8.1
093	Interstitial lung disease w/o cc	1.0186	4.6	1.0928	4.6

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
094	Pneumothorax w cc	1.6682	7.9	1.6221	5.6
095	Pneumothorax w/o cc	1.2088	5.5	0.7643	3.6
096	Bronchitis & asthma age >17 w cc	1.1257	5.3	0.8673	3.7
097	Bronchitis & asthma age >17 w/o cc	0.8956	4.4	0.6982	3.1
099	Respiratory signs & symptoms w cc	1.2382	4.7	0.8269	2.9
100	Respiratory signs & symptoms w/o cc	0.9320	3.8	0.5863	2.3
101	Other respiratory system diagnoses w cc	1.0478	4.3	0.8981	3.5
102	Other respiratory system diagnoses w/o cc	0.8798	3.8	0.6238	2.5
103	Heart transplant	42.4149	35.8	17.4903	23.5
104	Cardiac valve procedures w cardiac cath	12.6617	18.8	7.4270	7.7
105	Cardiac valve procedures w/o cardiac cath	9.7738	14.4	6.0810	7.4
106	Coronary bypass w cardiac cath	10.3915	16.5	6.9890	10.3
107	Coronary bypass w/o cardiac cath	7.7574	12.3	4.8362	6.1
108	Other cardiothoracic proc w/o pdx congenital anomaly	8.1325	11.6	4.2292	5.3
110	Major cardiovascular procedures w cc	5.6628	12.7	5.1252	10.9
111	Major cardiovascular procedures w/o cc	4.7932	9.8	3.1770	5.4
112	Percutaneous cardiovascular proc w/o AMI,heart failure or shock	3.3700	5.7	2.6119	3.4
113	Amputation for circ system disord except upper limb & toe	4.5607	16.2	3.0004	12.0
114	Upper limb & toe amputation for circ system disorders	2.2554	9.2	2.2657	9.5
115	Perm cardiac pacemaker impl w AMI,heart failure or shock	5.6753	14.3	5.5094	10.5
116	Oth perm cardiac pacemaker implant or AICD lead or generator proc	4.4629	7.8	3.6698	5.3
117	Cardiac pacemaker revision except device replacement	2.3200	6.0	1.6314	9.3
118	Cardiac pacemaker device replacement	3.1799	2.4	2.5462	4.0
119	Vein ligation & stripping	0.9809	3.0	1.2000	1.0
120	Other circulatory system O.R. procedures	3.5175	11.7	2.1850	7.5
121	Circulatory disorders w AMI & c.v. comp disch alive	2.8333	8.2	2.5183	6.9

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
122	Circulatory disorders w AMI w/o c.v. comp disch alive	2.1701	6.5	1.9791	4.8
123	Circulatory disorders w AMI, expired	2.7389	4.6	2.4101	5.2
124	Circulatory disord except AMI, w card cath & complex diag	2.1853	5.7	1.9650	4.7
125	Circulatory disord except AMI, w card cath w/o complex diag	1.6931	4.2	1.4434	3.2
126	Acute & subacute endocarditis	4.3340	19.9	3.4995	17.5
127	Heart failure & shock	1.5667	6.4	1.2510	4.7
128	Deep vein thrombophlebitis	1.0115	6.1	0.9037	5.3
129	Cardiac arrest, unexplained	1.1186	2.4	1.3314	4.5
130	Peripheral vascular disorders w cc	1.5495	7.7	1.2704	5.8
131	Peripheral vascular disorders w/o cc	1.2116	6.4	1.0362	4.7
132	Atherosclerosis w cc	2.1509	5.0	1.0308	3.2
133	Atherosclerosis w/o cc	1.5097	4.7	0.8041	2.7
134	Hypertension	1.0845	4.9	0.8789	3.6
135	Cardiac congenital & valvular disorders age >17 w cc	1.5848	5.5	1.2577	5.8
136	Cardiac congenital & valvular disorders age >17 w/o cc	0.8346	4.8	0.7925	3.2
137	Cardiac congenital & valvular disorders age <18	1.2848	2.7	1.3166	1.8
138	Cardiac arrhythmia & conduction disorders w cc	1.3100	4.8	1.1917	3.9
139	Cardiac arrhythmia & conduction disorders w/o cc	1.0419	3.7	0.7926	2.6
140	Angina pectoris	0.9794	3.5	0.8024	2.6
141	Syncope & collapse w cc	0.9609	4.2	0.9601	3.8
142	Syncope & collapse w/o cc	0.8131	3.3	0.6233	2.4
143	Chest pain	0.8365	3.1	0.7137	2.2
144	Other circulatory system diagnoses w cc	1.7705	6.3	1.4746	5.3
145	Other circulatory system diagnoses w/o cc	1.6868	5.9	1.0251	3.4
146	Rectal resection w cc	3.8233	10.9	3.7080	10.3
147	Rectal resection w/o cc	3.1578	7.4	2.5136	6.5
148	Major small & large bowel procedures w cc	4.4556	14.7	3.3327	11.1

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
149	Major small & large bowel procedures w/o cc	3.1964	10.1	2.0379	6.2
150	Peritoneal adhesiolysis w cc	2.8873	10.6	2.2923	7.2
151	Peritoneal adhesiolysis w/o cc	1.8795	6.9	1.6216	5.5
152	Minor small & large bowel procedures w cc	2.6820	8.0	1.8664	5.8
153	Minor small & large bowel procedures w/o cc	1.9536	6.8	2.0699	4.1
154	Stomach, esophageal & duodenal procedures age >17 w cc	4.4969	14.4	2.7841	7.9
155	Stomach, esophageal & duodenal procedures age >17 w/o cc	3.2651	10.6	2.1369	5.8
156	Stomach, esophageal & duodenal procedures age <18	2.0822	6.9	1.3384	3.9
157	Anal & stomal procedures w cc	1.5363	5.6	1.4589	4.4
158	Anal & stomal procedures w/o cc	1.0136	3.8	0.7600	2.6
159	Hernia procedures except inguinal & femoral age >17 w cc	1.5578	6.1	1.5042	4.9
160	Hernia procedures except inguinal & femoral age >17 w/o cc	1.1306	3.7	0.8547	2.5
161	Inguinal & femoral hernia procedures age >17 w cc	1.2028	4.2	1.3720	3.4
162	Inguinal & femoral hernia procedures age >17 w/o cc	0.8472	2.5	0.8567	2.3
163	Hernia procedures age <18	0.8343	2.3	0.7302	2.3
164	Appendectomy w complicated principal diag w cc	2.4738	10.4	1.8910	6.8
165	Appendectomy w complicated principal diag w/o cc	1.8367	6.6	1.2546	4.1
166	Appendectomy w/o complicated principal diag w cc	1.3399	4.7	1.2975	3.8
167	Appendectomy w/o complicated principal diag w/o cc	0.9211	3.2	0.8396	2.5
168	Mouth procedures w cc	1.1565	4.9	2.0827	10.6
169	Mouth procedures w/o cc	1.0347	2.8	1.3173	4.2
170	Other digestive system O.R. procedures w cc	3.4790	9.2	2.7024	8.5
171	Other digestive system O.R. procedures w/o cc	1.8733	6.2	1.7122	3.5
172	Digestive malignancy w cc	2.1559	9.5	1.4603	5.5

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
173	Digestive malignancy w/o cc	1.4343	6.5	0.9430	5.5
174	G.I. hemorrhage w cc	1.4721	5.5	1.1935	4.3
175	G.I. hemorrhage w/o cc	1.1637	4.8	0.6941	2.7
176	Complicated peptic ulcer	1.5884	7.0	1.1386	3.7
177	Uncomplicated peptic ulcer w cc	0.9791	4.9	0.9213	4.0
178	Uncomplicated peptic ulcer w/o cc	0.8421	4.1	0.6231	2.5
179	Inflammatory bowel disease	1.2590	6.3	1.3288	6.6
180	G.I. obstruction w cc	1.0552	5.3	0.9798	4.6
181	G.I. obstruction w/o cc	0.7945	4.0	0.5963	2.9
182	Esophagitis, gastroent & misc digest disord age >17 w cc	0.9288	4.6	0.8830	3.7
183	Esophagitis, gastroent & misc digest disord age >17 w/o cc	0.7458	3.7	0.6759	2.9
185	Dental & oral dis except extractions & restorations, age >17	0.9369	3.9	1.0267	4.9
186	Dental & oral dis except extractions & restorations, age <18	0.5975	3.0	0.5484	2.4
187	Dental extractions & restorations	0.8010	2.3	0.9904	5.0
188	Other digestive system diagnoses age >17 w cc	1.5917	6.9	1.2307	5.5
189	Other digestive system diagnoses age >17 w/o cc	1.0805	4.8	0.6057	2.8
191	Pancreas, liver & shunt procedures w cc	6.2985	18.4	3.7425	8.5
192	Pancreas, liver & shunt procedures w/o cc	3.1875	14.2	3.0020	7.4
193	Biliary tract proc except only cholecyst w or w/o c.d.e. w cc	2.9227	10.9	4.3177	9.6
194	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o cc	2.5963	8.4	2.5533	8.4
195	Cholecystectomy w c.d.e. w cc	2.4547	8.5	3.1819	6.5
196	Cholecystectomy w c.d.e. w/o cc	2.4256	8.5	2.4196	5.0
197	Cholecystectomy w/o c.d.e. w cc	2.1045	7.9	1.8889	6.2
198	Cholecystectomy w/o c.d.e. w/o cc	1.3119	4.4	1.3564	3.6
199	Hepatobiliary diagnostic procedure for malignancy	3.3442	9.6	2.8258	8.0
200	Hepatobiliary diagnostic procedure for non-malignancy	2.6138	8.1	1.2930	4.2

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
201	Other hepatobiliary or pancreas O.R. procedures	3.2519	10.8	4.0085	5.0
202	Cirrhosis & alcoholic hepatitis	1.9334	7.9	1.4910	5.5
203	Malignancy of hepatobiliary system or pancreas	1.9617	8.7	1.4393	6.0
204	Disorders of pancreas except malignancy	1.4828	7.0	1.0976	5.1
205	Disorders of liver except malig,cirr,alc hepa w cc	1.9724	8.7	1.1830	4.9
206	Disorders of liver except malig,cirr,alc hepa w/o cc	1.1996	5.9	0.8696	4.2
207	Disorders of the biliary tract w cc	1.4316	5.9	0.8425	3.1
208	Disorders of the biliary tract w/o cc	0.8155	3.5	0.6508	2.6
209	Maj joint & limb reattach proc of low ext exc for complications	3.8776	9.2	2.8273	5.3
210	Hip & femur procedures except major joint age >17 w cc	2.7599	10.0	2.3128	6.9
211	Hip & femur procedures except major joint age >17 w/o cc	2.1047	7.2	1.8031	4.6
212	Hip & femur procedures except major joint age <18	1.8863	6.9	1.7708	5.2
213	Amputation for musculoskelet system & conn tissue disorders	3.5794	21.4	2.5048	9.4
216	Biopsies of musculoskeletal system & connective tissue	2.5355	7.5	2.2624	10.4
217	Wnd debrid & skin grft exc opn wnd,for ms & conn tis dis,exc hand	3.8381	13.7	3.0599	9.0
218	Lower extrem & humer proc exc hip,foot,femur age >17 w cc	2.0852	6.4	2.0506	6.1
219	Lower extrem & humer proc exc hip,foot,femur age >17 w/o cc	1.4250	4.2	1.3910	2.9
220	Lower extrem & humer proc exc hip,foot,femur age <18	1.1850	3.1	1.0132	2.0
221	Knee procedures w cc	2.2441	5.3	2.0645	4.5
222	Knee procedures w/o cc	1.4159	4.0	1.6893	2.7
223	Major shoulder/elbow proc, or oth upper extremity proc w cc	1.2187	3.0	1.1919	2.7

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
224	Shoulder,elbow or forearm proc,exc major joint proc, w/o cc	1.1099	2.9	1.0460	2.1
225	Foot procedures	1.2718	3.7	1.2487	3.2
226	Soft tissue procedures w cc	1.9190	6.5	1.8422	9.0
227	Soft tissue procedures w/o cc	1.0384	3.2	1.1299	2.6
228	Major thumb or joint proc,or oth hand or wrist proc w cc	1.1351	2.6	1.4294	2.3
229	Hand or wrist proc, except major joint proc, w/o cc	0.9656	2.1	1.1156	2.3
230	Local excision & removal of int fix devices of hip & femur	1.0026	3.6	1.4797	5.3
231	Local excision & removal of int fix devices exc hip & femur	1.3246	3.6	1.3899	3.6
232	Arthroscopy	1.1477	2.2	1.3776	3.0
233	Other musculoskelet sys & conn tiss O.R. proc w cc	3.2530	8.2	3.3134	5.0
234	Other musculoskelet sys & conn tiss O.R. proc w/o cc	2.4298	5.4	2.8027	4.5
235	Fractures of femur	1.6355	10.1	1.5804	5.2
236	Fractures of hip & pelvis	1.3988	7.5	0.9353	4.4
237	Sprains, strains, & dislocations of hip, pelvis & thigh	0.8348	3.5	0.8337	3.4
238	Osteomyelitis	1.8737	10.5	1.7890	6.9
239	Pathological fractures & muscskelet & conn tiss malignancy	1.7561	7.9	1.0692	4.7
240	Connective tissue disorders w cc	1.6166	7.0	1.1954	5.2
241	Connective tissue disorders w/o cc	1.5252	6.6	0.9676	3.6
242	Septic arthritis	1.5821	8.3	1.1834	2.8
243	Medical back problems	0.8154	4.1	0.8964	4.3
244	Bone diseases & specific arthropathies w cc	1.4049	6.3	0.9897	4.3
245	Bone diseases & specific arthropathies w/o cc	1.0513	4.8	0.7215	2.9
246	Non-specific arthropathies	0.9880	4.6	0.7621	4.4
247	Signs & symptoms of musculoskeletal system & conn tissue	0.6800	3.3	0.6952	2.9
248	Tendonitis, myositis & bursitis	0.7575	3.9	0.8143	4.5

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
249	Aftercare, musculoskeletal system & connective tissue	0.5976	2.6	0.9069	3.6
250	Fx, sprn,strn & disl of forearm, hand, foot age >17 w cc	0.9782	3.9	0.9698	4.4
251	Fx, sprn,strn & disl of forearm, hand, foot age >17 w/o cc	0.6403	2.5	0.7094	3.3
252	Fx, sprn,strn & disl of forearm, hand, foot age <18	0.5003	1.6	0.4700	1.2
253	Fx, sprn,strn & disl of uparm,lowleg ex foot age >17 w cc	0.3883	5.3	1.0358	2.3
254	Fx, sprn,strn & disl of uparm,lowleg ex foot age >17 w/o cc	0.7713	3.6	0.7070	3.3
255	Fx, sprn,strn & disl of uparm,lowleg ex foot age <18	0.6529	2.9	0.5168	1.9
256	Other musculoskeletal system & connective tissue diagnoses	1.0133	4.4	0.9287	5.0
257	Total mastectomy for malignancy w cc	1.3718	4.9	0.9678	2.6
258	Total mastectomy for malignancy w/o cc	1.1148	3.9	1.0722	2.8
259	Subtotal mastectomy for malignancy w cc	1.3482	2.9	1.4043	2.0
260	Subtotal mastectomy for malignancy w/o cc	0.7889	2.4	1.1880	3.5
261	Breast proc for non-malignancy except biopsy & local excision	1.3497	3.1	1.2634	2.6
262	Breast biopsy & local excision for non-malignancy	0.8422	2.0	1.2331	6.3
263	Skin graft &/or debrid for skn ulcer,cellulitis w cc	4.6826	22.0	3.2073	12.1
264	Skin graft &/or debrid for skn ulcer,cellulitis w/o cc	3.9477	17.1	1.8783	6.3
265	Skin graft &/or debrid exc for skin ulcer, cellulitis w cc	2.7136	7.5	2.2204	8.3
266	Skin graft &/or debrid exc for skin ulcer, cellulitis w/o cc	1.6928	6.2	1.5037	5.9
267	Perianal & pilonidal procedures	0.6329	1.8	0.7217	2.4
268	Skin, subcutaneous tissue & breast plastic procedures	0.9191	2.2	1.2934	4.5
269	Other skin, subcut tiss & breast proc w cc	1.5135	6.3	2.0332	7.7

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
270	Other skin, subcut tiss & breast proc w/o cc	1.2880	4.8	1.0097	3.3
271	Skin ulcers	2.5851	12.7	1.0796	4.9
272	Major skin disorders w cc	2.0077	9.1	1.3014	2.8
273	Major skin disorders w/o cc	0.6963	3.6	0.8420	3.3
274	Malignant breast disorders w cc	2.7351	13.4	1.5652	6.1
275	Malignant breast disorders w/o cc	0.9646	7.8	1.2930	3.7
276	Non-maligant breast disorders	0.8679	4.1	0.7390	3.8
277	Cellulitis age >17 w cc	1.2938	6.6	1.1602	5.5
278	Cellulitis age >17 w/o cc	1.1149	5.8	0.8659	4.4
279	Cellulitis age <18	0.6570	3.7	0.6391	3.2
280	Trauma to the skin, subcut tiss & breast age >17 w cc	0.8189	3.4	0.9168	3.9
281	Trauma to the skin, subcut tiss & breast age >17 w/o cc	0.6720	2.8	0.5541	1.8
282	Trauma to the skin, subcut tiss & breast age <18	0.4858	2.0	0.4184	1.8
283	Minor skin disorders w cc	0.9979	5.6	0.9857	3.9
284	Minor skin disorders w/o cc	0.6451	3.5	0.5437	2.4
285	Amputat of low limb for endocrine,nutrit,& metabol disorders	3.2729	14.0	3.5470	12.3
286	Adrenal & pituitary procedures	3.4690	8.9	3.7075	7.6
287	Skin graft & wound debrid for endoc,nutrit & metab disorders	2.7509	12.9	2.8066	12.6
288	O.R. procedures for obesity	1.6716	5.0	2.5685	5.5
289	Parathyroid procedures	1.1248	2.4	1.3290	3.5
290	Thyroid procedures	1.2741	3.3	1.0212	2.3
291	Thyroglossal procedures	0.5581	1.1	0.9289	1.0
292	Other endocrine, nutrit & metab O.R. proc w cc	4.0683	14.9	3.0976	3.8
293	Other endocrine, nutrit & metab O.R. proc w/o cc	2.2760	9.8	1.6604	2.5
294	Diabetes age >35	1.0673	5.8	0.8250	3.9
295	Diabetes age <36	0.8908	4.4	0.7744	3.3

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
296	Nutritional & misc metabolic disorders age >17 w cc	1.3067	6.1	0.9952	4.4
297	Nutritional & misc metabolic disorders age >17 w/o cc	0.9000	4.5	0.6115	3.0
298	Nutritional & misc metabolic disorders age <18	0.6515	3.8	0.4889	2.6
299	Inborn errors of metabolism	1.1754	6.7	0.9619	2.5
300	Endocrine disorders w cc	1.2613	4.9	1.3131	4.2
301	Endocrine disorders w/o cc	0.9691	4.8	0.8110	3.9
302	Kidney transplant	13.0635	15.6	11.9237	9.0
303	Kidney,ureter & maj bladder proc for neoplasm	3.1130	9.2	2.9698	7.6
304	Kidney,ureter & maj bladder proc for non-neoplasm w cc	3.1045	9.0	2.3212	6.4
305	Kidney,ureter & maj bladder proc for non-neoplasm w/o cc	2.6609	7.5	1.6217	3.8
306	Prostatectomy w cc	1.7727	8.0	1.8195	8.0
307	Prostatectomy w/o cc	1.0978	3.2	1.1861	3.7
308	Minor bladder procedures w cc	2.5114	6.8	2.0393	7.9
309	Minor bladder procedures w/o cc	1.8578	3.6	1.3463	1.0
310	Transurethral procedures w cc	1.3810	4.5	1.5046	3.8
311	Transurethral procedures w/o cc	1.1572	3.8	0.9935	2.6
312	Urethral procedures age >17 w cc	1.3074	6.7	1.7259	3.0
313	Urethral procedures age >17 w/o cc	0.7071	3.3	1.1566	2.8
314	Urethral procedures age <18	1.5127	4.0	1.0569	7.0
315	Other kidney & urinary tract O.R. procedures	2.7355	8.5	2.8756	8.8
316	Renal failure	2.1678	8.1	1.5291	5.5
317	Admit for renal dialysis	0.3995	2.2	0.4410	2.7
318	Kidney & urinary tract neoplasms w cc	1.6953	7.3	1.3980	12.0
319	Kidney & urinary tract neoplasms w/o cc	0.8033	3.8	1.1417	3.0
320	Kidney & urinary tract infections age >17 w cc	1.2829	6.3	0.9110	4.2
321	Kidney & urinary tract infections age >17 w/o cc	0.8180	4.3	0.6977	3.2
322	Kidney & urinary tract infections age <18	0.6746	3.6	0.6378	3.1

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
323	Urinary stones w cc, &/or esw lithotripsy	1.1757	4.6	0.7055	2.4
324	Urinary stones w/o cc	0.7064	3.0	0.5670	2.0
325	Kidney & urinary tract signs & symptoms age >17 w cc	0.8748	4.9	0.8865	5.2
326	Kidney & urinary tract signs & symptoms age >17 w/o cc	0.7759	4.5	0.6496	3.2
327	Kidney & urinary tract signs & symptoms age <18	0.5790	2.7	0.7288	3.4
328	Urethral stricture age >17 w cc	0.8538	5.6	1.3173	4.3
329	Urethral stricture age >17 w/o cc	0.7748	3.3	0.8204	2.3
330	Urethral stricture age <18	0.8519	4.5	0.8325	3.0
331	Other kidney & urinary tract diagnoses age >17 w cc	1.7125	7.5	1.2112	5.2
332	Other kidney & urinary tract diagnoses age >17 w/o cc	1.2784	5.3	0.9019	3.1
333	Other kidney & urinary tract diagnoses age <18	0.8296	4.3	1.0200	4.4
334	Major male pelvic procedures w cc	3.1257	8.2	2.6254	6.5
335	Major male pelvic procedures w/o cc	2.7242	7.1	2.2568	5.7
336	Transurethral prostatectomy w cc	1.3359	6.6	0.8099	2.6
337	Transurethral prostatectomy w/o cc	0.9948	4.1	0.9752	3.0
338	Testes procedures, for malignancy	1.5624	4.3	1.4748	2.0
339	Testes procedures, non-malignancy age >17	0.7591	2.6	1.1618	3.7
340	Testes procedures, non-malignancy age <18	0.8218	1.7	0.8148	1.5
341	Penis procedures	1.1564	2.6	1.6604	3.8
342	Circumcision age >17	0.6333	2.6	0.7042	2.0
343	Circumcision age <18	0.5390	1.6	0.3615	2.0
344	Other male reproductive syst O.R. proc for malignancy	2.2994	5.0	1.6331	2.3
345	Other male reproductive syst O.R. proc except for malignancy	1.0046	4.3	1.2181	5.0
346	Malignancy, male reproductive system, w cc	1.8198	7.1	1.2476	6.4
347	Malignancy, male reproductive system, w/o cc	0.6523	3.9	0.8052	3.0
348	Benign prostatic hypertrophy w cc	1.5378	5.2	0.9919	4.0
349	Benign prostatic hypertrophy w/o cc	1.3049	3.8	0.6979	5.0

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
350	Inflammation of the male reproductive system	1.0987	4.6	0.8542	3.4
351	Sterilization, male	0.4320	2.6	0.2840	2.0
352	Other male reproductive system diagnoses	0.5339	2.6	0.3811	2.0
353	Pelvic evisceration,radical hysterect & radical vulvectomy	2.8480	8.0	1.8782	4.1
354	Uterine,adnexa proc for non-ovarian/adnexal malignancy w cc	2.1512	6.0	2.1034	3.3
355	Uterine,adnexa proc for non-ovarian/adnexal malignancy w/o cc	1.3484	4.6	1.1148	2.6
356	Female reproductive system reconstructive procedures	1.0444	4.0	0.8992	2.5
357	Uterine & adnexa proc for ovarian or adnexal malignancy	2.2625	7.5	2.9245	6.9
358	Uterine & adnexa proc for ca in situ & non-malignancy w cc	1.4052	4.8	1.2286	3.6
359	Uterine & adnexa proc for ca in situ & non-malignancy w/o cc	1.0888	3.8	0.9840	2.6
360	Vagina, cervix & vulva procedures	0.9178	3.3	0.8749	3.1
361	Laparoscopy & incisional tubal interruption	0.9658	3.3	0.9129	2.7
362	Endoscopic tubal interruption	0.4245	2.2	0.5248	9.0
363	D&C, conization & radio-implant, for malignancy	1.0335	3.4	0.9281	2.3
364	D&C, conization except for malignancy	0.9701	3.5	0.7690	2.6
365	Other female reproductive system O.R. procedures	1.5063	5.3	0.9480	2.4
366	Malignancy, female reproductive system, w cc	1.9966	8.5	1.4583	3.5
367	Malignancy, female reproductive system, w/o cc	1.0299	5.4	0.8124	1.7
368	Infections, female reproductive system	0.7083	3.6	0.6582	3.0
369	Menstrual & other female reproductive system disorders	0.6953	2.9	0.4920	2.3
370	Cesarean section w cc	1.2867	4.6	1.0622	3.3
371	Cesarean section w/o cc	1.0641	3.7	0.8811	2.6
372	Vaginal delivery w complicating diagnoses	0.7190	2.5	0.6084	1.8
373	Vaginal delivery w/o complicating diagnoses	0.5980	2.0	0.4804	1.3

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
374	Vaginal delivery w sterilization &/or D&C	0.8581	2.2	0.7458	1.5
375	Vaginal delivery w O.R. proc except steril &/or D&C	0.6424	2.1	0.5111	1.4
376	Postpartum & post abortion diagnoses w/o O.R. procedure	0.6505	3.0	0.5946	2.6
377	Postpartum & post abortion diagnoses w O.R. procedure	0.9944	3.1	1.0684	2.9
378	Ectopic pregnancy	1.0850	3.3	0.9114	2.1
379	Threatened abortion	0.5921	2.8	0.5437	2.4
380	Abortion w/o D&C	0.4465	1.5	0.4346	1.4
381	Abortion w D&C, aspiration curettage or hysterotomy	0.6276	1.6	0.6281	1.7
382	False labor	0.2946	1.3	0.2885	1.4
383	Other antepartum diagnoses w medical complications	0.4967	2.8	0.5174	2.5
384	Other antepartum diagnoses w/o medical complications	0.7108	2.8	0.4414	1.9
392	Splenectomy age >17	2.5057	8.9	3.2360	7.1
393	Splenectomy age <18	1.8249	4.8	2.4008	3.0
394	Other O.R. procedures of blood and blood forming organs	1.2215	5.0	1.6079	4.6
395	Red blood cell disorders age >17	1.3497	6.8	1.0345	4.9
397	Coagulation disorders	1.1308	4.5	0.8343	2.8
398	Reticuloendothelial & immunity disorders w cc	1.3930	6.1	1.2641	4.1
399	Reticuloendothelial & immunity disorders w/o cc	1.2047	5.2	0.9380	4.1
400	Lymphoma & leukemia w major O.R. procedure	3.0200	8.1	2.8655	5.9
401	Lymphoma & non-acute leukemia w other O.R. proc w cc	3.4217	12.8	3.3210	9.5
402	Lymphoma & non-acute leukemia w other O.R. proc w/o cc	1.9719	5.0	1.8897	6.8
403	Lymphoma & non-acute leukemia w cc	2.8142	9.7	2.1245	7.0
404	Lymphoma & non-acute leukemia w/o cc	1.8161	6.1	1.4128	4.6
406	Myeloprolif disord or poor diff neopl w maj O.R.proc w cc	5.2461	13.5	3.8595	12.2

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
407	Myeloprolif disord or poor diff neopl w maj O.R.proc w/o cc	2.2131	9.8	1.1745	3.2
408	Myeloprolif disord or poorly diff neopl w other O.R.proc	1.6770	6.1	2.2178	8.2
409	Radiotherapy	1.0485	5.1	1.1077	3.9
410	Chemotherapy	1.1528	3.7	1.0323	3.0
411	History of malignancy w/o endoscopy	0.7097	4.9	0.4657	2.0
412	History of malignancy w endoscopy	0.5280	2.5	0.4657	2.0
413	Other myeloprolif dis or poor diff neopl diag w cc	2.6125	10.0	1.6652	6.9
414	Other myeloprolif dis or poor diff neopl diag w/o cc	1.5578	7.1	1.2926	8.6
415	O.R. procedure for infectious & parasitic diseases	4.7229	18.0	2.6588	9.2
416	Septicemia age >17	2.0276	8.7	1.5240	6.4
417	Septicemia age <18	1.0761	5.4	0.8407	4.1
418	Postoperative & post-traumatic infections	1.0985	5.5	0.9895	4.5
419	Fever of unknown origin age >17 w cc	1.4419	6.6	1.3161	4.7
420	Fever of unknown origin age >17 w/o cc	1.0622	4.5	0.9365	5.8
421	Viral illness age >17	0.9386	4.1	0.7616	3.3
422	Viral illness & fever of unknown origin age <18	0.6629	3.3	0.5086	2.5
423	Other infectious & parasitic diseases diagnoses	1.3544	6.4	1.8080	4.8
424	O.R. procedure w principal diagnoses of mental illness	LOC	LOC	LOC	LOC
425	Acute adjust react & disturbance of psychosocial dysfunction	LOC	LOC	LOC	LOC
426	Depressive neuroses	LOC	LOC	LOC	LOC
427	Neuroses except depressive	LOC	LOC	LOC	LOC
428	Disorders of personality & impulse control	LOC	LOC	LOC	LOC
429	Organic disturbances & mental retardation	2.2275	17.2	1.5768	4.5
430	Psychoses	LOC	LOC	LOC	LOC
431	Childhood mental disorders	LOC	LOC	LOC	LOC
432	Other mental disorder diagnoses	LOC	LOC	LOC	LOC
439	Skin grafts for injuries	1.8965	10.8	2.5100	7.3

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
440	Wound debridements for injuries except open wounds	2.4174	8.9	2.4351	10.8
441	Hand procedures for injuries	1.7142	4.1	1.5877	26.0
442	Other O.R. procedures for injuries w cc	2.7405	7.9	2.5979	8.7
443	Other O.R. procedures for injuries w/o cc	2.0326	6.4	0.9763	2.8
444	Injuries to unspecified or multiple sites age >17 w cc	0.8598	4.3	0.9168	9.8
445	Injuries to unspecified or multiple sites age >17 w/o cc	0.8257	3.6	0.7654	2.6
446	Injuries to unspecified or multiple sites age <18	0.5908	2.7	0.5821	2.4
447	Allergic reactions age >17	0.7151	2.3	0.4712	2.1
448	Allergic reactions age <18	0.3635	2.0	0.3646	1.3
449	Poisoning & toxic effects of drugs age >17 w cc	1.1601	5.5	0.7376	2.7
450	Poisoning & toxic effects of drugs age >17 w/o cc	0.8665	3.8	0.5535	1.7
451	Poisoning & toxic effects of drugs age <18	0.4845	2.0	0.4439	1.6
452	Complications of treatment w cc	1.6678	6.2	1.1595	4.9
453	Complications of treatment w/o cc	1.2626	4.7	0.6963	2.1
454	Other injury, poisoning & toxic effect diagnosis w cc	1.9220	7.8	0.9862	3.0
455	Other injury, poisoning & toxic effect diagnosis w/o cc	0.4508	2.2	0.6818	2.2
456	Burns, transferred to another acute care facility	LOC	LOC	LOC	LOC
457	Extensive burns w/o O.R. procedure	LOC	LOC	LOC	LOC
458	Non-extensive burns w skin graft	LOC	LOC	LOC	LOC
459	Non-extensive burns w wound debridement or other O.R. proc	LOC	LOC	LOC	LOC
460	Non-extensive burns w/o O.R. procedure	1.4178	5.6	1.3921	5.3
461	O.R. proc w diagnoses of other contact w health services	1.6252	5.4	3.3559	6.1
462	Rehabilitation	LOC	LOC	LOC	LOC
463	Signs & symptoms w cc	1.1550	5.5	0.7946	3.33.3
464	Signs & symptoms w/o cc	0.8080	3.8	0.7747	2.52.5

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
465	Aftercare w history of malignancy as secondary diagnosis	0.3818	2.1	0.6801	3.0
466	Aftercare w/o history of malignancy as secondary diagnosis	0.6519	2.0	0.8639	1.5
467	Other factors influencing health status	0.8112	3.5	0.4703	1.5
468	Extensive O.R. procedure unrelated to principal diagnosis	4.5870	13.5	3.8705	10.8
469	Principal diagnosis invalid as discharge diagnosis	0.0000	0.0	0.0000	0.0
470	Ungroupable	0.0000	0.0	0.0000	0.0
471	Bilateral or multiple major joint procs of lower extremity	10.5666	14.6	6.5613	7.3
472	Extensive burns w O.R. procedure	LOC	LOC	LOC	LOC
475	Respiratory system diagnosis with ventilator support	4.3216	10.0	4.8454	11.8
476	Prostatic O.R. procedure unrelated to principal diagnosis	4.0705	13.9	3.2769	11.5
477	Non-extensive O.R. procedure unrelated to principal diagnosis	2.2535	8.4	2.3755	7.9
478	Other vascular procedures w cc	3.1349	8.8	3.4541	8.7
479	Other vascular procedures w/o cc	2.4628	6.2	1.6276	3.5
480	Liver transplant	33.2151	38.3	29.4300	21.4
481	Bone Marrow Transplant	35.6734	38.6	0.0000	0.0
482	Tracheostomy for face,mouth & neck diagnoses	6.2367	17.3	5.5569	15.8
483	Tracheostomy except for face,mouth & neck diagnoses	23.6684	48.7	20.9933	42.0
491	Major joint & limb reattachment procedures of upper extremity	2.2272	4.4	2.6432	3.7
493	Laparoscopic cholecystectomy w/o c.d.e w cc	1.7661	4.8	1.6477	4.3
494	Laparoscopic cholecystectomy w/o c.d.e w/o cc	1.2444	2.6	1.1865	2.5
530	Craniotomy w major cc	9.6766	17.3	9.7056	22.6
531	Nervous system procedures except craniotomy w major cc	4.7849	10.7	6.0063	15.4

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
532	TIA, precerebral occlusions, seizure & headache w major cc	1.4608	5.5	1.7883	5.9
533	Other nervous system disord except TIA, seizure & headache w majo	4.3419	15.2	3.6795	12.0
534	Eye procedures w major cc	2.1498	5.8	2.1462	10.3
535	Eye disorders w major cc	1.4461	6.7	1.8069	4.8
536	ENT & mouth procedures except major head & neck w major cc	2.4874	6.6	3.6856	11.0
537	ENT & mouth disorders w major cc	0.8014	4.0	0.0000	0.0
538	Major chest procedures w major cc	8.3375	21.1	7.7922	15.6
539	Respiratory procedures except major chest w major cc	5.7974	13.8	4.9767	12.8
540	Respiratory infections & inflammations w major cc	3.9176	16.6	2.3355	8.7
541	Respiratory disord except infections, bronchitis, asthma w major	2.4317	8.6	2.2158	7.7
542	Bronchitis & asthma w major cc	0.9040	4.4	1.0782	4.1
543	Circ disorders except AMI, endocarditis, CHF & arrhythmia w major	2.5637	9.2	2.4547	8.1
544	CHF & cardiac arrhythmia w major cc	2.5092	8.4	2.3388	7.1
545	Cardiac valve procedure w major cc	16.0763	19.9	15.6754	20.9
546	Coronary bypass w major cc	8.6692	14.8	9.7099	14.7
547	Other cardiothoracic procedures w major cc	16.5167	20.4	14.5157	29.0
548	Oth cardiac pacemaker implant/revision or AICD proc w major cc	8.3224	17.5	8.1438	13.2
549	Major cardiovascular procedures w major cc	10.2458	16.0	5.8158	11.9
550	Other vascular procedures w major cc	5.1406	13.5	4.6557	10.6
551	Esophagitis, gastroenteritis & uncomplicated ulcers w major cc	1.1928	5.7	1.2994	5.2
552	Digest syst disord except esoph,gastroent & uncompl ulcers w majo	2.5353	9.4	2.3316	8.0
553	Digest syst proc exc hernia & major stomach or bowel proc w major	3.8706	11.2	3.1184	8.7
554	Hernia procedures w major cc	2.4774	8.7	2.8750	8.5
555	Pancreas,liver & oth bil tract proc except liver transplnt w majo	9.6224	17.6	8.7989	21.9

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
556	Cholecystectomy and other hepatobiliary procedures w major cc	3.7797	10.1	4.6153	12.3
557	Hepatobiliary and pancreas disorders w major cc	2.6063	10.3	2.8963	9.5
558	Major musculoskelet procs except bilat or mult major joint w majo	4.6712	14.6	4.8189	12.6
559	Non-major musculoskeletal procedures w major cc	3.7824	11.7	4.0069	9.5
560	Musculoskel disord exc osteo,septic arth & conn tissue dis w majo	2.6708	7.2	1.1855	4.8
561	Osteomyelitis, septic arthritis & conn tissue disorder w major cc	5.9884	20.0	3.1786	10.5
562	Major skin & breast disorders w major cc	4.2398	12.3	2.4611	7.1
563	Other skin disorders w major cc	1.7732	7.0	1.3220	5.5
564	Skin & breast procedures w major cc	5.7195	18.5	4.6270	16.9
565	Endocrine, nutrit & metab proc except lower limb amputat w major	5.0345	15.6	2.9942	8.2
566	Endocrine, nutrit & metab disord exc eating disorder or CF w majo	1.9220	8.2	1.5383	6.0
567	Kidney & urinary tract procedures except kidney transplant w majo	6.2634	14.1	5.5856	13.7
568	Renal failure w major cc	4.5478	20.0	3.5397	10.3
569	Kidney & urinary tract disorders except renal failure w major cc	1.4765	6.6	1.6339	6.6
570	Male reproductive disorders w major cc	2.7976	9.2	1.9794	5.2
571	Male reproductive procedures w major cc	4.3149	15.7	2.9113	12.5
572	Female reproductive disorders w major cc	2.6643	11.8	2.1958	10.2
573	Non-radical female reproductive procedures w major cc	1.9109	6.5	2.4919	6.4
574	Blood, blood forming organs & immunological disorders w major cc	1.9516	8.7	1.8294	6.8
575	Blood, blood forming organs & immunological procedures w major cc	4.8312	11.9	6.7615	18.0
576	Acute leukemia w major cc	12.3205	30.5	9.6627	17.5
577	Myeloprolif disorders & poorly differentiated neoplasms w major c	5.6998	15.6	4.2379	17.8

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
578	Lymphoma & non-acute leukemia w major cc	6.3196	18.3	2.9909	9.4
579	Procedures for lymphoma, leukemia, myeloprolif disorders w major	11.7915	25.6	9.0972	26.1
580	Systemic infections & parasitic disord except septicemia w major	1.8655	7.7	1.9685	6.9
581	Systemic infections & parasitic disorder procedures w major cc	6.9612	20.9	7.4582	18.6
582	Injuries except multiple trauma w major cc	2.0798	6.5	2.1647	6.0
583	Procedures for injuries except multiple trauma w major cc	6.7675	21.6	5.6124	18.6
584	Septicemia w major cc	2.1239	8.5	2.4709	8.7
585	Major stomach,esophageal,duodenal,small & large	7.1986	19.2	7.0711	18.2
586	ENT & mouth disorders age >17 w major cc	0.0000	0.0	2.0849	4.0
587	ENT & mouth disorders age <18 w major cc	0.0000	0.0	1.3148	3.1
602	Neonate, birthwt <750g, discharged alive	47.6538	123.2	30.2576	87.3
603	Neonate, birthwt <750g, died	15.6682	36.4	11.2833	17.2
604	Neonate, birthwt 750-999g, discharged alive	25.7203	75.4	25.9043	79.3
605	Neonate, birthwt 750-999g, died	24.3020	40.6	6.8087	12.0
606	Neonate, birthwt 1000-1499g, w signif or proc, discharged alive	29.2753	89.6	21.7385	87.1
607	Neonate, birthwt 1000-1499g, w/o signif or proc, discharged alive	11.1921	40.3	10.9390	37.8
608	Neonate, birthwt 1000-1499g, died	11.4916	22.3	10.7831	41.6
609	Neonate, birthwt 1500-1999g, w signif or proc, w mult major prob	23.9968	84.0	21.9366	69.3
610	Neonate, birthwt 1500-1999g, w signif or proc, w/o mult major pro	16.4020	23.8	3.5944	24.5
611	Neonate, birthwt 1500-1999g, w/o signif or proc, w mult major pro	9.3797	40.6	7.0074	25.7
612	Neonate, birthwt 1500-1999g, w/o signif or proc, w major prob	6.4615	25.6	5.1921	21.5
613	Neonate, birthwt 1500-1999g, w/o signif or proc, w minor prob	4.6067	28.0	4.2466	17.0
614	Neonate, birthwt 1500-1999g, w/o signif or proc, w other prob	3.5375	16.3	2.2738	10.5

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
615	Neonate, birthwt 2000-2499g, w signif or proc, w mult major prob	21.9410	74.2	14.7956	36.9
616	Neonate, birthwt 2000-2499g, w signif or proc, w/o mult major pro	4.5767	21.0	3.5309	16.2
617	Neonate, birthwt 2000-2499g, w/o signif or proc, w mult major pro	5.2197	22.4	4.2637	16.3
618	Neonate, birthwt 2000-2499g, w/o signif or proc, w major prob	3.9090	14.5	2.8077	11.4
619	Neonate, birthwt 2000-2499g, w/o signif or proc, w minor prob	1.2250	5.4	1.9818	8.2
620	Neonate, bwt 2000-2499g, w/o signif or proc, w norm newborn diag	0.9961	5.5	0.5200	3.0
621	Neonate, birthwt 2000-2499g, w/o signif or proc, w other prob	1.5248	9.8	1.7535	7.7
622	Neonate, birthwt >2499g, w signif or proc, w mult major prob	14.6539	31.8	9.4408	23.2
623	Neonate, birthwt >2499g, w signif or proc, w/o mult major prob	9.8441	26.6	2.2009	10.5
624	Neonate, birthwt >2499g, w minor abdom procedure	1.5785	5.6	0.9420	3.1
626	Neonate, birthwt >2499g, w/o signif or proc, w mult major prob	4.7435	13.4	2.6448	9.2
627	Neonate, birthwt >2499g, w/o signif or proc, w major prob	2.5111	9.6	1.1010	4.7
628	Neonate, birthwt >2499g, w/o signif or proc, w minor prob	0.9167	4.6	0.7046	3.3
629	Neonate, bwt >2499g, w/o signif or proc, w normal newborn diag	0.2805	2.5	0.2244	1.5
630	Neonate, birthwt >2499g, w/o signif or proc, w other prob	1.0338	5.2	0.7405	3.7
631	Bpd and oth chronic respiratory diseases arising in perinatal per	2.2857	7.6	1.4548	5.8
633	Multiple, other and unspecified congenital anomalies, w cc	2.2329	11.3	2.0907	6.0
634	Multiple, other and unspecified congenital anomalies, w/o cc	1.8705	7.0	2.0907	9.0
635	Neonatal aftercare for weight gain	0.9611	9.5	1.6133	8.2

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
636	Infant aftercare for weight gain, age >28 days <1 year	1.8264	8.2	2.2631	18.0
637	Neonate, died w/in one day of birth, born here	0.5699	0.5	1.0163	1.0
638	Neonate, died w/in one day of birth, not born here	0.8442	0.5	2.0338	1.0
639	Neonate, transferred <5 days old, born here	0.3357	1.0	0.3390	1.3
640	Neonate, transferred <5 days old, not born here	0.3332	2.8	0.8898	2.1
641	Neonate, birthweight >2499g, w ecmo	18.7408	22.4	13.5752	19.2
650	High risk cesarean section w cc	1.6105	6.0	1.3928	4.5
651	High risk cesarean section w/o cc	1.3050	4.8	1.0962	3.5
652	High risk vaginal delivery w sterilization and/or D&C	0.9317	2.5	0.9008	2.1
700	Tracheostomy for hiv infection	22.7064	68.1	21.2831	42.0
701	HIV w o.r procedure & ventilator or nutritional support	10.0224	33.3	11.4546	18.3
702	HIV w o.r procedure w multiple major related infections	11.1409	62.3	10.5351	3.0
703	HIV w o.r procedure w major related diagnosis	6.6578	28.9	4.9194	14.6
704	HIV w o.r procedure w/o major related diagnosis	3.0314	11.8	3.9423	17.3
705	HIV w multiple major related infections w TB	7.2976	32.3	7.1882	7.5
706	HIV w multiple major related infections w/o TB	7.1859	26.5	3.1862	9.7
707	HIV w ventilator or nutritional support	7.3311	21.9	7.2096	19.0
708	HIV w major related diagnosis, discharged ama	2.5784	17.3	2.5395	5.6
709	HIV w major related diag w mult major or signif diag w TB	4.3665	26.5	4.2991	13.4
710	HIV w major related diag w mult major or signif diag w/o TB	4.0429	24.2	1.9818	7.6
711	HIV w major related diag w/o mult major or signif diag w TB	3.3345	14.9	2.8437	12.0
712	HIV w major related diag w/o mult major or signif diag w/o TB	3.1692	11.8	0.9198	3.6
713	HIV w significant related diagnosis, discharged ama	1.7677	10.4	1.2914	8.3

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
714	HIV w significant related diagnosis	2.0980	8.6	1.5530	6.0
715	HIV w other related diagnosis	1.3651	5.6	0.7295	3.4
716	HIV w/o other related diagnosis	0.6636	5.8	0.4823	3.2
730	Craniotomy for multiple significant trauma	21.1682	47.5	9.1065	35.5
731	Spine, hip, femur or limb proc for multiple significant trauma	8.2164	16.0	8.2091	22.1
732	Other O.R. procedure for multiple significant trauma	5.7812	14.8	5.1601	12.2
733	Head, chest and lower limb diagnoses of multiple significant trau	2.8552	7.4	2.7372	7.4
734	Other diagnoses of multiple significant trauma	2.1615	10.1	1.9992	7.8
737	Ventricular shunt revision age <18	1.5891	3.6	1.2734	2.5
738	Craniotomy age <18 w cc	2.4581	5.3	4.8049	11.0
739	Craniotomy age <18 w/o cc	3.2321	8.3	3.9513	4.4
740	Cystic fibrosis	2.5240	9.5	2.1812	7.9
743	Opioid abuse or dependence, left against medical advice	0.6874	5.8	0.5372	2.9
744	Opioid abuse or dependence w cc	2.0719	15.3	0.6728	4.8
745	Opioid abuse or dependence w/o cc	1.8197	13.8	0.7349	5.5
746	Cocaine or other drug abuse or dependence, left against medical a	1.0523	7.3	0.5240	3.2
747	Cocaine or other drug abuse or dependence w cc	1.9833	14.0	0.7884	5.2
748	Cocaine or other drug abuse or dependence w/o cc	1.8393	14.4	0.7476	5.4
749	Alcohol abuse or dependence, left against medical advice	0.7743	5.5	0.3979	2.4
750	Alcohol abuse or dependence, w cc	1.6113	11.0	0.9411	5.4
751	Alcohol abuse or dependence, w/o cc	1.2790	11.1	0.6354	4.4
752	Lead poisoning	0.6789	3.8	1.1984	5.5
753	Compulsive nutrition disorder rehabilitation	2.9891	22.8	2.5685	9.6
754	Tertiary aftercare, age =>1 year	1.9714	9.3	2.0165	4.5
755	Spinal fusion w cc	4.7673	10.9	3.1295	5.5
756	Spinal fusion w/o cc	2.5714	6.6	2.8036	3.5

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
757	Back & neck procedures except spinal fusion w cc	2.1782	6.9	2.2238	5.6
758	Back & neck procedures except spinal fusion w/o cc	1.6840	5.2	1.1687	2.6
759	Multiple channel cochlear implants	6.2332	3.6	9.7107	2.0
760	Hemophilia factors VIII and IX	1.2694	4.0	1.8348	4.5
761	Traumatic stupor & coma, coma >1 hr	1.4643	4.7	1.8904	13.3
762	Concussion, intracranial injury w coma <1 hr or no coma age <18	0.4987	1.8	0.4887	1.8
763	Traumatic stupor & coma, coma <1 hr age <18	0.7391	3.0	0.7203	2.5
764	Concussion, intracranial injury w coma <1 hr or no coma age >17 w	1.1336	5.2	1.0362	2.8
765	Concussion, intracranial injury w coma <1 hr or no coma age >17 w	0.4610	2.1	0.7158	3.2
766	Traumatic stupor & coma, coma <1 hr age >17 w cc	1.8374	6.1	1.7682	6.4
767	Traumatic stupor & coma, coma <1 hr age >17 w/o cc	1.1805	3.9	1.1483	4.0
768	Seizure & headache age <18 w cc	1.0174	3.9	0.6660	2.6
769	Seizure & headache age <18 w/o cc	0.6474	2.9	0.5119	2.1
770	Respiratory infections & inflammations age <18 w cc	2.2589	8.0	1.4509	5.8
771	Respiratory infections & inflammations age <18 w/o cc	1.7866	7.1	0.8050	3.8
772	Simple pneumonia & pleurisy age <18 w cc	0.8760	4.4	0.7837	3.4
773	Simple pneumonia & pleurisy age <18 w/o cc	0.7234	3.9	0.6561	3.2
774	Bronchitis & asthma age <18 w cc	0.8661	4.3	0.7989	3.6
775	Bronchitis & asthma age <18 w/o cc	0.6619	3.4	0.5597	2.7
776	Esophagitis, gastroent & misc digest disord age <18 w cc	0.7141	3.7	0.5551	2.9
777	Esophagitis, gastroent & misc digest disord age <18 w/o cc	0.4811	2.8	0.3949	2.3
778	Other digestive system diagnoses age <18 w cc	0.8389	3.3	0.9200	4.6
779	Other digestive system diagnoses age <18 w/o cc	0.6095	2.6	0.5458	1.7

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
780	Acute leukemia w/o major O.R. procedure age <18 w cc	4.5569	17.2	4.5790	13.8
781	Acute leukemia w/o major O.R. procedure age <18 w/o cc	2.6500	6.1	3.0638	5.3
782	Acute leukemia w/o major O.R. procedure age >17 w cc	9.8134	38.0	4.3454	13.4
783	Acute leukemia w/o major O.R. procedure age >17 w/o cc	4.0655	18.4	2.1404	1.0
784	Acquired hemolytic anemia or sickle cell crisis age <18	0.8027	4.2	0.6723	3.5
785	Other red blood cell disorders age <18	0.8407	3.8	1.5481	3.1
786	Major head & neck procedures for malignancy	5.2866	14.7	4.3886	13.3
787	Laparoscopic cholecystectomy w c.d.e	1.3788	1.2	1.2336	2.4
789	Maj joint & limb reattach proc of low ext for complications	4.2590	8.9	3.4699	4.5
790	Wound debrid & skin grft for open wnd,ms & conn tiss dis,exc hand	1.4806	4.2	1.5535	2.8
791	Wound debridements for open wound injuries	1.5835	7.1	1.1703	3.1
792	Craniotomy for multiple sig trauma with non-traumatic major cc	22.3482	47.3	16.3461	37.5
793	Proc for mul sig trauma exc craniotomy w non-traumatic major cc	11.7123	31.6	13.7299	29.7
794	Diag for multiple significant trauma with non-traumatic major cc	8.1758	30.4	6.3165	21.7
795	Lung transplant	52.3689	41.5	31.8235	18.5
796	Lower extremity revascularization w cc	5.1027	14.4	3.0398	7.3
797	Lower extremity revascularization w/o cc	3.0111	8.2	2.1168	4.3
798	Tuberculosis w operating room procedure	5.5427	20.4	5.5937	15.6
799	Tuberculosis, left against medical advice	2.2604	14.7	2.3246	4.0
800	Tuberculosis w cc	3.5319	21.5	3.4228	17.6
801	Tuberculosis w/o cc	2.4048	14.5	1.4818	25.4
802	Pneumocystosis	2.7613	17.0	2.7643	9.0
803	Allogeneic bone marrow transplant	0.0000	0.0	39.7190	46.1
804	Autologous bone marrow transplant	0.0000	0.0	13.7074	21.5
805	Simultaneous kidney/pancreas transplant	0.0000	0.0	20.6010	37.2

		Current		Admissions on or after 5/15/99	
DRG	**Description**	**DRG Weight**	**ALOS**	**DRG Weight**	**ALOS**
806	Combined anterior/posterior spinal fusion w cc	0.0000	0.0	6.8134	6.0
808	Percutaneous cardiovascular proc w AMI,heart failure or shock	0.0000	0.0	3.2175	5.1
809	Other cardiothoracic proc w pdx congenital anomaly	0.0000	0.0	6.4213	7.8

Note: Rates for the period prior to 5/15/99 may vary by time period. Please refer to Indiana Medical Assistance Program Updates for the appropriate rate and time period.

Appendix C: Outpatient Rates by Revenue Codes

Revenue Codes	Revenue Description	Current Rates	Rates on or after 5/15/99	Notes
250	Pharmacy - General Classification	$9.00	$10.12	*
251	Pharmacy - Generic Drugs	$9.00	$10.12	*
252	Pharmacy - Non-generic drugs	$9.00	$10.12	*
253	Pharmacy - Take Home Drugs	$0.00	$0.00	
255	Pharmacy - Drugs Incident to Radiology	$105.00	$118.04	*
257	Pharmacy - Non-prescription	$3.00	$3.37	*
258	Pharmacy - IV Solutions	$18.00	$20.23	*
259	Pharmacy - Other Pharmacy	$9.00	$10.12	*
260	IV Therapy - General Classification	$20.00	$20.00	@
261	IV Therapy - Infusion Pump	$45.00	$45.00	@
270	Med/Surg Suppl - General Classification	$10.00	$26.27	@
271	Med/Surg Suppl - Non Sterile Supply	$10.00	$22.23	@
272	Med/Surg Suppl - Sterile Supply	$10.00	$33.02	@
273	Med/Surg Suppl - Take Home Supplies	$10.00	$21.93	@
274	Med/Surg Suppl - Prosthetic/Orthotic Devices	$0.00	$0.00	*
275	Med/Surg Suppl - Pacemaker	$20.00	$22.48	@
276	Med/Surg Suppl - Intraocular Lens	$554.00	$554.00	@
277	Med/Surg Suppl - Oxygen-Take Home	$20.00	$20.00	@
278	Med/Surg Suppl - Other Implants	$54.00	$142.22	@
279	Med/Surg Suppl - Other Supplies/Devices	$6.00	$6.00	@
280	Oncology	CPT Code	CPT Code	
290	DME - General Classification	$31.00	$34.85	*
291	DME - Rental	$80.00	$89.93	*
292	DME - Purchase of new DME	$204.00	$229.33	*
299	DME - Other Equipment	$0.00	$0.00	
300	Lab - General Classification	Medicare	Medicare	
301	Lab - Chemistry	Medicare	Medicare	
302	Lab - Immunology	Medicare	Medicare	
303	Lab - Renal Patient (home)	Medicare	Medicare	
304	Lab - Non-Routine Dialysis	Medicare	Medicare	
305	Lab - Hematology	Medicare	Medicare	

Revenue Codes	Revenue Description	Current Rates	Rates on or after 5/15/99	Notes
306	Lab - Bacteriology and Microbiology	Medicare	Medicare	
307	Lab - Urology	Medicare	Medicare	
309	Lab - Other Laboratory	Medicare	Medicare	
310	Lab Path - General Classification	Medicare	Medicare	
311	Lab Path - Cytology	Medicare	Medicare	
312	Lab Path - Histology	Medicare	Medicare	
314	Lab Path - Biopsy	Medicare	Medicare	
319	Lab Path - Other	Medicare	Medicare	
320	Diagnostic X - Ray	CPT Code	CPT Code	
321	Diagnostic X - Angiogram	CPT Code	CPT Code	
322	Unknown Radiology Procedure	CPT Code	CPT Code	
323	Unknown Radiology Procedure	CPT Code	CPT Code	
324	Diagnostic X - Chest	CPT Code	CPT Code	
329	Diagnostic X - Other	CPT Code	CPT Code	
330	RX X - Ray	CPT Code	CPT Code	
331	Chemotherapy - Injection	CPT Code	CPT Code	
332	Chemotherapy - Oral	CPT Code	CPT Code	
333	Radiation RX	CPT Code	CPT Code	
335	Chemotherapy - IV	CPT Code	CPT Code	
339	Unknown	CPT Code	CPT Code	
340	Nuc Med - General Classification	CPT Code	CPT Code	
341	Nuc Med - Diagnostic	CPT Code	CPT Code	
342	Nuc Med - Therapeutic	CPT Code	CPT Code	
349	Nuc Med - Other	CPT Code	CPT Code	
350	CT Scan	CPT Code	CPT Code	
351	CT Scan - Head	CPT Code	CPT Code	
352	CT Scan - Body	CPT Code	CPT Code	
359	CT Scan - Other	CPT Code	CPT Code	
360	Operating Room General Classification	CPT Code	CPT Code	
361	Operating Room - Minor	CPT Code	CPT Code	
362	OR Services- Organ Transplant - Other than Kidney	CPT Code	CPT Code	
367	OR Services- Kidney Transplant	CPT Code	CPT Code	
369	Operating Room - Other	CPT Code	CPT Code	
370	Anest - General Classification	$64.00	$64.00	@

Revenue Codes	Revenue Description	Current Rates	Rates on or after 5/15/99	Notes
374	Anesthesia - Acupuncture	$0.00	$0.00	
379	Anesthesia - Other Anesthesia	$0.00	$0.00	
380	Blood - General Classification	$0.00	$0.00	
381	Blood - Packed Red Cells	$0.00	$0.00	
382	Blood - Whole Blood	$0.00	$0.00	
383	Blood - Plasma	$55.00	$55.00	@
384	Blood - Platelets	$450.00	$473.36	@
385	Blood - Leucocytes	$0.00	$0.00	
386	Blood - Other components	$111.00	$271.92	@
387	Blood - Other derivatives (Cryopricipi	$32.00	$49.59	@
389	Blood - Other Blood	$0.00	$0.00	
390	Blood Stor & Process - General Classification	$35.00	$75.63	@
391	Blood Stor & Process - Blood Administration	$55.00	$104.03	@
399	Blood - Other Blood Storage and Processing	$0.00	$0.00	
400	Image Service	CPT Code	CPT Code	
401	Mammography	CPT Code	CPT Code	
402	Ultrasound	CPT Code	CPT Code	
403	Unknown	CPT Code	CPT Code	
409	Other Imaging Services	CPT Code	CPT Code	
410	Respir Svcs - General Classification	$6.00	$6.74	*
412	Respir Svcs - Inhalation Services	$10.00	$11.24	*
413	Respir Svcs - Hyperbaric Oxygen Therapy	$166.00	$186.61	*
419	Respir Svcs - Other Respiratory Services	$23.00	$25.86	*
420	Phys Ther - General Classification	$45.00	$50.59	*
421	Phys Ther - Visit Charge	$45.00	$50.59	*
422	Phys Ther - Hourly Charge	$45.00	$50.59	*
423	Physical Therapy - Group Rate	$0.00	$0.00	*
424	Phys Ther - Evaluation or Re-evaluation	$45.00	$50.59	*
429	Phys Ther - Other Physical Therapy	$45.00	$50.59	*
430	Occup Ther - General Classification	$45.00	$50.59	*
431	Occup Ther - Visit Charge	$45.00	$50.59	*
432	Occup Ther - Hourly Charge	$45.00	$50.59	*
434	Occup Ther - Evaluation or re-evaluation	$45.00	$50.59	*
439	Physical Therapy - Other Physical Therapy	$0.00	$0.00	

Revenue Codes	Revenue Description	Current Rates	Rates on or after 5/15/99	Notes
440	Speech Path - General Classification	$45.00	$50.59	*
441	Speech Path - Visit Charge	$45.00	$50.59	*
442	Speech Path - Hourly Charge	$45.00	$50.59	*
443	Speech Path - Group Rate	$45.00	$50.59	*
444	Speech Path - Evaluation or re-evaluation	$45.00	$50.59	*
449	Speech-Language Pathology - Other	$0.00	$0.00	
460	Pulm Fcn - General Classification	$38.00	$38.49	@
469	Pulm Fcn - Other Pulmonary Function	$27.00	$71.77	@
470	Audiology - General Classification	$45.00	$50.59	*
471	Audiology - Diagnostic	$45.00	$50.59	*
472	Audiology - Treatment	$45.00	$50.59	*
479	Audiology - Other Audiology	$45.00	$50.59	*
480	Cardiology - General Classification	$176.00	$176.00	@
481	Cardiology - Cardiac Cath Lab	$210.00	$503.19	@
482	Cardiology - Stress Test	$129.00	$129.00	@
489	Cardiology - Other Cardiology	$214.00	$214.00	@
490	Ambulatory Surgical	CPT Code	CPT Code	
499	ASC - Other Ambulatory Surgical Care	CPT Code	CPT Code	
530	Osteopathic Svcs - General Classification	$0.00	$0.00	
531	Osteopathic Svcs - Osteopathic Therapy	$0.00	$0.00	
539	Osteopathic Svcs - Other Osteopathic Svcs	$0.00	$0.00	
541	Ambulance - Supplies	$0.00	$0.00	
551	Skilled Nursing/Visit (Home Health Only)	$0.00	$0.00	
552	Skilled Nursing/Hour (Home Health Only)	$0.00	$0.00	
602	Oxygen HHA - Oxygen--State/Equip/Suppl/under 1 LPM	$0.00	$0.00	
610	MRI	CPT Code	CPT Code	
611	MRI - Brain	CPT Code	CPT Code	
612	MRI - Spine	CPT Code	CPT Code	
619	MRI - Other	CPT Code	CPT Code	
621	Med/Surg Supplies - Supplies incident to radiology	$10.00	$11.24	*
622	Med/Surg Supplies - Supplies incident to other diag svcs	$10.00	$11.24	*
623	Med/Surg Supplies - Surgical Dressings	$0.00	$0.00	
636	Drugs requiring Specific ID - Drugs Requiring Detailed Co	$0.00	$0.00	
700	Cast Room - General Classification	$97.00	$109.04	*

Revenue Codes	Revenue Description	Current Rates	Rates on or after 5/15/99	Notes
709	Cast Room - Other Cast Room	$97.00	$109.04	@
710	Recov Room - General Classification	$97.00	$97.00	@
719	Recovery Room - Other Recovery Room	$97.00	$97.00	@
720	LDR - General Classification	$97.00	$133.68	@
721	LDR - Labor	$97.00	$146.09	@
722	LDR - Delivery	$0.00	$0.00	
723	LDR - Circumcision	$0.00	$0.00	
724	Labor Room/Delivery - Birthing Center	$0.00	$0.00	
729	LDR - Other Labor Room/Delivery	$0.00	$0.00	
730	EKG/ECG - General Classification	$37.00	$37.00	@
731	EKG/ECG - Holter monitor	$153.00	$153.00	@
732	EKG/ECG - Telemetry	$64.00	$64.00	@
739	EKG/ECG - Other EKG/ECG	$20.00	$22.48	@
740	EEG - General Classification	$108.00	$211.75	@
749	EEG - Other EEG	$428.00	$428.00	@
750	GI Svcs - General Classification	$37.00	$41.59	@
759	Gastro-Intestinal Services - Other Gastro-Intestinal	$37.00	$41.59	@
760	Trtmt/Obs Rm - General Classification	$97.00	$205.60	@
790	Lithortipsy - General Classification	$3,000.00	$3,000.00	@
799	Lithotripsy - Other Lithotripsy	$0.00	$0.00	@
800	Inpatient Renal Dialysis - General Classification	$0.00	$0.00	
801	Inpatient Renal Dialysis - Inpatient Hemodialysis	$0.00	$0.00	
802	Inpatient Renal Dialysis - Inpatient Peritoneal (non-CAPD)	$0.00	$0.00	
803	Inpatient Renal Dialysis - Inpatient Continuous Ambulatory	$0.00	$0.00	
804	Inpatient Renal Dialysis - Inaptient Continuous Cycling	$0.00	$0.00	
809	Inpatient Renal Dialysis - Other Inpatient Dialysis	$0.00	$0.00	
810	Organ Acquisition - General Classification	$0.00	$0.00	
811	Organ Acquistion - Living Donor\Kidney	$0.00	$0.00	
813	Organ Acquistion - Unknown Donor\Kidney	$0.00	$0.00	
814	Organ Acquistion - Other Kidney Acquisition	$0.00	$0.00	
815	Organ Acquistion - Cadaver Donor\Heart	$0.00	$0.00	
817	Organ Acquistion - Donor\Liver	$0.00	$0.00	
819	Organ Acquistion - Other Donor Acquisition	$0.00	$0.00	
820	Hemo Dial OP/Home - General Classification	$6.00	$6.74	*

Revenue Codes	Revenue Description	Current Rates	Rates on or after 5/15/99	Notes
821	Hemo Dial OP/Home - Hemodialysis/Composite or other rate	$98.00	$110.17	*
823	Hemodialysis - General Classification	$24.00	$26.98	*
824	Hemodialysis - Maintenance 100%	$0.00	$0.00	
825	Hemodialysis - Support Services	$101.00	$113.54	*
828	Hemo Dial Home / Supserv	$0.00	$0.00	
829	Hemo Dial OP/Home - Other Outpatient	$128.00	$143.89	*
830	Peritoneal Dialysis - General Classification	$254.00	$285.54	*
831	Peritoneal Dialysis - Peritoneal/Composite	$13.00	$14.61	*
832	Peritoneal Dialysis - Home Supplies	$0.00	$0.00	
833	Peritoneal Dialysis - Home Equipment	$0.00	$0.00	
834	Peritoneal Dialysis - Maintenance 100%	$0.00	$0.00	
835	Peritoneal Dialysis - Support Services	$0.00	$0.00	
839	Peritoneal Dialysis - Other Outpatient Services	$0.00	$0.00	
840	CAPD OP/Home - General Classification	$20.00	$22.48	*
841	CAPD OP/Home - CAPD/Composite or other Rate	$55.00	$61.83	*
842	CAPD OP/Home - Home Supplies	$17.00	$19.11	*
843	CAPD OP/Home - Home Equipment	$0.00	$0.00	
844	CAPD OP/Home - Maintenance 100%	$36.00	$40.47	*
845	CAPD OP/Home - Support Services	$63.00	$70.82	*
849	CAPD OP/Home - Other Outpatient CAPD	$140.00	$157.38	*
850	CCPD OP/Home - General Classification	$1.00	$1.12	*
851	CCPD OP/Home - CCPD/Composite or other Rate	$55.00	$61.83	*
852	CCPD OP/Home - Home Supplies	$0.00	$0.00	
853	CCPD OP/Home - Home Equipment	$0.00	$0.00	
854	CCPD OP/Home - Maintenance 100%	$0.00	$0.00	
855	CCPD OP/Home - Support Services	$13.00	$14.61	*
859	CCPD OP/Home - Other Outpatient CAPD	$0.00	$0.00	
890	Other Donor Bank - General Classification	$302.00	$339.50	*
891	Other Donor Bank - Bone	$21.00	$23.61	*
920	Other Diagnostic Services - General Classification	$0.00	$0.00	
921	Other Diagnostic Services - Peripheral Vascular Lab	$0.00	$0.00	
922	Other Diagnostic Services - Electromyelgram	$0.00	$0.00	
923	Other Diagnostic Services - Pap Smear	$0.00	$0.00	
924	Alleregy Test	$13.00	$14.61	*

Revenue Codes	Revenue Description	Current Rates	Rates on or after 5/15/99	Notes
925	Other Diagnostic Services - Pregnancy Test	CPT Code	CPT Code	*
926	Other Diagnostic Services - Other Diagnostic Service	$0.00	$0.00	
929	Other Diagnostic Services - Other Diagnostic Service	$0.00	$0.00	
943	Other Ther Svcs - Cardiac Rehabilitation	$58.00	$65.20	*
45e	ER - Emergent Treatments w/Diagnosis (SEE Note Below)	$46.00	$134.33	@
45n	ER - Non-Emergent Treatments (SEE Note Below)	$35.00	$39.35	*
45s	ER - Surgical Procedures (SEE Note Below)	CPT Code	CPT Code	
51e	Clinic - Emergent Treatments w/Diagnosis (SEE Note Below)	$46.00	$77.74	@
51n	Clinic - Non-Emergent Treatments (SEE Note Below)	$35.00	$39.35	
51s	Clinic - Surgeries (SEE Note Below)	CPT Code	CPT Code	
52e	Free Standing Clinic - Emergent Treatments w/Diagnosis (SEE Note Below)	$46.00	$98.37	@
52n	Free Standing Clinic - Non-Emergent Treatments (SEE Note Below)	$35.00	$39.35	*
52s	Free Standing Clinic - Surgeries (SEE Note Below)	CPT Code	CPT Code	

@ Reimbursed at or above 100% of adjusted aggregate provider cost

* Inflated using the Medicare market basket index for prospective payment systems

Note: For Emergency Room, Clinic, and Free Standing Clinic, please replace the last digit of the revenue code with the specific numeric digit that describes the service.

Appendix D: Outpatient Ambulatory Surgical

ASC Group	Group Description	Rates Current	On or After 5/15/99	Notes
1		$272.00	$337.08	@
2		$436.00	$469.08	@
3		$517.00	$517.00	@
4		$582.00	$616.91	@
5		$847.00	$847.00	@
6		$936.00	$1,142.68	@
7		$1,025.00	$1,073.87	@
8		$1,171.00	$1,171.00	@
A	Extensive	$219.00	$348.28	@
B	Complicated	$192.00	$283.50	@
C	Intermediate	$144.00	$175.87	@
D	Simple	$92.00	$103.42	*
E	Moderate	$69.00	$77.57	*
F	Minimal	$46.00	$51.71	*

@ Reimbursed at or above 100% of adjusted aggregate provider cost

* Inflated using the Medicare market basket index for prospective payment systems

Appendix E: Outpatient Radiology Rates

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
70010	Rad-Diag - General Classification	$117.61	$132.22	*
70015	Cisternography, Positive	$36.77	$41.35	*
70030	Rad-Diag - General Classification	$11.08	$12.47	*
70100	Rad-Diag - General Classification	$13.93	$15.67	*
70110	Rad-Diag - General Classification	$16.67	$18.75	*
70120	Radiologic Examination, M	$16.67	$18.75	*
70130	Rad-Diag - General Classification	$20.88	$23.48	*
70134	Radiologic Examination, I	$19.41	$21.83	*
70140	Rad-Diag - General Classification	$16.67	$18.75	*
70150	Rad-Diag - General Classification	$20.88	$23.48	*
70160	Rad-Diag - General Classification	$14.03	$15.78	*
70170	Dacryocystography, Nasola	$25.00	$28.12	*
70190	Rad-Diag - General Classification	$16.67	$18.75	*
70200	Rad-Diag - General Classification	$20.88	$23.48	*
70210	Rad-Diag - General Classification	$16.67	$18.75	*
70220	Rad-Diag - General Classification	$20.88	$52.67	@
70240	Rad-Diag - General Classification	$11.08	$12.47	*
70250	Rad-Diag - General Classification	$16.67	$42.68	@
70260	Rad-Diag - General Classification	$23.63	$26.58	*
70300	Rad-Diag - General Classification	$6.96	$7.84	*
70310	Radiologic Examination, T	$11.08	$12.47	*
70320	Rad-Diag - General Classification	$20.88	$23.48	*
70328	Rad-Diag - General Classification	$13.19	$14.84	*
70330	Rad-Diag - General Classification	$22.25	$25.02	*
70332	Temporomandibular Joint a	$55.58	$62.49	*
70336	Magnetic Resonance (Eg, P	$297.04	$333.93	*
70350	Rad-Diag - General Classification	$9.71	$10.93	*
70355	Rad-Diag - General Classification	$15.30	$17.21	*
70360	Rad-Diag - General Classification	$11.08	$12.47	*
70370	Rad-Diag - General Classification	$34.71	$39.03	*
70371	Rad-Diag - General Classification	$55.58	$62.49	*

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
70373	Laryngography, Contrast;	$47.25	$53.13	*
70380	Rad-Diag - General Classification	$18.04	$20.29	*
70390	Rad-Diag - General Classification	$47.25	$53.13	*
70450	CT Scan - Head Scan	$125.11	$125.12	@
70460	CT Scan - Head Scan	$150.08	$150.09	@
70470	CT Scan - Head Scan	$187.59	$187.60	@
70480	CT Scan - Head Scan	$125.11	$125.12	@
70481	CT Scan - Head Scan	$150.08	$150.09	@
70482	CT Scan - Head Scan	$187.59	$187.60	@
70486	CT Scan - Head Scan	$125.11	$125.12	@
70487	CT Scan - Head Scan	$150.08	$150.09	@
70488	CT Scan - Head Scan	$187.59	$187.60	@
70490	CT Scan - Body Scan	$125.11	$125.12	@
70491	CT Scan - Body Scan	$150.08	$150.09	@
70492	CT Scan - Head Scan	$187.59	$187.60	@
70540	MRI - General Classification	$297.04	$299.37	@
70541	Other Imaging Svcs - General Classification	$316.50	$316.51	@
70551	MRI - Brain (including Brainstem)	$297.04	$298.38	@
70552	MRI - Brain (including Brainstem)	$377.15	$377.16	@
70553	MRI - Brain (including Brainstem)	$676.29	$676.30	@
71010	Rad-Diag - Chest X-Ray	$12.89	$14.50	*
71015	Rad-Diag - General Classification	$16.20	$18.22	*
71020	Rad-Diag - Chest X-Ray	$16.67	$37.02	@
71021	Rad-Diag - Chest X-Ray	$19.41	$21.83	*
71022	Rad-Diag - Chest X-Ray	$19.41	$21.83	*
71023	Rad-Diag - General Classification	$20.88	$23.48	*
71030	Rad-Diag - General Classification	$20.88	$23.48	*
71034	Rad-Diag - Chest X-Ray	$38.19	$42.94	*
71035	Rad-Diag - Chest X-Ray	$13.93	$15.67	*
71036	Needle Biopsy of Intratho	$41.67	$46.85	*
71040	Rad-Diag - General Classification	$38.92	$43.76	*
71060	Bronchography, Bilateral;	$58.33	$65.58	*
71090	Insertion Pacemaker, Fluo	$44.51	$50.05	*

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
71100	Rad-Diag - Chest X-Ray	$15.35	$17.27	*
71101	Rad-Diag - General Classification	$18.04	$48.64	@
71110	Rad-Diag - General Classification	$20.88	$23.48	*
71111	Rad-Diag - General Classification	$23.63	$26.58	*
71120	Rad-Diag - General Classification	$17.40	$19.57	*
71130	Rad-Diag - General Classification	$18.77	$21.11	*
71250	CT Scan - Body Scan	$156.35	$156.36	@
71260	CT Scan - Body Scan	$187.59	$187.60	@
71270	CT Scan - Body Scan	$234.56	$234.57	@
71550	MRI - General Classification	$297.04	$297.05	@
71555	Magnetic Resonance Angiog	$316.50	$355.81	*
72010	Rad-Diag - General Classification	$27.10	$30.48	*
72020	Rad-Diag - General Classification	$11.08	$12.47	*
72040	Rad-Diag - General Classification	$16.03	$18.03	*
72050	Rad-Diag - General Classification	$23.64	$26.59	*
72052	Rad-Diag - General Classification	$29.85	$33.57	*
72069	Rad-Diag - General Classification	$17.40	$19.57	*
72070	Rad-Diag - General Classification	$17.43	$19.61	*
72072	Rad-Diag - General Classification	$19.41	$21.83	*
72074	Rad-Diag - General Classification	$24.36	$27.40	*
72080	Rad-Diag - General Classification	$18.04	$20.29	*
72090	Rad-Diag - General Classification	$18.04	$20.29	*
72100	Rad-Diag - General Classification	$18.07	$47.55	@
72110	Rad-Diag - General Classification	$24.36	$27.40	*
72114	Rad-Diag - General Classification	$31.23	$35.12	*
72120	Rad-Diag - General Classification	$23.63	$26.58	*
72125	CT Scan - Body Scan	$156.35	$156.36	@
72126	CT Scan - Body Scan	$187.59	$187.60	@
72127	CT Scan - General Classification	$234.56	$234.57	@
72128	CT Scan - Body Scan	$156.35	$156.36	@
72129	CT Scan - General Classification	$187.59	$187.60	@
72130	Without Contrast Material	$234.56	$263.70	*
72131	CT Scan - Body Scan	$156.35	$156.36	@

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
72132	MRI - Spinal Cord (including Spine)	$187.59	$187.60	@
72133	MRI - Spinal Cord (including Spine)	$234.56	$294.25	@
72141	MRI - Spinal Cord (including Spine)	$297.04	$308.73	@
72142	MRI - Spinal Cord (including Spine)	$376.98	$380.12	@
72146	MRI - Spinal Cord (including Spine)	$297.04	$318.21	@
72147	MRI - Spinal Cord (including Spine)	$376.98	$376.99	@
72148	MRI - Spinal Cord (including Spine)	$297.04	$316.54	@
72149	MRI - Spinal Cord (including Spine)	$377.15	$377.16	@
72156	MRI - Spinal Cord (including Spine)	$676.29	$676.30	@
72157	MRI - Spinal Cord (including Spine)	$676.29	$676.30	@
72158	MRI - Spinal Cord (including Spine)	$676.29	$676.30	@
72159	Magnetic Resonance Angiog	$351.29	$394.92	*
72170	Rad-Diag - General Classification	$13.99	$15.74	*
72190	Rad-Diag - General Classification	$18.04	$20.29	*
72192	CT Scan - Body Scan	$156.35	$156.36	@
72193	CT Scan - Body Scan	$181.40	$181.41	@
72194	CT Scan - Body Scan	$225.16	$225.17	@
72196	MRI - Spinal Cord (including Spine)	$297.04	$297.05	@
72198	MRI - General Classification	$316.50	$316.51	@
72200	Rad-Diag - General Classification	$13.93	$15.67	*
72202	Rad-Diag - General Classification	$16.67	$18.75	*
72220	Rad-Diag - General Classification	$15.30	$17.21	*
72240	Rad-Diag - General Classification	$128.83	$144.84	*
72255	Rad-Diag - General Classification	$117.63	$132.25	*
72265	Rad-Diag - General Classification	$110.49	$124.22	*
72270	Rad-Diag - General Classification	$165.52	$186.08	*
72285	Rad-Diag - Angiocardiography	$222.35	$249.96	*
72295	Rad-Diag - Angiocardiography	$208.43	$234.32	*
73000	Rad-Diag - General Classification	$13.93	$15.67	*
73010	Rad-Diag - General Classification	$13.93	$15.67	*
73020	Rad-Diag - General Classification	$12.54	$14.11	*
73030	Rad-Diag - General Classification	$15.31	$17.22	*
73040	Rad-Diag - General Classification	$55.58	$62.49	*

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
73050	Rad-Diag - General Classification	$18.04	$20.29	*
73060	Rad-Diag - General Classification	$15.32	$17.23	*
73070	Rad-Diag - General Classification	$13.93	$15.67	*
73080	Rad-Diag - General Classification	$15.33	$17.24	*
73085	Rad-Diag - General Classification	$55.58	$62.49	*
73090	Rad-Diag - General Classification	$14.09	$15.85	*
73092	Rad-Diag - General Classification	$13.19	$14.84	*
73100	Rad-Diag - General Classification	$13.19	$14.84	*
73110	Rad-Diag - General Classification	$14.59	$16.41	*
73115	Rad-Diag - General Classification	$41.67	$46.86	*
73120	Rad-Diag - General Classification	$13.20	$14.85	*
73130	Rad-Diag - General Classification	$14.58	$16.40	*
73140	Rad-Diag - General Classification	$11.09	$12.48	*
73200	CT Scan - General Classification	$131.38	$131.39	@
73201	CT Scan - Body Scan	$156.35	$156.36	@
73202	CT Scan - Body Scan	$196.98	$196.99	@
73220	MRI - General Classification	$297.04	$325.47	@
73221	MRI - General Classification	$297.04	$302.81	@
73225	MRI - General Classification	$316.50	$316.51	@
73500	Rad-Diag - General Classification	$12.70	$30.26	@
73510	Rad-Diag - General Classification	$15.30	$17.21	*
73520	Rad-Diag - General Classification	$18.04	$20.29	*
73525	Rad-Diag - General Classification	$55.58	$62.49	*
73530	Radiologic Examination, H	$13.93	$15.67	*
73540	Rad-Diag - General Classification	$15.30	$17.21	*
73550	Rad-Diag - General Classification	$15.36	$17.28	*
73560	Rad-Diag - General Classification	$13.94	$15.68	*
73562	Rad-Diag - General Classification	$15.30	$17.21	*
73564	Rad-Diag - General Classification	$16.67	$18.75	*
73565	Rad-Diag - General Classification	$18.14	$20.40	*
73580	Rad-Diag - General Classification	$69.51	$78.15	*
73590	Rad-Diag - General Classification	$13.94	$15.68	*
73592	Rad-Diag - General Classification	$13.19	$14.84	*

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
73600	Rad-Diag - General Classification	$13.20	$14.85	*
73610	Rad-Diag - General Classification	$14.57	$16.39	*
73615	Radiologic Examination, a	$55.58	$62.49	*
73620	Rad-Diag - General Classification	$13.19	$14.84	*
73630	Rad-Diag - General Classification	$14.58	$16.40	*
73650	Rad-Diag - General Classification	$12.54	$14.11	*
73660	Rad-Diag - General Classification	$11.08	$12.47	*
73700	CT Scan - Body Scan	$131.38	$131.39	@
73701	CT Scan - Body Scan	$156.35	$156.36	@
73702	CT Scan - General Classification	$196.98	$196.99	@
73720	MRI - General Classification	$297.04	$320.68	@
73721	MRI - General Classification	$297.04	$297.05	@
73725	MRI - General Classification	$316.50	$316.51	@
74000	Rad-Diag - General Classification	$13.97	$33.22	@
74010	Rad-Diag - General Classification	$15.30	$17.21	*
74020	Rad-Diag - General Classification	$16.70	$48.63	@
74022	Rad-Diag - General Classification	$19.41	$21.83	*
74150	CT Scan - Body Scan	$150.08	$150.09	@
74160	CT Scan - Body Scan	$181.40	$181.41	@
74170	CT Scan - Body Scan	$225.16	$225.17	@
74181	MRI - General Classification	$297.04	$340.80	@
74185	Rad-Diag - Angiocardiography	$316.50	$316.51	@
74190	Peritoneogram (E.g. after	$36.65	$41.21	*
74210	Rad-Diag - General Classification	$31.23	$35.12	*
74220	Rad-Diag - General Classification	$31.23	$35.12	*
74230	Rad-Diag - General Classification	$34.71	$39.03	*
74235	Removal of Foreign Body(s	$69.51	$78.15	*
74240	Rad-Diag - General Classification	$38.92	$43.76	*
74241	Rad-Diag - General Classification	$39.65	$71.78	@
74245	Rad-Diag - General Classification	$63.28	$71.15	*
74246	Rad-Diag - General Classification	$43.78	$49.23	*
74247	Rad-Diag - General Classification	$44.51	$50.05	*
74249	Rad-Diag - General Classification	$68.12	$76.59	*

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
74250	Rad-Diag - General Classification	$34.71	$39.03	*
74251	Rad-Diag - General Classification	$36.65	$41.21	*
74260	Rad-Diag - General Classification	$39.65	$44.58	*
74270	Rad-Diag - General Classification	$45.14	$50.76	*
74280	Rad-Diag - General Classification	$59.06	$66.40	*
74283	Rad-Diag - General Classification	$59.06	$123.03	@
74290	Rad-Diag - General Classification	$19.41	$21.83	*
74291	Rad-Diag - General Classification	$11.08	$12.47	*
74305	Rad-Diag - General Classification	$20.88	$23.48	*
74320	Rad-Diag - General Classification	$83.43	$93.80	*
74327	Postoperative Biliary Duc	$47.90	$53.86	*
74328	Rad-Diag - General Classification	$83.43	$93.80	*
74329	Rad-Diag - General Classification	$83.43	$93.80	*
74330	Rad-Diag - General Classification	$83.43	$93.80	*
74340	Rad-Diag - General Classification	$69.51	$78.15	*
74350	Rad-Diag - General Classification	$83.43	$93.80	*
74355	Rad-Diag - General Classification	$69.51	$78.15	*
74360	Intraluminal Dilation of	$83.43	$93.80	*
74363	Percutaneous Transhepatic	$83.43	$93.80	*
74400	Rad-Diag - General Classification	$44.51	$50.05	*
74410	Rad-Diag - General Classification	$51.47	$57.87	*
74415	Rad-Diag - General Classification	$56.32	$63.32	*
74420	Rad-Diag - General Classification	$69.51	$78.15	*
74425	Rad-Diag - General Classification	$34.71	$39.02	*
74430	Rad-Diag - General Classification	$27.84	$53.78	@
74440	Vasography, Vesiculograph	$29.85	$33.57	*
74445	Corpora Cavernosography;	$29.85	$33.57	*
74450	Rad-Diag - General Classification	$38.92	$43.75	*
74455	Rad-Diag - General Classification	$41.67	$96.38	@
74470	Radiologic Examination,re	$33.34	$37.48	*
74475	Rad-Diag - General Classification	$110.49	$124.22	*
74480	Rad-Diag - General Classification	$110.49	$124.21	*
74485	Rad-Diag - General Classification	$83.43	$93.80	*

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
74710	Rad-Diag - General Classification	$27.84	$31.31	*
74740	Rad-Diag - General Classification	$34.71	$39.03	*
74742	Transcervical Catherizati	$85.39	$96.00	*
74775	Perineogram (Eg, Vaginogr	$38.92	$43.76	*
75552	MRI - General Classification	$297.04	$297.05	@
75553	Cardiac Magnetic Resonanc	$316.50	$355.81	*
75554	Cardiac Magnetic Resonanc	$316.50	$355.81	*
75555	Cardiac Magnetic Resonanc	$333.16	$374.54	*
75600	Aortography, Thoracic, Wi	$342.25	$384.76	*
75605	Rad-Diag - General Classification	$342.25	$384.76	*
75625	Rad-Diag - Angiocardiography	$342.19	$384.69	*
75630	Rad-Diag - Angiocardiography	$356.82	$401.14	*
75650	Rad-Diag - General Classification	$342.19	$384.69	*
75658	Rad-Diag - Arteriography	$342.19	$384.69	*
75660	Angiography, External Car	$342.25	$384.76	*
75662	Rad-Diag - General Classification	$342.25	$384.76	*
75665	Rad-Diag - General Classification	$342.25	$384.76	*
75671	Rad-Diag - Angiocardiography	$342.25	$384.76	*
75676	Rad-Diag - Angiocardiography	$342.25	$384.76	*
75680	Rad-Diag - General Classification	$342.25	$384.76	*
75685	Rad-Diag - General Classification	$342.25	$384.76	*
75705	CT Scan - General Classification	$342.25	$342.26	@
75710	Rad-Diag - Angiocardiography	$342.25	$384.76	*
75716	Rad-Diag - General Classification	$342.25	$384.76	*
75722	Angiography, Renal, Unilateral	342.25	$384.75	*
75724	Rad-Diag - General Classification	$342.25	$384.76	*
75726	Rad-Diag - Angiocardiography	$342.25	$384.76	*
75731	Angiography, Adrenal, Unilateral	342.25	$384.75	*
75733	Angiography, Adrenal, Bil	$342.25	$384.76	*
75736	Angiography, Pelvic; Sele	$342.25	$384.76	*
75741	Angiography, Pulmonary, U	$342.25	$384.76	*
75743	Rad-Diag - General Classification	$342.25	$384.76	*
75746	Angiography,pulmonary;by	$342.25	$384.76	*

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
75756	Angiography, Internal Mam	$342.25	$384.76	*
75774	Rad-Diag - General Classification	$342.25	$384.76	*
75790	Rad-Diag - Angiocardiography	$36.84	$41.43	*
75801	Lymphangiography, Extremi	$147.17	$165.45	*
75803	Lymphangiography, Extremi	$147.17	$165.45	*
75805	Lymphangiography, Pelvic/	$165.52	$186.08	*
75807	Lymphangiography, Pelvic/	$165.52	$186.08	*
75809	Rad-Diag - General Classification	$21.45	$24.12	*
75810	Splenoportography; Superv	$342.25	$384.76	*
75820	Rad-Diag - General Classification	$25.64	$28.83	*
75822	Rad-Diag - General Classification	$40.34	$45.36	*
75825	Rad-Diag - Angiocardiography	$342.25	$384.76	*
75827	Venography, Caval, Superi	$342.25	$384.76	*
75831	Venography, Renal, Unilat	$342.25	$384.76	*
75833	Venography, Renal, Bilate	$342.25	$384.76	*
75840	Venography, Adrenal, Unil	$342.25	$384.76	*
75842	Venography, Adrenal, Bila	$342.25	$384.76	*
75860	Venography, Sinus or Jugu	$342.25	$384.76	*
75870	Venography, Superior Sagi	$342.25	$384.76	*
75872	Venography, Epidural; Sup	$342.25	$384.76	*
75880	Venography, Orbital; Supe	$25.64	$28.83	*
75885	Percutaneous Transhepatic	$342.25	$384.76	*
75887	Percutaneous Transhepatic	$342.25	$384.76	*
75889	Hepatic Venography Wedged	$342.25	$384.76	*
75891	Hepatic Venography,wedged	$342.25	$384.76	*
75893	Venous Sampling thru Cath	$342.25	$384.76	*
75894	Rad-Diag - General Classification	$655.91	$737.36	*
75896	Rad-Diag - Angiocardiography	$570.10	$640.90	*
75898	Rad-Diag - Angiocardiography	$27.84	$31.31	@
75940	Rad-Diag - General Classification	$342.25	$384.76	*
75945	Intravascular Ultrasound	$116.76	$131.26	*
75946	Intravascular Ultrasound	$58.51	$65.79	*
75960	Rad-Diag - General Classification	$404.69	$454.95	*

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
75961	Transcatheter Retrieval,	$285.10	$320.51	*
75962	Rad-Diag - General Classification	$427.60	$480.70	*
75964	Rad-Diag - Angiocardiography	$228.19	$256.53	*
75966	Rad-Diag - General Classification	$427.60	$480.70	*
75968	Percutaneous Transluminal	$228.27	$256.62	*
75970	Transcatheter Biopsy; Sup	$313.66	$352.62	*
75978	Rad-Diag - Angiocardiography	$453.04	$509.30	*
75980	Rad-Diag - General Classification	$147.17	$165.45	*
75982	Rad-Diag - General Classification	$165.49	$186.05	*
75984	Rad-Diag - General Classification	$51.47	$57.87	*
75989	Rad-Diag - General Classification	$40.29	$137.52	@
75992	Transluminal Atherectomy	$427.60	$480.70	*
75993	Transluminal Atherectomy	$228.27	$256.62	*
75994	Transluminal Atherectomy,	$427.64	$480.75	*
75995	Transluminal Atherectomy	$427.64	$480.75	*
75996	Transluminal Atherectomy	$228.27	$256.62	*
76000	Rad-Diag - General Classification	$34.71	$39.03	*
76001	Rad-Diag - General Classification	$69.51	$168.07	@
76003	Rad-Diag - General Classification	$34.71	$39.03	*
76010	Rad-Diag - General Classification	$13.93	$15.67	*
76020	Rad-Diag - General Classification	$13.93	$15.67	*
76040	Rad-Diag - General Classification	$20.88	$23.48	*
76061	Other Imaging Svcs - Diagnostic Mammography	$26.37	$93.61	@
76062	Rad-Diag - General Classification	$38.19	$42.94	*
76065	Rad-Diag - General Classification	$19.41	$21.83	*
76066	Rad-Diag - General Classification	$29.21	$32.85	*
76070	CT Scan - General Classification	$78.21	$78.22	@
76075	Rad-Diag - General Classification	$45.18	$74.93	@
76080	Rad-Diag - General Classification	$27.84	$31.31	*
76086	Rad-Diag - General Classification	$69.51	$78.15	*
76088	Rad-Diag - General Classification	$97.26	$179.30	@
76090	Other Imaging Svcs - Diagnostic Mammography	$27.84	$51.74	@

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
76091	Other Imaging Svcs - Diagnostic Mammography	$34.71	$63.46	@
76092	Other Imaging Svcs - Diagnostic Mammography	$37.57	$37.58	@
76095	Rad-Diag - General Classification	$202.42	$211.35	@
76096	Rad-Diag - General Classification	$69.51	$76.08	@
76098	Rad-Diag - General Classification	$11.08	$12.46	*
76100	Rad-Diag - General Classification	$30.01	$33.75	*
76101	Rad-Diag - General Classification	$37.54	$42.21	*
76102	Rad-Diag - General Classification	$45.88	$51.59	*
76120	Rad-Diag - General Classification	$27.84	$31.31	*
76125	Cineradiography to Comple	$20.88	$23.48	*
76355	CT Scan - Body Scan	$218.91	$218.92	@
76360	CT Scan - Body Scan	$218.91	$218.92	@
76365	CT Scan - General Classification	$218.91	$219.23	@
76370	Rad-Ther - Radiation Therapy	$78.21	$128.90	@
76375	CT Scan - Body Scan	$93.79	$93.80	@
76380	CT Scan - Head Scan	$95.10	$95.11	@
76400	Magnetic Resonance (Eg, P	$297.04	$333.93	*
76506	Other Imaging Svcs - Ultrasound	$37.54	$59.49	@
76511	Rad-Diag - General Classification	$33.34	$37.49	*
76512	Rad-Diag - General Classification	$40.29	$45.30	*
76513	Other Imaging Svcs - Ultrasound	$40.29	$45.30	@
76516	Opthalmic Biometry by Ult	$33.34	$37.49	*
76519	Ophthalmic Biometry by Ul	$33.34	$37.49	*
76529	Ophthalmic Ultrasonic for	$36.18	$40.68	*
76536	Other Imaging Svcs - Ultrasound	$37.54	$59.81	@
76604	Other Imaging Svcs - General Classification	$34.71	$44.89	@
76645	Other Imaging Svcs - Ultrasound	$27.84	$44.91	@
76700	Other Imaging Svcs - Ultrasound	$52.11	$78.08	@
76705	Other Imaging Svcs - Ultrasound	$37.54	$66.14	@
76770	Other Imaging Svcs - Ultrasound	$52.11	$65.61	@
76775	Other Imaging Svcs - Ultrasound	$37.54	$62.66	@

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
76778	Other Imaging Svcs - General Classification	$43.04	$71.25	@
76800	Echography, Spinal Canal	$52.11	$58.59	*
76805	Other Imaging Svcs - Ultrasound	$55.58	$67.92	@
76810	Other Imaging Svcs - Ultrasound	$113.72	$113.73	@
76815	Other Imaging Svcs - Ultrasound	$37.54	$72.16	@
76816	Other Imaging Svcs - Ultrasound	$29.21	$46.47	@
76818	Other Imaging Svcs - Ultrasound	$43.04	$60.40	@
76825	Other Imaging Svcs - Ultrasound	$52.11	$80.36	@
76826	Other Imaging Svcs - Ultrasound	$19.30	$42.45	@
76827	Other Imaging Svcs - Ultrasound	$47.13	$62.39	@
76828	Doppler Echocardigraphy F	$4.46	$5.03	*
76830	Other Imaging Svcs - Ultrasound	$40.29	$54.54	@
76856	Other Imaging Svcs - Ultrasound	$40.29	$71.32	@
76857	Other Imaging Svcs - Ultrasound	$27.84	$30.93	@
76870	Other Imaging Svcs - Ultrasound	$40.29	$51.72	@
76872	Other Imaging Svcs - Ultrasound	$40.29	$84.90	@
76880	Other Imaging Svcs - Ultrasound	$37.54	$56.47	@
76930	Ultrasonic Guidance for P	$40.29	$45.30	*
76932	Ultrasonic Guidance for E	$40.29	$45.30	*
76934	Other Imaging Svcs - Ultrasound	$40.29	$71.56	@
76936	Echo,guide,for,artery,rep	$160.96	$180.96	*
76938	Rad-Diag - General Classification	$40.29	$132.28	@
76942	Other Imaging Svcs - Ultrasound	$40.29	$58.98	@
76946	Other Imaging Svcs - Ultrasound	$40.29	$55.76	@
76948	Other Imaging Svcs - Ultrasound	$40.29	$43.44	@
76950	Echography for Placement	$34.71	$39.03	*
76960	Ultrasonic Guidance for P	$34.71	$39.03	*
76965	Gi Endoscopic Ultrasound	$142.36	$160.05	*
76970	Other Imaging Svcs - Ultrasound	$27.84	$35.86	@
76975	Other Imaging Svcs - Ultrasound	$43.20	$89.98	@
76986	Other Imaging Svcs - Ultrasound	$69.51	$69.52	@
77261	Rad-Ther - General Classification	$65.65	$65.66	@
77262	Rad-Ther - Radiation Therapy	$98.92	$98.93	@

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
77263	Rad-Ther - Radiation Therapy	$147.43	$203.25	@
77280	Rad-Ther - Radiation Therapy	$80.77	$128.12	@
77285	Rad-Ther - Radiation Therapy	$129.40	$145.01	@
77290	Rad-Ther - Radiation Therapy	$150.92	$238.78	@
77295	Rad-Ther - Radiation Therapy	$384.55	$1,123.09	@
77300	Rad-Ther - Radiation Therapy	$31.13	$81.77	@
77305	Rad-Ther - Radiation Therapy	$43.04	$44.63	@
77310	Rad-Ther - Radiation Therapy	$53.94	$184.35	@
77315	Rad-Ther - Radiation Therapy	$61.54	$174.46	@
77321	Rad-Ther - Radiation Therapy	$93.68	$109.36	@
77326	Brachytherapy Isodose Cal	$54.95	$61.77	*
77327	Rad-Ther - Radiation Therapy	$80.77	$209.99	@
77328	Rad-Ther - Radiation Therapy	$115.21	$360.66	@
77331	Rad-Ther - Radiation Therapy	$11.99	$13.48	@
77332	Rad-Ther - Radiation Therapy	$31.13	$80.26	@
77333	Rad-Ther - Radiation Therapy	$44.05	$131.25	@
77334	Rad-Ther - Radiation Therapy	$75.46	$174.97	@
77336	Rad-Ther - Radiation Therapy	$82.36	$85.07	@
77401	Rad-Ther - Radiation Therapy	$48.17	$70.27	@
77402	Rad-Ther - Radiation Therapy	$48.17	$102.13	@
77403	Rad-Ther - Radiation Therapy	$48.17	$72.57	@
77404	Rad-Ther - Radiation Therapy	$48.17	$76.40	@
77406	Rad-Ther - Radiation Therapy	$48.17	$70.31	@
77407	Rad-Ther - Radiation Therapy	$56.80	$83.86	@
77408	Rad-Ther - Radiation Therapy	$56.80	$85.68	@
77409	Rad-Ther - Radiation Therapy	$56.80	$90.06	@
77411	Rad-Ther - General Classification	$56.80	$97.30	@
77412	Rad-Ther - Radiation Therapy	$63.29	$134.78	@
77413	Rad-Ther - Radiation Therapy	$63.29	$135.63	@
77414	Rad-Ther - Radiation Therapy	$63.29	$114.62	@
77416	Rad-Ther - Radiation Therapy	$63.29	$149.04	@
77417	Rad-Ther - Radiation Therapy	$16.20	$26.05	@
77419	Weekly Radiology Therapy	$170.83	$192.04	*

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
77420	Weekly Megavoltage Treatm	$75.69	$85.10	*
77425	Rad-Ther - General Classification	$114.76	$128.73	@
77430	Rad-Ther - Radiation Therapy	$169.39	$169.40	@
77431	Radiation Therapy Managem	$77.96	$87.65	*
77432	Rad-Ther - Radiation Therapy	$393.31	$442.16	@
77470	Rad-Ther - Radiation Therapy	$258.70	$312.54	@
77600	Hyperthermia, Externally	$80.77	$90.81	*
77605	Hyperthermia, Externally	$107.61	$120.98	*
77610	Hyperthermia Generated by	$80.77	$90.81	*
77615	Hyperthermia Generated by	$107.61	$120.98	*
77620	Hyperthermia Generated by	$80.77	$90.81	*
77750	Rad-Ther - Radiation Therapy	$35.44	$39.85	@
77761	Rad-Ther - Radiation Therapy	$58.24	$69.92	@
77762	Rad-Ther - Radiation Therapy	$84.07	$206.61	@
77763	Rad-Ther - Radiation Therapy	$104.58	$117.58	@
77776	Interstitial Radioelement	$57.69	$64.86	*
77777	Rad-Ther - Radiation Therapy	$112.18	$126.12	@
77778	Rad-Ther - Radiation Therapy	$135.72	$152.58	@
77781	Remote Afterloading High	$538.65	$605.54	*
77782	Remote Afterloading High	$538.65	$605.54	*
77783	Remote Afterloading High	$538.65	$605.54	*
77784	Remote Afterloading High	$538.65	$605.54	*
77789	Surface Application of Ra	$11.90	$13.39	*
77790	Rad-Ther - Radiation Therapy	$11.90	$13.39	@
78000	Nuc Med - Diagnostic	$25.74	$57.93	@
78001	Nuc Med - Diagnostic	$34.71	$77.82	@
78003	Thyroid Uptake; Stimulat	$25.74	$28.95	*
78006	Nuc Med - General Classification	$63.28	$118.74	@
78007	Nuc Med - Diagnostic	$68.12	$126.15	@
78010	Nuc Med - General Classification	$47.98	$95.76	@
78011	Nuc Med - Diagnostic	$63.92	$63.93	@
78015	Nuc Med - Diagnostic	$68.12	$126.41	@
78016	Thyroid Carcinoma Metasta	$92.40	$103.88	*

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
78017	Nuc Med - General Classification	$98.72	$277.71	@
78018	Nuc Med - General Classification	$143.87	$255.46	@
78070	Nuc Med - General Classification	$47.98	$151.57	@
78075	Nuc Med - General Classification	$143.87	$305.29	@
78102	Nuc Med - General Classification	$54.22	$130.05	@
78103	Bone Marrow Imaging; Mult	$84.07	$94.52	*
78104	Bone Marrow Imaging; Whol	$107.69	$121.07	*
78110	Blood or Plasma Volume, R	$25.00	$28.12	*
78111	Nuc Med - General Classification	$68.12	$68.13	@
78120	Red Cell Mass Determinati	$45.88	$51.59	*
78121	Nuc Med - General Classification	$77.10	$114.84	@
78122	Whole Blood Volume Determ	$122.34	$137.54	*
78130	Red Cell Survival Study (	$75.73	$85.14	*
78135	With Splenic And/or Hepat	$129.21	$145.26	*
78140	Red Cell Splenic And/or H	$104.22	$117.17	*
78160	Plasma Radioiron Disappea	$97.26	$109.35	*
78162	Radioiron Oral Absorption	$84.80	$95.34	*
78170	Nuc Med - Diagnostic	$141.03	$141.04	@
78185	Nuc Med - General Classification	$62.55	$139.31	@
78190	Kinetics, Study of Platel	$255.78	$287.55	*
78191	Platelet Survival	$194.60	$218.77	*
78195	Nuc Med - General Classification	$107.69	$231.05	@
78201	Nuc Med - General Classification	$62.55	$62.56	@
78202	Nuc Med - Diagnostic	$76.47	$107.74	@
78205	Nuc Med - General Classification	$156.32	$217.34	@
78215	Nuc Med - Diagnostic	$77.84	$151.32	@
78216	Nuc Med - General Classification	$92.40	$172.77	@
78220	Nuc Med - General Classification	$98.72	$232.55	@
78223	Nuc Med - General Classification	$97.26	$188.67	@
78230	Salivary Gland Imaging	$57.69	$64.86	*
78231	Salivary Gland Imaging; W	$84.07	$94.52	*
78232	Salivary Gland Function S	$93.77	$105.42	*
78258	Esophageal Motility	$76.47	$85.98	*

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
78261	Gastric Mucosa Imaging	$108.42	$121.89	*
78262	Nuc Med - General Classification	$112.55	$116.98	@
78264	Nuc Med - General Classification	$109.07	$207.81	@
78270	Nuc Med - Diagnostic	$41.02	$96.64	@
78271	Nuc Med - General Classification	$43.78	$79.13	@
78272	Vitamin B-12 Absorption S	$61.18	$68.79	*
78278	Nuc Med - Diagnostic	$129.21	$178.31	@
78290	Nuc Med - General Classification	$80.59	$155.08	@
78291	Nuc Med - Diagnostic	$81.32	$81.33	@
78300	Nuc Med - General Classification	$70.60	$136.72	@
78305	Nuc Med - General Classification	$96.25	$156.27	@
78306	Nuc Med - General Classification	$113.28	$202.32	@
78315	Nuc Med - Diagnostic	$126.47	$211.04	@
78320	Nuc Med - General Classification	$156.32	$238.73	@
78350	Rad-Diag - General Classification	$20.15	$64.44	@
78428	Cardiac Shunt Detection	$59.80	$67.24	*
78445	Nuc Med - General Classification	$50.00	$71.03	@
78455	Venous Thrombosis Study	$105.59	$118.71	*
78457	Rad-Diag - General Classification	$70.15	$78.87	*
78458	Nuc Med - Diagnostic	$106.32	$106.33	@
78460	Nuc Med - Diagnostic	$62.55	$82.33	@
78461	Nuc Med - General Classification	$125.10	$282.80	@
78464	Nuc Med - Diagnostic	$187.63	$206.80	@
78465	Nuc Med - General Classification	$312.73	$385.69	@
78466	Nuc Med - Diagnostic	$69.51	$205.58	@
78468	Myocardial Imaging, Infar	$97.26	$109.35	*
78469	Myocardial Imaging, Infar	$139.01	$156.28	*
78472	Nuc Med - General Classification	$145.98	$224.67	@
78473	Nuc Med - Diagnostic	$224.35	$224.36	@
78478	Nuc Med - General Classification	$42.37	$85.59	@
78480	Nuc Med - Diagnostic	$42.37	$87.86	@
78481	Nuc Med - General Classification	$139.01	$172.37	@
78483	Nuc Med - General Classification	$213.84	$389.08	@

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
78580	Nuc Med - General Classification	$91.03	$167.13	@
78584	Nuc Med - Diagnostic	$84.80	$208.65	@
78585	Nuc Med - Diagnostic	$149.36	$212.55	@
78586	Nuc Med - Diagnostic	$68.78	$162.36	@
78587	Nuc Med - Diagnostic	$74.36	$134.30	@
78591	Nuc Med - Diagnostic	$75.73	$76.39	@
78593	Nuc Med - General Classification	$91.76	$167.37	@
78594	Nuc Med - General Classification	$132.05	$197.86	@
78596	Nuc Med - Diagnostic	$100.09	$192.29	@
78600	Brain Imaging, Limited Pr	$76.47	$85.98	*
78601	Brain Imaging, Limited Pr	$90.30	$101.52	*
78605	Nuc Med - General Classification	$90.30	$90.31	@
78606	Nuc Med - General Classification	$102.84	$216.70	@
78607	Nuc Med - General Classification	$173.72	$226.66	@
78610	Other Imaging Svcs - Ultrasound	$41.67	$122.37	@
78615	Cerebral Blood Flow	$102.11	$114.80	*
78630	Cerebrospinal Fluid Flow,	$133.43	$150.01	*
78635	Ventriculography	$67.39	$75.77	*
78645	Nuc Med - General Classification	$91.03	$192.08	@
78650	Cerebrospinal Fluid Flow,	$122.99	$138.27	*
78660	Dacryocystography (Lacrim	$56.32	$63.32	*
78700	Nuc Med - General Classification	$80.59	$120.64	@
78701	Nuc Med - General Classification	$94.51	$119.15	@
78704	Nuc Med - Diagnostic	$104.95	$124.00	@
78707	Nuc Med - General Classification	$118.86	$226.78	@
78710	Kidney Imaging (Spect)	$156.32	$175.74	*
78715	Nuc Med - General Classification	$41.67	$61.71	@
78725	Nuc Med - General Classification	$47.25	$80.14	@
78730	Urinary Bladder Residual	$38.92	$43.76	*
78740	Nuc Med - General Classification	$56.32	$177.12	@
78760	Nuc Med - Diagnostic	$70.88	$193.98	@
78761	Nuc Med - Diagnostic	$84.80	$135.05	@
78800	Nuc Med - Diagnostic	$90.30	$90.31	@

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
78801	Nuc Med - Diagnostic	$111.90	$194.10	@
78802	Nuc Med - General Classification	$146.61	$222.92	@
78803	Nuc Med - General Classification	$173.72	$331.66	@
78805	Nuc Med - General Classification	$90.30	$248.05	@
78806	Nuc Med - Diagnostic	$146.61	$262.61	@
78807	Radionuclide Localization	$185.09	$208.08	*
78890	Nuc Med - General Classification	$34.71	$53.13	@
78891	Nuc Med - General Classification	$69.51	$74.82	@
79000	Nuc Med - General Classification	$69.51	$172.09	@
79001	Nuc Med - Therapeutic	$34.71	$39.03	@
79020	Radionuclide Therapy,thyr	$69.51	$78.15	*
79030	Nuc Med - General Classification	$69.51	$78.15	@
79035	Nuc Med - Diagnostic	$69.51	$78.15	@
79100	Rad-Ther - Radiation Therapy	$69.51	$99.84	@
79200	Intracavitary Radioactive	$69.51	$78.15	*
79400	Nuc Med - General Classification	$69.51	$82.31	@
79440	Intra-articular Radionucl	$69.51	$78.15	*

@ Reimbursed at or above 100% of adjusted aggregate provider cost

* Inflated using the Medicare market basket index for prospective payment systems

Appendix F: Outpatient Chemotherapy

Procedure Code	Procedure Description	Rates Current	Rates On or After 5/15/99	Notes
96400	Chemotherapy Administration	$3.34	$3.77	@
96405	Chemotherapy Administration	$23.88	$57.92	@
96406	Chemotherapy Administration	$36.16	$40.66	@
96408	Chemotherapy Administration	$23.72	$26.68	@
96410	Chemotherapy Administration	$37.91	$88.07	@
96412	Chemotherapy Administration	$28.43	$31.97	@
96414	Chemotherapy Administration	$32.75	$69.50	@
96420	Chemotherapy Administration	$30.78	$34.60	*
96422	Chemotherapy Administration	$30.29	$93.50	@
96423	Chemotherapy Administration	$11.98	$13.48	@
96425	Chemotherapy Administration	$35.21	$39.59	@
96440	Chemotherapy Administration	$84.94	$95.50	@
96445	Chemotherapy Administration	$84.75	$95.28	@
96450	Chemotherapy Administration	$73.36	$77.28	@
96520	Chemotherapy Administration	$22.00	$24.74	@
96545	Chemotherapy Administration	$13.20	$14.85	@
96549	Unlisted Chemotherapy Pro	$83.95	$114.83	@

@ Reimbursed at or above 100% of adjusted aggregate provider cost

* Inflated using the Medicare market basket index for prospective payment systems