Fee Schedule Guidelines

Inpatient Hospital

WSI
North Dakota Workforce Safety & Insurance

January 2023

Notice

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The WSI Fee Schedule is not a guarantee of payment. The fact that WSI assigns a procedure or service a HCPCS code and a payment rate does not imply coverage by WSI but indicates the maximum allowable payment for approved services. Services represented are subject to provisions of WSI including: compensability, claim payment logic, applicable medical policy, benefit limitations and exclusions, bundling logic, and licensing scope of practice limitations.

Any changes made to Pricing Methodology are subject to the North Dakota Public Hearing process. WSI reserves the right to implement changes to the Payment Parameters, Billing Requirements, and Reimbursement Procedures as needed. WSI incorporates all applicable changes into the relevant Fee Schedule Guideline at the time of implementation, and communicates these changes in Medical Providers News, available on the WSI website at www.workforcesafety.com/news/medical-providers. WSI reviews and updates all Fee Schedule rates on an annual basis, with additional updates made on a quarterly basis when applicable.

For reference purposes, the sections of the North Dakota Administrative Code (N.D.A.C.) that regulate medical services are **92-01-02-27 through 92-01-02-46**. The complete N.D.A.C. is accessible on the North Dakota Legislative Council website: http://www.legis.nd.gov/agency-rules/north-dakota-administrative-code.

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North Dakota Workforce Safety & Insurance

Inpatient Hospital Pricing Methodology

Inpatient Hospital Pricing Methodology outlines the methods used by Workforce Safety and Insurance (WSI) to determine the final rates represented on the Inpatient Hospital Fee Schedule. The Inpatient Hospital Fee Schedule uses Medicare Severity Diagnosis Related Groups (MS-DRGs) and their respective payment amounts. In accordance with North Dakota Administrative Code 92-01-02-29.2, any provider who renders treatment to a claimant under the jurisdiction of WSI is reimbursed according to the rates assigned in the Inpatient Hospital Fee Schedule. A provider may access the complete Inpatient Hospital Fee Schedule and other resources referenced within this document by visiting the Medical Provider section of the WSI website: www.workforcesafety.com.

Calculation of the Reimbursement Rates

Inpatient Acute and Psychiatric Services

WSI reimburses inpatient acute and acute psychiatric services based on Diagnosis Related Groups (DRGs). WSI uses the following formula to calculate the WSI DRG Rate:

Conversion Factor	X	Medicare's MS-DRG Weights	=	WSI DRG Reimbursement Rate

For 2023, The Conversion Factor for Inpatient Hospital DRG rates is $10,840.00.

WSI calculates the conversion factor by adding the operating cost portion of the rate to the capital cost portion of the rate. Medicare publishes the factors used to determine the WSI DRG Rate each year in the Federal Register, which are effective for the following calendar year.

If necessary, WSI adjusts the WSI conversion factor to account for aggregate weight changes. WSI does not adjust this formula for wage index or GAF factors, disproportionate share hospitals (DSH), indirect medical education/graduate medical education (IME/GME), or other Medicare pass-through amounts. WSI does not adjust this formula in relation to the Hospital Quality Initiative program, the Hospital Value Based Purchasing program, the Hospital Readmission Reduction Program, or other special Medicare programs.

Outlier Calculations

WSI uses the following formula for calculating the reimbursement rate for bills that reach the outlier threshold:

DRG Amount + [(Billed Charges – (DRG Amount + Threshold)) X .80] = Reimbursement Rate

For 2023, the outlier threshold is $79,500.00.

WSI sets the outlier target for each year at an amount equal to 10% of the estimated DRG payments plus the anticipated outlier payments. Estimated DRG payments are based on claims paid between January 1 and September 30th of the current year. WSI multiplies the following year's conversion factor by the following year's weights to arrive at estimated DRG payments. When determining the outlier target and threshold, WSI eliminates those cases where the actual outlier payments were greater than $100,000 from the database of claims. WSI rounds the outlier threshold to the nearest $500.

Transfer Calculations

WSI bases payment for transfers between acute facilities on Medicare's existing transfer methodology. The methodology for the per diem rate for transfers is as follows:

DRG payment amount

Geometric Mean Length of Stay (GMLOS)	= Per diem rate for transfer
1st day's payment	= 2 times the per diem rate
2nd and subsequent day's payments	= Per diem rate up to the full DRG amount plus allowable outlier payments

When a hospital discharges a patient from an acute care hospital, and a different acute care hospital readmits the patient for symptoms related to the prior stay's medical condition on the same or subsequent calendar day, WSI pays the discharging hospital's claim under the current WSI transfer policy.

WSI considers transfers to post-acute settings as discharges and not transfers; therefore, the transfer payment policy does not apply to these circumstances and each provider will receive payment based on the appropriate DRG(s). WSI monitors the movement of patients from acute to post-acute settings through the utilization review process.

New Technology Add-On Calculations

WSI calculates the reimbursement rates for inpatient new technology services using the following calculation:

Conversion Factor	X	Medicare's MS-DRG Weights	+	New Technology Add-On	=	New Technology Reimbursement

For new technology bills that reach outlier status, WSI uses the following calculation to determine the reimbursement rate:

DRG Amount	+	New Technology Add-On	+	(Billed Charges – [DRG Amount + *New Technology Add-On* + Threshold]) X .80	=	New Technology Outlier Reimbursement

WSI identifies the qualifying criteria and reimbursement rates for new technology add-ons in the following chart:

New Technology	**Qualifying Criteria**		**Payment Amount**
Abecma® (idecabtagene vicleucel)	Procedure:	XW033K7 or XW043K7	$347,439.30
aprevo®	Procedure:	XRGA0R7, XRGA3R7, XRGA4R7, XRGB0R7, XRGB3R7, XRGB4R7, XRGC0R7, XRGC3R7, XRGC4R7, XRGD0R7, XRGD3R7, or XRGD4R7	$49,140.00
Ascope duodeno	Procedure:	XFJB8A7 or XFJD8A7	$1556.10
Caption Guidance	Procedure:	X2JAX47	$2,241.72
Carvykti™ (ciltacabtagene autoleucel)	Procedure:	XW033A7 or XW043A7	$347,439.30
Cerament® G	Procedure:	XW0V0P7	$5,902.26

New Technology	Qualifying Criteria		Payment Amount
Cosela™(trilaciclib)	Procedure:	XW03377 or XW04377	$6,734.52
DARZALEX FASPRO®	Procedure:	XW01318 in combination with E85.81	$6,191.29
DefenCath™	Procedure:	XY0YX28	$5,265.00
Fetroja® (cefiderocol) (HABP/VABP)	Procedure:	XW033A6 or XW043A6 in combination with Y95 and one of the following: J14, J15.0, J15.1, J15.5, J15.6, J15.8 OR XW033A6 or XW043A6 in combination with J95.851 and one of the following: B96.1, B96.20, B96.21, B96.22, B96.23, B96.29, B96.3, B96.5, B96.89	$10,295.81
GORE® TAG® Thoracic Branch Endoprosthesis	Procedure:	02VW3DZ in combination with 02VX3EZ	$33,368.40
Harmony TPV	Procedure:	02RH38M	$32,370.00
Hemolung Respiratory Assist System (RAS)	Procedure:	5A0920Z	$7,800.00
iFuse Bedrock Granite Implant System	Procedure:	XNH6058, XNH6358, XNH7058, XNH7358, XRGE058, XRGE358, XRGF058, or XRGF358	$11,793.60
Intercept® Fibrinogen Complex (PRCFC)	Procedure:	30233D1 or 30243D1 in combination with one of the following: D62, D65, D68.2, D68.4, or D68.9	$3,042.00
Livtencity™ (maribavir)	Procedure:	XW0DX38 or XW0G738 or XW0H738	$39,000.00
RECARBRIO™	Procedure:	XW033U5, XW043U5 in combination with Y95 and one of the following: J14, J15.0, J15.1, J15.5, J15.6, or J15.8 OR XW033U5 or XW043U5 in combination with J95.851 and one of the following: B96.1, B96.20, B96.21, B96.22, B96.23, B96.29, B96.3, B96.5, B96.89	$11,491.81
Rybrevant® (amivantamab)	Procedure:	XW033B7 or XW043B7	$7,687.07
Shockwave Coronary IVL	Procedure:	02F03ZZ or 02F13ZZ or 02F23ZZ or 02F33ZZ	$4,399.20
StrataGraft	Procedure:	XHRPXF7	$53,040.00
Tecartus® (brexucabtagene autoleucel)	Procedure:	XW033M7 or XW043M7	$311,220.00
Thoraflex™ Hybrid Device	Procedure:	X2RX0N7 in combination with X2VW0N7	$27,300.00
Veklury	Procedure:	XW033E5 or XW043E5	$2,433.60
ViviStim® Paired VNS System	Procedure:	X0HQ3R8	$28,080.00
Zepzelca	Procedure:	XW03387 or XW04387	$10,347.48

Other Inpatient Service Calculations

DRG reimbursement rates do not apply to certain services, which are outlined below along with the applicable reimbursement methodology:

Inpatient Swing Bed Services	80 % of billed charges
Rehabilitation Services (Distinct Unit)	80 % of billed charges
Long-Term Acute Care	Per Long Term Care Hospital Fee Schedule
Nursing Facility Services	100% of billed charges
Physician, mid-level practitioner, and CRNA services	Per Medical Provider Fee Schedule
Durable medical equipment & supplies for home use	Per DME Fee Schedule
Take home supplies and/or drugs (if allowable)	Per Physician Drug Fee Schedule

Annual Updates

WSI updates the Inpatient Hospital Fee Schedule base rate each year based on the hospital Market Basket increase published by Medicare in the Inpatient Prospective Payment System final rule. WSI makes appropriate adjustments for DRG weight changes when necessary. If Medicare publishes a separate Market Basket for capital costs, WSI applies the update to the capital portion of the base rate. If Medicare does not publish a separate Market Basket for capital costs, WSI applies the operating cost update to both the operating portion and the capital portion of the base rates.

Limitations of the Inpatient Hospital Fee Schedule

The payment rates listed on the Inpatient Hospital Fee Schedule indicate the maximum allowable payment for approved services only. The fact that a procedure or service is assigned a HCPCS code and a payment rate does not imply coverage by WSI but indicates the maximum allowable payment for approved services. The final payment rate may be impacted by the payment parameters and billing requirements enforced by WSI. A hospital is encouraged to carefully review WSI's Payment Parameters, Billing Requirements, and Reimbursement Procedures to avoid unneccesary delays and denials of payment.

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Inpatient Hospital Payment Parameters

Inpatient Hospital Payment Parameters outline the rules for payment adopted by WSI. While WSI has adopted many of Medicare's rules for payment, WSI has developed a set of unique rules that are applied to the final payment of approved services. The complete payment parameters enforced by WSI are as follows:

Advanced Beneficiary Notice (ABN) – A provider may utilize the ABN form to notify an injured employee of the costs associated with a recommended procedure that is: statutorily excluded from coverage, statutorily limited in quantity, deemed by WSI as not medically necessary to treat the work injury. To identify a charge accompanied with a signed ABN, a provider should append modifier GA to each applicable bill line. A provider should then submit the signed ABN along with the bill and medical documentation to WSI.

Authorization – Non-emergent admissions require prior authorization. A hospital must submit the request for prior authorization at least 24 hours prior to the proposed admission or surgery. Emergent and urgent admissions do not require prior authorization; however, a hospital must notify WSI of the admission as soon as possible.

Device Replacement Calculations – WSI will subtract the reported device credit amount from the DRG payment amount when the cost of the device has been determined to be greater than 50% of the cost of the inpatient stay.

End of Year Admission Reimbursement – For hospital admissions beginning in one year and spanning into the next year (e.g. 12/30/18 – 1/02/19), WSI issues reimbursement based on the fee schedule rate in effect at the date of admission.

Inpatient Swing Bed Services (Skilled and Non-Skilled) – A three-day acute stay is not necessary to qualify for swing bed services. Both skilled and non-skilled swing bed services are reimbursable to a Medicare certified hospital only.

Nursing Facility Services (Skilled and Non-Skilled) – A three-day acute stay is not necessary to qualify for nursing facility services.

Observation – Outpatient observation stays may be greater than 24 hours; however, WSI limits the initial payment to 48 hours. A hospital may appeal the 48-hour cap if medical documentation substantiates an extended observation stay.

Prospective Payments – WSI pays inpatient hospital services at the rate indicated on the WSI Inpatient Hospital Fee Schedule, regardless of the billed amount, except for codes assigned a status indicator of 'Z'. For codes assigned a status indicator of 'Z', WSI pays the "lesser of" the billed charge or the Fee Schedule amount.

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Inpatient Hospital Billing Requirements

Inpatient Hospital Billing Requirements outline the rules for billing adopted by WSI. WSI returns or denies inappropriately submitted bills. WSI notifies a provider of inappropriately submitted bills via a return letter or remittance advice. A provider must correct any returned bills prior to resubmission.

Bill Form – A hospital must submit a medical bill for an inpatient hospital service on a standard UB-04 form or via EDI.

Bill Form Submission – WSI offers the following options for bill submission:

Electronic Billing – A provider submitting more than 50 bills per year to WSI must send charges electronically through Carisk Intelligent Clearinghouse. This option allows for the electronic submission of professional (837p) and institutional (837i) charges along with supporting medical documentation. Contact Carisk at 888-238-4792 for additional information.

Paper Billing – A provider submitting less than 50 bills per year to WSI may send charges in red and white paper format with supporting medical documentation at the following address:

Workforce Safety & Insurance
PO Box 5585
Bismarck, ND 58506

Coding – A hospital is required to bill using only current and appropriate CPT, HCPCS Level II, and MS-DRG codes for inpatient hospital services.

Device Replacements – A hospital must report a manufacturer's device replacement credit with Value Code FD when the credit is 50% of the cost or more.

Inpatient Hospital vs. Outpatient Hospital Classification – WSI requires a hospital to bill a patient stay of 24 hours or less as outpatient, unless the surgical procedure performed has a status indicator of "C". A hospital must bill all patient stays for surgical services where the HCPCS code for the surgery has a status indicator of "C" (inpatient only) as inpatient, regardless of the length of the stay.

Medical Documentation – A hospital must submit medical documentation to support all billed charges. WSI's Documentation Policies are available for detailed information on documentation requirements.

Medical Necessity – A hospital is required to bill using the same medical necessity guidelines used for Medicare.

Readmissions – When a patient is discharged and/or transferred from an acute care hospital and is readmitted to the same hospital on the same or subsequent calendar day for the evaluation and management of symptoms related to the prior stay's medical condition, the hospital must combine the original and subsequent stays onto a single claim. Services rendered by other entities during a combined stay must be included on the combined claim.

National Provider Identification (NPI) – WSI requires entities who are eligible for NPI to be registered with National Plan & Provider Enumeration System. When applicable, WSI requires hospital to include the NPI at both the rendering provider and billing provider levels.

Timely Filing – A hospital must submit bills to WSI within 365 days of the date of discharge.

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Inpatient Hospital Reimbursement Procedures

Inpatient Hospital Reimbursement Procedures outline how WSI communicates bill processing information and issues payment to a hospital. In addition, it outlines the WSI's requirements for reimbursement. A hospital is encouraged to follow WSI Reimbursement Procedures to prevent delays in the payment processing of medical charges submitted to WSI.

Provider Registration – Prior to reimbursement for treatment, a provider is required to register the applicable Billing NPIs with WSI by completing the Medical Provider Payee Registration form. For additional information, visit the Provider Registration section of WSI's website.

Payment Address – WSI issues payment to the Pay-to Address registered on the Medical Provider Payee Registration form, regardless of the address submitted on the bill form. To update a payment address, a provider must resubmit the registration form for each applicable Billing NPI.

Remittance Advice – WSI issues remittance advices for processed medical bills each Friday. The remittance advice includes important information about a medical charge, including: patient name, date of service, procedure billed, billed amount, paid amount, and remittance advice reason codes. A provider should refer to the How to Read the WSI Remittance Advice document for assistance with interpretation of the remittance advice. This reference includes a sample remittance advice, along with definitions for significant fields within the remittance advice. Contact customer service at 1-800-777-5033 with questions or to obtain a duplicate remittance advice.

Reason Codes – The WSI Remittance Advice Reason Codes document provides a comprehensive listing and description of the reason codes utilized by WSI. Each reason code identifies a cause for the adjudication of a medical charge and specifies whether a provider may bill a patient. When a reason code specifies a provider may bill a patient, WSI sends a "Notice of Non-Payment" letter to the patient informing them of their responsibility for the charge. In accordance with North Dakota Administrative Code 92-01-02-45.1, if a reason code does not state that a provider may bill a patient, the provider cannot bill the charge for the reduced or denied service to the patient, the employer, or another insurer.

Bill Status Inquiries – Bill status information is available 24/7 via myWSI. The Provider Bill Status application permits a registered user to view bill receipt status and processing details as well as export results. For access, a practice must submit a myWSI Portal Registration (M14) form for each group/billing NPI. With the availability of this resource, a provider or their TPA will not need to contact WSI via phone or email to inquire on the status of a billed charge.

Overpayments – When an overpayment occurs on a medical bill, WSI will notify the hospital of the overpayment in a letter. WSI allows 30 days from the date of the letter for a hospital to issue the requested refund. If a hospital does not issue the refund within 30 days of the date of the letter, WSI will withhold the overpayment from future payments.

Medical Services Disputes – North Dakota Administrative Code 92-01-02-46 provides the procedures followed for managed care disputes. A hospital who wishes to dispute a denial or reduction of a service charge must submit the Medical Bill Appeal (M6) form, along with supporting documentation, within 30 days of the remittance advice issue date. WSI will not address a hospital dispute submitted without the M6 form.

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Inpatient Hospital Transfer Fee Schedule

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
001	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITH MCC	29.9	$20,408.28	$10,204.14
002	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITHOUT MCC	12.3	$23,747.71	$11,873.85
003	ECMO OR TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS EXCEPT FACE, MOUTH AND NECK WITH MAJOR O.R. PROCEDURES	24.7	$17,762.77	$8,881.38
004	TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS EXCEPT FACE, MOUTH AND NECK WITHOUT MAJOR O.R. PROCEDURES	24.2	$12,301.79	$6,150.89
005	LIVER TRANSPLANT WITH MCC OR INTESTINAL TRANSPLANT	15.0	$16,486.92	$8,243.46
006	LIVER TRANSPLANT WITHOUT MCC	7.6	$13,719.16	$6,859.58
007	LUNG TRANSPLANT	17.8	$14,868.22	$7,434.11
008	SIMULTANEOUS PANCREAS AND KIDNEY TRANSPLANT	8.7	$13,932.76	$6,966.38
010	PANCREAS TRANSPLANT	7.4	$12,149.00	$6,074.50
011	TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY WITH MCC	11.7	$9,571.07	$4,785.54
012	TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY WITH CC	8.4	$10,090.23	$5,045.12
013	TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY WITHOUT CC/MCC	6.4	$9,580.87	$4,790.43
014	ALLOGENEIC BONE MARROW TRANSPLANT	25.7	$9,442.19	$4,721.09
016	AUTOLOGOUS BONE MARROW TRANSPLANT WITH CC/MCC	16.6	$7,946.37	$3,973.19
017	AUTOLOGOUS BONE MARROW TRANSPLANT WITHOUT CC/MCC	7.3	$12,978.60	$6,489.30
018	CHIMERIC ANTIGEN RECEPTOR (CAR) T-CELL AND OTHER IMMUNOTHERAPIES	14.7	$53,308.02	$26,654.01
019	SIMULTANEOUS PANCREAS AND KIDNEY TRANSPLANT WITH HEMODIALYSIS	10.8	$14,322.05	$7,161.02
020	INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITH MCC	10.7	$18,850.05	$9,425.03
021	INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITH CC	8.1	$18,171.59	$9,085.79
022	INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITHOUT CC/MCC	3.2	$29,528.84	$14,764.42
023	CRANIOTOMY WITH MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PRINCIPAL DIAGNOSIS WITH MCC OR CHEMOTHERAPY IMPLANT OR EPILEPSY WITH NEUROSTIMULATOR	7.3	$17,021.47	$8,510.74
024	CRANIOTOMY WITH MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PRINCIPAL DIAGNOSIS WITHOUT MCC	4.1	$20,880.48	$10,440.24

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
025	CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITH MCC	6.6	$14,914.85	$7,457.43
026	CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITH CC	3.6	$18,208.19	$9,104.09
027	CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITHOUT CC/MCC	1.8	$30,055.71	$15,027.86
028	SPINAL PROCEDURES WITH MCC	9.8	$13,002.47	$6,501.23
029	SPINAL PROCEDURES WITH CC OR SPINAL NEUROSTIMULATORS	4.9	$15,121.13	$7,560.57
030	SPINAL PROCEDURES WITHOUT CC/MCC	2.7	$18,798.97	$9,399.49
031	VENTRICULAR SHUNT PROCEDURES WITH MCC	6.9	$12,948.30	$6,474.15
032	VENTRICULAR SHUNT PROCEDURES WITH CC	2.7	$16,496.87	$8,248.44
033	VENTRICULAR SHUNT PROCEDURES WITHOUT CC/MCC	1.6	$23,014.68	$11,507.34
034	CAROTID ARTERY STENT PROCEDURES WITH MCC	5.1	$17,001.37	$8,500.69
035	CAROTID ARTERY STENT PROCEDURES WITH CC	2.0	$24,756.39	$12,378.20
036	CAROTID ARTERY STENT PROCEDURES WITHOUT CC/MCC	1.2	$33,977.98	$16,988.99
037	EXTRACRANIAL PROCEDURES WITH MCC	5.0	$14,625.33	$7,312.66
038	EXTRACRANIAL PROCEDURES WITH CC	1.9	$18,661.92	$9,330.96
039	EXTRACRANIAL PROCEDURES WITHOUT CC/MCC	1.2	$20,825.45	$10,412.73
040	PERIPHERAL, CRANIAL NERVE AND OTHER NERVOUS SYSTEM PROCEDURES WITH MCC	7.0	$11,733.22	$5,866.61
041	PERIPHERAL, CRANIAL NERVE AND OTHER NERVOUS SYSTEM PROCEDURES WITH CC OR PERIPHERAL NEUROSTIMULATOR	3.9	$12,997.44	$6,498.72
042	PERIPHERAL, CRANIAL NERVE AND OTHER NERVOUS SYSTEM PROCEDURES WITHOUT CC/MCC	2.4	$16,708.96	$8,354.48
052	SPINAL DISORDERS AND INJURIES WITH CC/MCC	4.1	$9,413.88	$4,706.94
053	SPINAL DISORDERS AND INJURIES WITHOUT CC/MCC	2.5	$8,869.72	$4,434.86
054	NERVOUS SYSTEM NEOPLASMS WITH MCC	3.8	$7,913.20	$3,956.60
055	NERVOUS SYSTEM NEOPLASMS WITHOUT MCC	2.9	$7,537.91	$3,768.96
056	DEGENERATIVE NERVOUS SYSTEM DISORDERS WITH MCC	5.7	$8,484.87	$4,242.43
057	DEGENERATIVE NERVOUS SYSTEM DISORDERS WITHOUT MCC	3.8	$7,425.40	$3,712.70
058	MULTIPLE SCLEROSIS AND CEREBELLAR ATAXIA WITH MCC	4.8	$7,792.60	$3,896.30
059	MULTIPLE SCLEROSIS AND CEREBELLAR ATAXIA WITH CC	3.5	$7,083.17	$3,541.58
060	MULTIPLE SCLEROSIS AND CEREBELLAR ATAXIA WITHOUT CC/MCC	2.9	$6,775.37	$3,387.69

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
061	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA WITH THROMBOLYTIC AGENT WITH MCC	4.9	$12,975.26	$6,487.63
062	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA WITH THROMBOLYTIC AGENT WITH CC	3.2	$12,989.03	$6,494.52
063	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA WITH THROMBOLYTIC AGENT WITHOUT CC/MCC	2.3	$14,902.64	$7,451.32
064	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITH MCC	4.5	$9,500.66	$4,750.33
065	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITH CC OR TPA IN 24 HOURS	2.9	$7,598.47	$3,799.23
066	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITHOUT CC/MCC	1.9	$7,970.25	$3,985.13
067	NONSPECIFIC CVA AND PRECEREBRAL OCCLUSION WITHOUT INFARCTION WITH MCC	3.3	$9,290.21	$4,645.10
068	NONSPECIFIC CVA AND PRECEREBRAL OCCLUSION WITHOUT INFARCTION WITHOUT MCC	2.1	$9,329.63	$4,664.81
069	TRANSIENT ISCHEMIA WITHOUT THROMBOLYTIC	2.0	$8,649.24	$4,324.62
070	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH MCC	4.6	$8,126.23	$4,063.12
071	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH CC	3.4	$6,816.45	$3,408.22
072	NONSPECIFIC CEREBROVASCULAR DISORDERS WITHOUT CC/MCC	2.3	$7,276.94	$3,638.47
073	CRANIAL AND PERIPHERAL NERVE DISORDERS WITH MCC	3.8	$8,553.90	$4,276.95
074	CRANIAL AND PERIPHERAL NERVE DISORDERS WITHOUT MCC	2.8	$7,925.59	$3,962.79
075	VIRAL MENINGITIS WITH CC/MCC	5.4	$7,327.04	$3,663.52
076	VIRAL MENINGITIS WITHOUT CC/MCC	3.4	$6,295.49	$3,147.74
077	HYPERTENSIVE ENCEPHALOPATHY WITH MCC	4.1	$8,271.19	$4,135.59
078	HYPERTENSIVE ENCEPHALOPATHY WITH CC	2.8	$7,687.11	$3,843.55
079	HYPERTENSIVE ENCEPHALOPATHY WITHOUT CC/MCC	2.0	$7,955.48	$3,977.74
080	NONTRAUMATIC STUPOR AND COMA WITH MCC	5.1	$8,671.15	$4,335.57
081	NONTRAUMATIC STUPOR AND COMA WITHOUT MCC	2.7	$7,214.62	$3,607.31
082	TRAUMATIC STUPOR AND COMA >1 HOUR WITH MCC	4.4	$11,161.75	$5,580.88
083	TRAUMATIC STUPOR AND COMA >1 HOUR WITH CC	3.3	$8,857.27	$4,428.63
084	TRAUMATIC STUPOR AND COMA >1 HOUR WITHOUT CC/MCC	2.1	$9,461.77	$4,730.89
085	TRAUMATIC STUPOR AND COMA <1 HOUR WITH MCC	4.6	$11,008.26	$5,504.13
086	TRAUMATIC STUPOR AND COMA <1 HOUR WITH CC	2.9	$9,716.38	$4,858.19
087	TRAUMATIC STUPOR AND COMA <1 HOUR WITHOUT CC/MCC	2.0	$9,456.82	$4,728.41

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
088	CONCUSSION WITH MCC	3.6	$9,492.83	$4,746.41
089	CONCUSSION WITH CC	2.5	$10,126.30	$5,063.15
090	CONCUSSION WITHOUT CC/MCC	1.8	$9,913.78	$4,956.89
091	OTHER DISORDERS OF NERVOUS SYSTEM WITH MCC	4.3	$8,709.31	$4,354.66
092	OTHER DISORDERS OF NERVOUS SYSTEM WITH CC	2.9	$7,433.25	$3,716.62
093	OTHER DISORDERS OF NERVOUS SYSTEM WITHOUT CC/MCC	2.1	$7,895.65	$3,947.82
094	BACTERIAL AND TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM WITH MCC	8.1	$9,564.63	$4,782.31
095	BACTERIAL AND TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM WITH CC	5.9	$9,395.16	$4,697.58
096	BACTERIAL AND TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM WITHOUT CC/MCC	4.5	$11,005.25	$5,502.62
097	NON-BACTERIAL INFECTION OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS WITH MCC	9.1	$9,263.32	$4,631.66
098	NON-BACTERIAL INFECTION OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS WITH CC	5.8	$7,790.60	$3,895.30
099	NON-BACTERIAL INFECTION OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS WITHOUT CC/MCC	3.7	$8,194.45	$4,097.23
100	SEIZURES WITH MCC	4.4	$9,465.29	$4,732.65
101	SEIZURES WITHOUT MCC	2.6	$7,517.12	$3,758.56
102	HEADACHES WITH MCC	3.0	$8,309.95	$4,154.97
103	HEADACHES WITHOUT MCC	2.3	$7,847.22	$3,923.61
113	ORBITAL PROCEDURES WITH CC/MCC	4.5	$10,817.36	$5,408.68
114	ORBITAL PROCEDURES WITHOUT CC/MCC	2.3	$12,280.30	$6,140.15
115	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	3.8	$8,666.86	$4,333.43
116	INTRAOCULAR PROCEDURES WITH CC/MCC	4.1	$9,975.44	$4,987.72
117	INTRAOCULAR PROCEDURES WITHOUT CC/MCC	2.1	$10,249.48	$5,124.74
121	ACUTE MAJOR EYE INFECTIONS WITH CC/MCC	4.2	$6,324.88	$3,162.44
122	ACUTE MAJOR EYE INFECTIONS WITHOUT CC/MCC	2.8	$5,348.76	$2,674.38
123	NEUROLOGICAL EYE DISORDERS	2.0	$8,604.79	$4,302.40
124	OTHER DISORDERS OF THE EYE WITH MCC	3.6	$8,435.33	$4,217.66
125	OTHER DISORDERS OF THE EYE WITHOUT MCC	2.5	$7,476.13	$3,738.06
135	SINUS AND MASTOID PROCEDURES WITH CC/MCC	4.7	$11,304.51	$5,652.25
136	SINUS AND MASTOID PROCEDURES WITHOUT CC/MCC	1.6	$15,722.06	$7,861.03
137	MOUTH PROCEDURES WITH CC/MCC	3.4	$9,562.15	$4,781.08
138	MOUTH PROCEDURES WITHOUT CC/MCC	1.8	$10,650.90	$5,325.45
139	SALIVARY GLAND PROCEDURES	2.1	$12,982.19	$6,491.10

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
140	MAJOR HEAD AND NECK PROCEDURES WITH MCC	7.2	$12,515.08	$6,257.54
141	MAJOR HEAD AND NECK PROCEDURES WITH CC	3.3	$14,667.50	$7,333.75
142	MAJOR HEAD AND NECK PROCEDURES WITHOUT CC/MCC	2.1	$17,568.03	$8,784.01
143	OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITH MCC	5.8	$11,858.96	$5,929.48
144	OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITH CC	3.0	$13,075.21	$6,537.60
145	OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITHOUT CC/MCC	1.8	$14,547.28	$7,273.64
146	EAR, NOSE, MOUTH AND THROAT MALIGNANCY WITH MCC	5.4	$8,086.64	$4,043.32
147	EAR, NOSE, MOUTH AND THROAT MALIGNANCY WITH CC	3.5	$7,501.90	$3,750.95
148	EAR, NOSE, MOUTH AND THROAT MALIGNANCY WITHOUT CC/MCC	2.2	$8,057.07	$4,028.54
149	DYSEQUILIBRIUM	1.9	$8,614.95	$4,307.47
150	EPISTAXIS WITH MCC	3.5	$8,543.78	$4,271.89
151	EPISTAXIS WITHOUT MCC	2.2	$7,597.85	$3,798.93
152	OTITIS MEDIA AND URI WITH MCC	3.4	$7,637.10	$3,818.55
153	OTITIS MEDIA AND URI WITHOUT MCC	2.2	$6,804.56	$3,402.28
154	OTHER EAR, NOSE, MOUTH AND THROAT DIAGNOSES WITH MCC	4.0	$8,145.72	$4,072.86
155	OTHER EAR, NOSE, MOUTH AND THROAT DIAGNOSES WITH CC	2.8	$7,118.01	$3,559.00
156	OTHER EAR, NOSE, MOUTH AND THROAT DIAGNOSES WITHOUT CC/MCC	2.1	$7,037.74	$3,518.87
157	DENTAL AND ORAL DISEASES WITH MCC	4.4	$8,237.41	$4,118.71
158	DENTAL AND ORAL DISEASES WITH CC	2.8	$7,193.89	$3,596.94
159	DENTAL AND ORAL DISEASES WITHOUT CC/MCC	2.2	$7,389.93	$3,694.96
163	MAJOR CHEST PROCEDURES WITH MCC	8.1	$12,964.37	$6,482.19
164	MAJOR CHEST PROCEDURES WITH CC	3.9	$14,357.16	$7,178.58
165	MAJOR CHEST PROCEDURES WITHOUT CC/MCC	2.3	$18,163.13	$9,081.57
166	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH MCC	7.4	$10,739.80	$5,369.90
167	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH CC	3.5	$11,775.95	$5,887.98
168	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITHOUT CC/MCC	1.9	$16,175.56	$8,087.78
175	PULMONARY EMBOLISM WITH MCC OR ACUTE COR PULMONALE	3.9	$7,764.77	$3,882.39
176	PULMONARY EMBOLISM WITHOUT MCC	2.5	$7,090.22	$3,545.11

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
177	RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH MCC	5.2	$7,420.82	$3,710.41
178	RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH CC	3.6	$6,546.16	$3,273.08
179	RESPIRATORY INFECTIONS AND INFLAMMATIONS WITHOUT CC/MCC	2.7	$6,306.47	$3,153.24
180	RESPIRATORY NEOPLASMS WITH MCC	4.7	$7,813.57	$3,906.78
181	RESPIRATORY NEOPLASMS WITH CC	3.2	$7,680.82	$3,840.41
182	RESPIRATORY NEOPLASMS WITHOUT CC/MCC	2.2	$8,745.91	$4,372.95
183	MAJOR CHEST TRAUMA WITH MCC	4.3	$7,573.88	$3,786.94
184	MAJOR CHEST TRAUMA WITH CC	3.0	$7,553.31	$3,776.66
185	MAJOR CHEST TRAUMA WITHOUT CC/MCC	2.2	$7,440.18	$3,720.09
186	PLEURAL EFFUSION WITH MCC	4.3	$7,697.91	$3,848.96
187	PLEURAL EFFUSION WITH CC	3.1	$7,314.55	$3,657.28
188	PLEURAL EFFUSION WITHOUT CC/MCC	2.3	$6,824.49	$3,412.24
189	PULMONARY EDEMA AND RESPIRATORY FAILURE	3.5	$7,476.50	$3,738.25
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH MCC	3.4	$6,921.66	$3,460.83
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH CC	2.7	$6,939.21	$3,469.60
192	CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITHOUT CC/MCC	2.2	$6,426.15	$3,213.07
193	SIMPLE PNEUMONIA AND PLEURISY WITH MCC	4.0	$7,038.96	$3,519.48
194	SIMPLE PNEUMONIA AND PLEURISY WITH CC	2.9	$6,281.22	$3,140.61
195	SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC	2.3	$6,049.66	$3,024.83
196	INTERSTITIAL LUNG DISEASE WITH MCC	5.0	$7,534.67	$3,767.33
197	INTERSTITIAL LUNG DISEASE WITH CC	3.0	$7,108.15	$3,554.07
198	INTERSTITIAL LUNG DISEASE WITHOUT CC/MCC	2.2	$7,005.60	$3,502.80
199	PNEUMOTHORAX WITH MCC	5.1	$7,475.77	$3,737.89
200	PNEUMOTHORAX WITH CC	3.1	$7,497.08	$3,748.54
201	PNEUMOTHORAX WITHOUT CC/MCC	2.3	$6,861.25	$3,430.63
202	BRONCHITIS AND ASTHMA WITH CC/MCC	2.8	$7,168.34	$3,584.17
203	BRONCHITIS AND ASTHMA WITHOUT CC/MCC	2.1	$6,887.01	$3,443.50
204	RESPIRATORY SIGNS AND SYMPTOMS	2.1	$8,356.10	$4,178.05
205	OTHER RESPIRATORY SYSTEM DIAGNOSES WITH MCC	4.4	$8,775.47	$4,387.74
206	OTHER RESPIRATORY SYSTEM DIAGNOSES WITHOUT MCC	2.4	$8,070.38	$4,035.19

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
207	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT >96 HOURS	13.8	$10,315.12	$5,157.56
208	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT <=96 HOURS	5.0	$11,274.03	$5,637.02
215	OTHER HEART ASSIST SYSTEM IMPLANT	4.9	$45,586.40	$22,793.20
216	CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITH CARDIAC CATHETERIZATION WITH MCC	11.3	$18,690.65	$9,345.33
217	CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITH CARDIAC CATHETERIZATION WITH CC	5.5	$25,025.81	$12,512.91
218	CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITH CARDIAC CATHETERIZATION WITHOUT CC/MCC	2.3	$55,978.70	$27,989.35
219	CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITHOUT CARDIAC CATHETERIZATION WITH MCC	8.9	$19,800.17	$9,900.09
220	CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITHOUT CARDIAC CATHETERIZATION WITH CC	5.8	$20,316.03	$10,158.01
221	CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITHOUT CARDIAC CATHETERIZATION WITHOUT CC/MCC	3.3	$31,085.18	$15,542.59
222	CARDIAC DEFIBRILLATOR IMPLANT WITH CARDIAC CATHETERIZATION WITH AMI, HF OR SHOCK WITH MCC	8.9	$18,651.13	$9,325.57
223	CARDIAC DEFIBRILLATOR IMPLANT WITH CARDIAC CATHETERIZATION WITH AMI, HF OR SHOCK WITHOUT MCC	5.0	$22,628.28	$11,314.14
224	CARDIAC DEFIBRILLATOR IMPLANT WITH CARDIAC CATHETERIZATION WITHOUT AMI, HF OR SHOCK WITH MCC	7.4	$20,769.44	$10,384.72
225	CARDIAC DEFIBRILLATOR IMPLANT WITH CARDIAC CATHETERIZATION WITHOUT AMI, HF OR SHOCK WITHOUT MCC	4.0	$27,412.74	$13,706.37
226	CARDIAC DEFIBRILLATOR IMPLANT WITHOUT CARDIAC CATHETERIZATION WITH MCC	6.0	$23,128.59	$11,564.29
227	CARDIAC DEFIBRILLATOR IMPLANT WITHOUT CARDIAC CATHETERIZATION WITHOUT MCC	2.9	$37,534.06	$18,767.03
228	OTHER CARDIOTHORACIC PROCEDURES WITH MCC	6.4	$16,694.62	$8,347.31
229	OTHER CARDIOTHORACIC PROCEDURES WITHOUT MCC	2.7	$26,505.01	$13,252.50
231	CORONARY BYPASS WITH PTCA WITH MCC	10.5	$17,329.96	$8,664.98
232	CORONARY BYPASS WITH PTCA WITHOUT MCC	7.6	$16,710.14	$8,355.07
233	CORONARY BYPASS WITH CARDIAC CATHETERIZATION OR OPEN ABLATION WITH MCC	11.3	$14,859.24	$7,429.62
234	CORONARY BYPASS WITH CARDIAC CATHETERIZATION OR OPEN ABLATION WITHOUT MCC	7.9	$14,232.78	$7,116.39

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
235	CORONARY BYPASS WITHOUT CARDIAC CATHETERIZATION WITH MCC	8.3	$15,646.17	$7,823.08
236	CORONARY BYPASS WITHOUT CARDIAC CATHETERIZATION WITHOUT MCC	5.9	$14,986.39	$7,493.20
239	AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS EXCEPT UPPER LIMB AND TOE WITH MCC	10.3	$9,787.78	$4,893.89
240	AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS EXCEPT UPPER LIMB AND TOE WITH CC	6.8	$8,653.51	$4,326.75
241	AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS EXCEPT UPPER LIMB AND TOE WITHOUT CC/MCC	4.1	$8,190.28	$4,095.14
242	PERMANENT CARDIAC PACEMAKER IMPLANT WITH MCC	5.0	$15,061.10	$7,530.55
243	PERMANENT CARDIAC PACEMAKER IMPLANT WITH CC	2.9	$17,523.42	$8,761.71
244	PERMANENT CARDIAC PACEMAKER IMPLANT WITHOUT CC/MCC	2.1	$19,626.59	$9,813.30
245	AICD GENERATOR PROCEDURES	3.9	$27,105.56	$13,552.78
246	PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH DRUG-ELUTING STENT WITH MCC OR 4+ ARTERIES OR STENTS	3.8	$17,089.55	$8,544.77
247	PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH DRUG-ELUTING STENT WITHOUT MCC	2.0	$20,698.98	$10,349.49
248	PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH NON-DRUG-ELUTING STENT WITH MCC OR 4+ ARTERIES OR STENTS	4.3	$15,174.99	$7,587.50
249	PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH NON-DRUG-ELUTING STENT WITHOUT MCC	2.2	$17,902.75	$8,951.38
250	PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITHOUT CORONARY ARTERY STENT WITH MCC	3.4	$15,429.15	$7,714.57
251	PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITHOUT CORONARY ARTERY STENT WITHOUT MCC	2.0	$17,618.25	$8,809.13
252	OTHER VASCULAR PROCEDURES WITH MCC	5.2	$13,938.99	$6,969.49
253	OTHER VASCULAR PROCEDURES WITH CC	3.9	$14,864.70	$7,432.35
254	OTHER VASCULAR PROCEDURES WITHOUT CC/MCC	1.9	$20,864.15	$10,432.07
255	UPPER LIMB AND TOE AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS WITH MCC	6.3	$8,828.92	$4,414.46
256	UPPER LIMB AND TOE AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS WITH CC	4.8	$7,372.10	$3,686.05
257	UPPER LIMB AND TOE AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS WITHOUT CC/MCC	3.4	$6,687.01	$3,343.50
258	CARDIAC PACEMAKER DEVICE REPLACEMENT WITH MCC	4.7	$13,152.38	$6,576.19
259	CARDIAC PACEMAKER DEVICE REPLACEMENT WITHOUT MCC	2.5	$17,292.83	$8,646.42
260	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT WITH MCC	6.0	$12,641.61	$6,320.80
261	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT WITH CC	3.0	$13,808.71	$6,904.36

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
262	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT WITHOUT CC/MCC	2.1	$17,310.96	$8,655.48
263	VEIN LIGATION AND STRIPPING	4.6	$13,130.54	$6,565.27
264	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	6.6	$10,871.86	$5,435.93
265	AICD LEAD PROCEDURES	4.2	$17,458.08	$8,729.04
266	ENDOVASCULAR CARDIAC VALVE REPLACEMENT AND SUPPLEMENT PROCEDURES WITH MCC	2.8	$51,108.28	$25,554.14
267	ENDOVASCULAR CARDIAC VALVE REPLACEMENT AND SUPPLEMENT PROCEDURES WITHOUT MCC	1.4	$79,915.57	$39,957.79
268	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON WITH MCC	6.0	$25,007.16	$12,503.58
269	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON WITHOUT MCC	1.5	$61,806.79	$30,903.39
270	OTHER MAJOR CARDIOVASCULAR PROCEDURES WITH MCC	6.5	$17,052.49	$8,526.24
271	OTHER MAJOR CARDIOVASCULAR PROCEDURES WITH CC	3.9	$19,366.35	$9,683.18
272	OTHER MAJOR CARDIOVASCULAR PROCEDURES WITHOUT CC/MCC	1.8	$31,272.20	$15,636.10
273	PERCUTANEOUS AND OTHER INTRACARDIAC PROCEDURES WITH MCC	3.8	$22,895.22	$11,447.61
274	PERCUTANEOUS AND OTHER INTRACARDIAC PROCEDURES WITHOUT MCC	1.3	$56,026.12	$28,013.06
280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE WITH MCC	4.1	$8,494.33	$4,247.17
281	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE WITH CC	2.4	$8,298.02	$4,149.01
282	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE WITHOUT CC/MCC	1.7	$9,140.04	$4,570.02
283	ACUTE MYOCARDIAL INFARCTION, EXPIRED WITH MCC	3.1	$13,417.82	$6,708.91
284	ACUTE MYOCARDIAL INFARCTION, EXPIRED WITH CC	1.6	$9,964.68	$4,982.34
285	ACUTE MYOCARDIAL INFARCTION, EXPIRED WITHOUT CC/MCC	1.3	$9,035.55	$4,517.78
286	CIRCULATORY DISORDERS EXCEPT AMI, WITH CARDIAC CATHETERIZATION WITH MCC	5.2	$8,842.94	$4,421.47
287	CIRCULATORY DISORDERS EXCEPT AMI, WITH CARDIAC CATHETERIZATION WITHOUT MCC	2.1	$11,358.26	$5,679.13
288	ACUTE AND SUBACUTE ENDOCARDITIS WITH MCC	7.3	$8,008.24	$4,004.12
289	ACUTE AND SUBACUTE ENDOCARDITIS WITH CC	5.3	$6,573.95	$3,286.97
290	ACUTE AND SUBACUTE ENDOCARDITIS WITHOUT CC/MCC	3.7	$7,064.75	$3,532.38
291	HEART FAILURE AND SHOCK WITH MCC	3.9	$7,114.37	$3,557.19
292	HEART FAILURE AND SHOCK WITH CC	3.0	$6,235.17	$3,117.58
293	HEART FAILURE AND SHOCK WITHOUT CC/MCC	2.1	$5,784.43	$2,892.21
294	DEEP VEIN THROMBOPHLEBITIS WITH CC/MCC	3.3	$7,584.72	$3,792.36

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
295	DEEP VEIN THROMBOPHLEBITIS WITHOUT CC/MCC	2.1	$9,143.80	$4,571.90
296	CARDIAC ARREST, UNEXPLAINED WITH MCC	2.1	$16,913.50	$8,456.75
297	CARDIAC ARREST, UNEXPLAINED WITH CC	1.3	$10,611.52	$5,305.76
298	CARDIAC ARREST, UNEXPLAINED WITHOUT CC/MCC	1.1	$9,627.89	$4,813.95
299	PERIPHERAL VASCULAR DISORDERS WITH MCC	3.9	$8,549.70	$4,274.85
300	PERIPHERAL VASCULAR DISORDERS WITH CC	3.0	$7,451.41	$3,725.71
301	PERIPHERAL VASCULAR DISORDERS WITHOUT CC/MCC	2.1	$7,393.91	$3,696.96
302	ATHEROSCLEROSIS WITH MCC	2.7	$9,682.13	$4,841.06
303	ATHEROSCLEROSIS WITHOUT MCC	1.8	$8,143.24	$4,071.62
304	HYPERTENSION WITH MCC	2.9	$8,212.98	$4,106.49
305	HYPERTENSION WITHOUT MCC	2.1	$7,697.43	$3,848.71
306	CARDIAC CONGENITAL AND VALVULAR DISORDERS WITH MCC	3.8	$8,419.83	$4,209.91
307	CARDIAC CONGENITAL AND VALVULAR DISORDERS WITHOUT MCC	2.2	$8,981.44	$4,490.72
308	CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITH MCC	3.4	$7,477.05	$3,738.52
309	CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITH CC	2.3	$6,952.68	$3,476.34
310	CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITHOUT CC/MCC	1.8	$6,638.90	$3,319.45
311	ANGINA PECTORIS	1.9	$7,623.37	$3,811.68
312	SYNCOPE AND COLLAPSE	2.3	$8,037.63	$4,018.81
313	CHEST PAIN	1.7	$9,225.48	$4,612.74
314	OTHER CIRCULATORY SYSTEM DIAGNOSES WITH MCC	4.9	$9,214.44	$4,607.22
315	OTHER CIRCULATORY SYSTEM DIAGNOSES WITH CC	2.7	$7,776.70	$3,888.35
316	OTHER CIRCULATORY SYSTEM DIAGNOSES WITHOUT CC/MCC	1.8	$8,214.31	$4,107.16
319	OTHER ENDOVASCULAR CARDIAC VALVE PROCEDURES WITH MCC	7.3	$12,790.01	$6,395.01
320	OTHER ENDOVASCULAR CARDIAC VALVE PROCEDURES WITHOUT MCC	2.1	$25,514.27	$12,757.13
326	STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITH MCC	9.4	$11,805.91	$5,902.96
327	STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITH CC	4.3	$12,913.72	$6,456.86
328	STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITHOUT CC/MCC	2.2	$16,335.88	$8,167.94
329	MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH MCC	9.8	$10,227.87	$5,113.94

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
330	MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH CC	5.3	$10,043.98	$5,021.99
331	MAJOR SMALL AND LARGE BOWEL PROCEDURES WITHOUT CC/MCC	3.0	$12,348.93	$6,174.46
332	RECTAL RESECTION WITH MCC	7.4	$11,895.58	$5,947.79
333	RECTAL RESECTION WITH CC	4.0	$12,103.40	$6,051.70
334	RECTAL RESECTION WITHOUT CC/MCC	2.4	$15,487.65	$7,743.83
335	PERITONEAL ADHESIOLYSIS WITH MCC	8.9	$8,973.57	$4,486.79
336	PERITONEAL ADHESIOLYSIS WITH CC	5.6	$8,234.53	$4,117.26
337	PERITONEAL ADHESIOLYSIS WITHOUT CC/MCC	3.6	$9,488.01	$4,744.01
338	APPENDECTOMY WITH COMPLICATED PRINCIPAL DIAGNOSIS WITH MCC	5.9	$9,761.51	$4,880.76
339	APPENDECTOMY WITH COMPLICATED PRINCIPAL DIAGNOSIS WITH CC	3.7	$9,541.55	$4,770.77
340	APPENDECTOMY WITH COMPLICATED PRINCIPAL DIAGNOSIS WITHOUT CC/MCC	2.3	$11,310.37	$5,655.18
341	APPENDECTOMY WITHOUT COMPLICATED PRINCIPAL DIAGNOSIS WITH MCC	4.4	$11,130.71	$5,565.35
342	APPENDECTOMY WITHOUT COMPLICATED PRINCIPAL DIAGNOSIS WITH CC	2.5	$12,602.15	$6,301.08
343	APPENDECTOMY WITHOUT COMPLICATED PRINCIPAL DIAGNOSIS WITHOUT CC/MCC	1.6	$14,806.09	$7,403.04
344	MINOR SMALL AND LARGE BOWEL PROCEDURES WITH MCC	6.6	$8,647.36	$4,323.68
345	MINOR SMALL AND LARGE BOWEL PROCEDURES WITH CC	4.2	$8,008.70	$4,004.35
346	MINOR SMALL AND LARGE BOWEL PROCEDURES WITHOUT CC/MCC	2.9	$9,350.06	$4,675.03
347	ANAL AND STOMAL PROCEDURES WITH MCC	5.6	$9,826.46	$4,913.23
348	ANAL AND STOMAL PROCEDURES WITH CC	3.4	$8,805.91	$4,402.95
349	ANAL AND STOMAL PROCEDURES WITHOUT CC/MCC	1.9	$11,378.58	$5,689.29
350	INGUINAL AND FEMORAL HERNIA PROCEDURES WITH MCC	5.1	$10,019.56	$5,009.78
351	INGUINAL AND FEMORAL HERNIA PROCEDURES WITH CC	3.0	$10,624.65	$5,312.32
352	INGUINAL AND FEMORAL HERNIA PROCEDURES WITHOUT CC/MCC	2.0	$11,946.76	$5,973.38
353	HERNIA PROCEDURES EXCEPT INGUINAL AND FEMORAL WITH MCC	5.7	$10,907.70	$5,453.85
354	HERNIA PROCEDURES EXCEPT INGUINAL AND FEMORAL WITH CC	3.6	$10,550.93	$5,275.47
355	HERNIA PROCEDURES EXCEPT INGUINAL AND FEMORAL WITHOUT CC/MCC	2.3	$12,935.42	$6,467.71
356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH MCC	7.7	$11,888.81	$5,944.40

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
357	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CC	4.4	$11,067.64	$5,533.82
358	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITHOUT CC/MCC	2.7	$11,138.70	$5,569.35
368	MAJOR ESOPHAGEAL DISORDERS WITH MCC	4.2	$9,055.01	$4,527.51
369	MAJOR ESOPHAGEAL DISORDERS WITH CC	3.0	$7,386.37	$3,693.19
370	MAJOR ESOPHAGEAL DISORDERS WITHOUT CC/MCC	2.1	$7,729.44	$3,864.72
371	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS WITH MCC	5.2	$7,053.50	$3,526.75
372	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS WITH CC	3.7	$5,964.93	$2,982.46
373	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS WITHOUT CC/MCC	2.8	$5,621.31	$2,810.66
374	DIGESTIVE MALIGNANCY WITH MCC	5.3	$8,153.72	$4,076.86
375	DIGESTIVE MALIGNANCY WITH CC	3.5	$7,461.63	$3,730.82
376	DIGESTIVE MALIGNANCY WITHOUT CC/MCC	2.4	$7,929.46	$3,964.73
377	GASTROINTESTINAL HEMORRHAGE WITH MCC	4.5	$8,566.01	$4,283.00
378	GASTROINTESTINAL HEMORRHAGE WITH CC	3.0	$7,118.27	$3,559.13
379	GASTROINTESTINAL HEMORRHAGE WITHOUT CC/MCC	2.1	$6,543.23	$3,271.61
380	COMPLICATED PEPTIC ULCER WITH MCC	5.0	$8,256.18	$4,128.09
381	COMPLICATED PEPTIC ULCER WITH CC	3.1	$7,381.69	$3,690.85
382	COMPLICATED PEPTIC ULCER WITHOUT CC/MCC	2.3	$7,256.20	$3,628.10
383	UNCOMPLICATED PEPTIC ULCER WITH MCC	3.9	$7,560.21	$3,780.10
384	UNCOMPLICATED PEPTIC ULCER WITHOUT MCC	2.6	$7,517.95	$3,758.98
385	INFLAMMATORY BOWEL DISEASE WITH MCC	5.0	$7,062.04	$3,531.02
386	INFLAMMATORY BOWEL DISEASE WITH CC	3.4	$6,311.43	$3,155.71
387	INFLAMMATORY BOWEL DISEASE WITHOUT CC/MCC	2.6	$5,766.88	$2,883.44
388	GASTROINTESTINAL OBSTRUCTION WITH MCC	4.6	$6,915.92	$3,457.96
389	GASTROINTESTINAL OBSTRUCTION WITH CC	3.0	$5,832.64	$2,916.32
390	GASTROINTESTINAL OBSTRUCTION WITHOUT CC/MCC	2.3	$5,330.45	$2,665.23
391	ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS WITH MCC	3.8	$7,325.56	$3,662.78
392	ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS WITHOUT MCC	2.6	$6,567.37	$3,283.68
393	OTHER DIGESTIVE SYSTEM DIAGNOSES WITH MCC	4.3	$8,123.95	$4,061.97
394	OTHER DIGESTIVE SYSTEM DIAGNOSES WITH CC	3.0	$6,814.75	$3,407.37
395	OTHER DIGESTIVE SYSTEM DIAGNOSES WITHOUT CC/MCC	2.1	$6,657.83	$3,328.91

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
405	PANCREAS, LIVER AND SHUNT PROCEDURES WITH MCC	9.1	$13,203.12	$6,601.56
406	PANCREAS, LIVER AND SHUNT PROCEDURES WITH CC	5.1	$12,454.10	$6,227.05
407	PANCREAS, LIVER AND SHUNT PROCEDURES WITHOUT CC/MCC	3.6	$13,403.66	$6,701.83
408	BILIARY TRACT PROCEDURES EXCEPT ONLY CHOLECYSTECTOMY WITH OR WITHOUT C.D.E. WITH MCC	7.9	$10,070.22	$5,035.11
409	BILIARY TRACT PROCEDURES EXCEPT ONLY CHOLECYSTECTOMY WITH OR WITHOUT C.D.E. WITH CC	4.8	$9,626.83	$4,813.41
410	BILIARY TRACT PROCEDURES EXCEPT ONLY CHOLECYSTECTOMY WITH OR WITHOUT C.D.E. WITHOUT CC/MCC	3.3	$11,153.38	$5,576.69
411	CHOLECYSTECTOMY WITH C.D.E. WITH MCC	6.0	$12,206.56	$6,103.28
412	CHOLECYSTECTOMY WITH C.D.E. WITH CC	4.5	$11,060.17	$5,530.09
413	CHOLECYSTECTOMY WITH C.D.E. WITHOUT CC/MCC	2.9	$12,113.89	$6,056.94
414	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE WITHOUT C.D.E. WITH MCC	7.6	$10,083.20	$5,041.60
415	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE WITHOUT C.D.E. WITH CC	4.7	$9,225.53	$4,612.77
416	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE WITHOUT C.D.E. WITHOUT CC/MCC	2.9	$10,289.78	$5,144.89
417	LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITH MCC	5.0	$10,309.71	$5,154.85
418	LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITH CC	3.4	$10,591.32	$5,295.66
419	LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITHOUT CC/MCC	2.3	$12,301.04	$6,150.52
420	HEPATOBILIARY DIAGNOSTIC PROCEDURES WITH MCC	6.7	$10,552.66	$5,276.33
421	HEPATOBILIARY DIAGNOSTIC PROCEDURES WITH CC	3.7	$10,614.99	$5,307.50
422	HEPATOBILIARY DIAGNOSTIC PROCEDURES WITHOUT CC/MCC	2.2	$13,654.45	$6,827.23
423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES WITH MCC	7.8	$10,928.67	$5,464.33
424	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES WITH CC	4.5	$11,411.39	$5,705.69
425	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES WITHOUT CC/MCC	2.2	$14,097.91	$7,048.95
432	CIRRHOSIS AND ALCOHOLIC HEPATITIS WITH MCC	4.9	$8,354.32	$4,177.16
433	CIRRHOSIS AND ALCOHOLIC HEPATITIS WITH CC	3.3	$6,831.17	$3,415.58
434	CIRRHOSIS AND ALCOHOLIC HEPATITIS WITHOUT CC/MCC	2.1	$6,480.26	$3,240.13
435	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS WITH MCC	4.7	$8,064.04	$4,032.02

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
436	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS WITH CC	3.3	$7,229.30	$3,614.65
437	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS WITHOUT CC/MCC	2.3	$7,973.53	$3,986.77
438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITH MCC	4.7	$7,645.20	$3,822.60
439	DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITH CC	3.1	$6,082.99	$3,041.49
440	DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITHOUT CC/MCC	2.3	$5,715.98	$2,857.99
441	DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS OR ALCOHOLIC HEPATITIS WITH MCC	4.7	$8,740.27	$4,370.13
442	DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS OR ALCOHOLIC HEPATITIS WITH CC	3.1	$6,615.90	$3,307.95
443	DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS OR ALCOHOLIC HEPATITIS WITHOUT CC/MCC	2.4	$5,888.83	$2,944.42
444	DISORDERS OF THE BILIARY TRACT WITH MCC	4.4	$8,202.43	$4,101.22
445	DISORDERS OF THE BILIARY TRACT WITH CC	3.0	$7,946.44	$3,973.22
446	DISORDERS OF THE BILIARY TRACT WITHOUT CC/MCC	2.2	$7,998.94	$3,999.47
453	COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION WITH MCC	7.5	$26,463.47	$13,231.74
454	COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION WITH CC	3.7	$35,689.38	$17,844.69
455	COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION WITHOUT CC/MCC	2.4	$43,251.60	$21,625.80
456	SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITH MCC	9.7	$18,884.40	$9,442.20
457	SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITH CC	5.2	$25,168.81	$12,584.41
458	SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITHOUT CC/MCC	2.8	$37,267.14	$18,633.57
459	SPINAL FUSION EXCEPT CERVICAL WITH MCC	7.3	$19,699.10	$9,849.55
460	SPINAL FUSION EXCEPT CERVICAL WITHOUT MCC	2.8	$29,159.60	$14,579.80
461	BILATERAL OR MULTIPLE MAJOR JOINT PROCEDURES OF LOWER EXTREMITY WITH MCC	6.4	$21,731.49	$10,865.75
462	BILATERAL OR MULTIPLE MAJOR JOINT PROCEDURES OF LOWER EXTREMITY WITHOUT MCC	2.4	$26,969.92	$13,484.96
463	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WITH MCC	10.1	$11,251.28	$5,625.64
464	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WITH CC	5.5	$11,775.00	$5,887.50

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
465	WOUND DEBRIDEMENT AND SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WITHOUT CC/MCC	2.7	$16,000.64	$8,000.32
466	REVISION OF HIP OR KNEE REPLACEMENT WITH MCC	7.1	$16,016.02	$8,008.01
467	REVISION OF HIP OR KNEE REPLACEMENT WITH CC	3.4	$23,120.45	$11,560.22
468	REVISION OF HIP OR KNEE REPLACEMENT WITHOUT CC/MCC	1.8	$33,595.57	$16,797.78
469	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITH MCC OR TOTAL ANKLE REPLACEMENT	3.1	$22,598.95	$11,299.48
470	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC	1.7	$24,382.35	$12,191.18
471	CERVICAL SPINAL FUSION WITH MCC	7.0	$15,600.31	$7,800.15
472	CERVICAL SPINAL FUSION WITH CC	2.6	$25,607.42	$12,803.71
473	CERVICAL SPINAL FUSION WITHOUT CC/MCC	1.7	$32,329.98	$16,164.99
474	AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORDERS WITH MCC	9.2	$9,654.43	$4,827.22
475	AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORDERS WITH CC	5.8	$8,302.69	$4,151.35
476	AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORDERS WITHOUT CC/MCC	3.0	$8,870.73	$4,435.37
477	BIOPSIES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH MCC	8.6	$8,578.22	$4,289.11
478	BIOPSIES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH CC	5.2	$9,793.11	$4,896.55
479	BIOPSIES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITHOUT CC/MCC	3.2	$11,980.91	$5,990.46
480	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH MCC	6.2	$10,371.43	$5,185.72
481	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH CC	4.4	$10,408.37	$5,204.19
482	HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITHOUT CC/MCC	3.2	$11,152.33	$5,576.16
483	MAJOR JOINT OR LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITIES	1.4	$36,509.11	$18,254.56
485	KNEE PROCEDURES WITH PRINCIPAL DIAGNOSIS OF INFECTION WITH MCC	8.0	$8,810.21	$4,405.11
486	KNEE PROCEDURES WITH PRINCIPAL DIAGNOSIS OF INFECTION WITH CC	4.9	$9,229.49	$4,614.74
487	KNEE PROCEDURES WITH PRINCIPAL DIAGNOSIS OF INFECTION WITHOUT CC/MCC	3.5	$9,935.63	$4,967.82
488	KNEE PROCEDURES WITHOUT PRINCIPAL DIAGNOSIS OF INFECTION WITH CC/MCC	3.5	$14,056.07	$7,028.04
489	KNEE PROCEDURES WITHOUT PRINCIPAL DIAGNOSIS OF INFECTION WITHOUT CC/MCC	1.7	$16,955.04	$8,477.52
492	LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITH MCC	6.3	$11,995.92	$5,997.96

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
493	LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITH CC	4.0	$12,876.84	$6,438.42
494	LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITHOUT CC/MCC	2.7	$15,166.36	$7,583.18
495	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH MCC	7.8	$10,324.13	$5,162.06
496	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC	3.6	$12,644.86	$6,322.43
497	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC/MCC	1.9	$17,363.40	$8,681.70
498	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES OF HIP AND FEMUR WITH CC/MCC	5.8	$9,580.69	$4,790.34
499	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES OF HIP AND FEMUR WITHOUT CC/MCC	2.1	$13,614.01	$6,807.00
500	SOFT TISSUE PROCEDURES WITH MCC	7.4	$9,388.32	$4,694.16
501	SOFT TISSUE PROCEDURES WITH CC	4.1	$9,294.90	$4,647.45
502	SOFT TISSUE PROCEDURES WITHOUT CC/MCC	2.3	$12,956.16	$6,478.08
503	FOOT PROCEDURES WITH MCC	7.0	$7,845.99	$3,923.00
504	FOOT PROCEDURES WITH CC	4.5	$8,550.59	$4,275.30
505	FOOT PROCEDURES WITHOUT CC/MCC	2.5	$15,321.69	$7,660.84
506	MAJOR THUMB OR JOINT PROCEDURES	3.8	$8,043.28	$4,021.64
507	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES WITH CC/MCC	4.7	$8,555.76	$4,277.88
508	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES WITHOUT CC/MCC	2.2	$14,271.35	$7,135.68
509	ARTHROSCOPY	3.6	$9,141.13	$4,570.57
510	SHOULDER, ELBOW OR FOREARM PROCEDURES, EXCEPT MAJOR JOINT PROCEDURES WITH MCC	5.0	$12,522.80	$6,261.40
511	SHOULDER, ELBOW OR FOREARM PROCEDURES, EXCEPT MAJOR JOINT PROCEDURES WITH CC	3.2	$13,407.73	$6,703.86
512	SHOULDER, ELBOW OR FOREARM PROCEDURES, EXCEPT MAJOR JOINT PROCEDURES WITHOUT CC/MCC	2.1	$16,585.20	$8,292.60
513	HAND OR WRIST PROCEDURES, EXCEPT MAJOR THUMB OR JOINT PROCEDURES WITH CC/MCC	3.9	$8,861.01	$4,430.50
514	HAND OR WRIST PROCEDURES, EXCEPT MAJOR THUMB OR JOINT PROCEDURES WITHOUT CC/MCC	2.2	$10,176.79	$5,088.40
515	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE O.R. PROCEDURES WITH MCC	6.6	$10,241.50	$5,120.75
516	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE O.R. PROCEDURES WITH CC	3.8	$11,603.36	$5,801.68
517	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE O.R. PROCEDURES WITHOUT CC/MCC	2.2	$14,879.38	$7,439.69

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
518	BACK AND NECK PROCEDURES EXCEPT SPINAL FUSION WITH MCC OR DISC DEVICE OR NEUROSTIMULATOR	5.2	$15,541.64	$7,770.82
519	BACK AND NECK PROCEDURES EXCEPT SPINAL FUSION WITH CC	3.2	$13,545.26	$6,772.63
520	BACK AND NECK PROCEDURES EXCEPT SPINAL FUSION WITHOUT CC/MCC	2.0	$16,041.03	$8,020.52
521	HIP REPLACEMENT WITH PRINCIPAL DIAGNOSIS OF HIP FRACTURE WITH MCC	6.2	$10,557.46	$5,278.73
522	HIP REPLACEMENT WITH PRINCIPAL DIAGNOSIS OF HIP FRACTURE WITHOUT MCC	4.0	$11,777.12	$5,888.56
533	FRACTURES OF FEMUR WITH MCC	4.1	$7,542.00	$3,771.00
534	FRACTURES OF FEMUR WITHOUT MCC	2.7	$6,390.79	$3,195.39
535	FRACTURES OF HIP AND PELVIS WITH MCC	3.8	$7,356.94	$3,678.47
536	FRACTURES OF HIP AND PELVIS WITHOUT MCC	2.7	$6,239.82	$3,119.91
537	SPRAINS, STRAINS, AND DISLOCATIONS OF HIP, PELVIS AND THIGH WITH CC/MCC	3.1	$6,947.39	$3,473.70
538	SPRAINS, STRAINS, AND DISLOCATIONS OF HIP, PELVIS AND THIGH WITHOUT CC/MCC	2.3	$6,562.44	$3,281.22
539	OSTEOMYELITIS WITH MCC	6.2	$6,979.21	$3,489.61
540	OSTEOMYELITIS WITH CC	4.4	$6,635.06	$3,317.53
541	OSTEOMYELITIS WITHOUT CC/MCC	2.9	$6,115.26	$3,057.63
542	PATHOLOGICAL FRACTURES AND MUSCULOSKELETAL AND CONNECTIVE TISSUE MALIGNANCY WITH MCC	5.1	$7,770.79	$3,885.40
543	PATHOLOGICAL FRACTURES AND MUSCULOSKELETAL AND CONNECTIVE TISSUE MALIGNANCY WITH CC	3.4	$6,943.98	$3,471.99
544	PATHOLOGICAL FRACTURES AND MUSCULOSKELETAL AND CONNECTIVE TISSUE MALIGNANCY WITHOUT CC/MCC	2.6	$6,488.15	$3,244.08
545	CONNECTIVE TISSUE DISORDERS WITH MCC	5.6	$9,711.86	$4,855.93
546	CONNECTIVE TISSUE DISORDERS WITH CC	3.4	$7,687.47	$3,843.74
547	CONNECTIVE TISSUE DISORDERS WITHOUT CC/MCC	2.6	$7,628.02	$3,814.01
548	SEPTIC ARTHRITIS WITH MCC	5.8	$7,251.21	$3,625.61
549	SEPTIC ARTHRITIS WITH CC	4.0	$6,567.42	$3,283.71
550	SEPTIC ARTHRITIS WITHOUT CC/MCC	2.8	$8,116.84	$4,058.42
551	MEDICAL BACK PROBLEMS WITH MCC	4.4	$8,245.30	$4,122.65
552	MEDICAL BACK PROBLEMS WITHOUT MCC	2.8	$7,437.01	$3,718.51
553	BONE DISEASES AND ARTHROPATHIES WITH MCC	4.0	$7,186.38	$3,593.19
554	BONE DISEASES AND ARTHROPATHIES WITHOUT MCC	2.7	$6,585.90	$3,292.95

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
555	SIGNS AND SYMPTOMS OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH MCC	3.7	$7,800.11	$3,900.06
556	SIGNS AND SYMPTOMS OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITHOUT MCC	2.5	$7,006.98	$3,503.49
557	TENDONITIS, MYOSITIS AND BURSITIS WITH MCC	4.5	$6,898.58	$3,449.29
558	TENDONITIS, MYOSITIS AND BURSITIS WITHOUT MCC	3.0	$6,279.97	$3,139.99
559	AFTERCARE, MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH MCC	4.8	$8,062.25	$4,031.13
560	AFTERCARE, MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH CC	3.7	$6,419.62	$3,209.81
561	AFTERCARE, MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITHOUT CC/MCC	2.7	$6,345.01	$3,172.51
562	FRACTURE, SPRAIN, STRAIN AND DISLOCATION EXCEPT FEMUR, HIP, PELVIS AND THIGH WITH MCC	4.0	$7,928.38	$3,964.19
563	FRACTURE, SPRAIN, STRAIN AND DISLOCATION EXCEPT FEMUR, HIP, PELVIS AND THIGH WITHOUT MCC	2.7	$6,915.12	$3,457.56
564	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DIAGNOSES WITH MCC	4.7	$7,165.01	$3,582.50
565	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DIAGNOSES WITH CC	3.3	$6,486.92	$3,243.46
566	OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DIAGNOSES WITHOUT CC/MCC	2.5	$6,440.70	$3,220.35
570	SKIN DEBRIDEMENT WITH MCC	7.5	$8,432.36	$4,216.18
571	SKIN DEBRIDEMENT WITH CC	4.8	$7,446.18	$3,723.09
572	SKIN DEBRIDEMENT WITHOUT CC/MCC	2.9	$8,997.94	$4,498.97
573	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS WITH MCC	11.3	$11,263.05	$5,631.52
574	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS WITH CC	8.1	$9,647.87	$4,823.93
575	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS WITHOUT CC/MCC	4.4	$10,098.94	$5,049.47
576	SKIN GRAFT EXCEPT FOR SKIN ULCER OR CELLULITIS WITH MCC	9.6	$12,757.33	$6,378.66
577	SKIN GRAFT EXCEPT FOR SKIN ULCER OR CELLULITIS WITH CC	4.5	$12,616.32	$6,308.16
578	SKIN GRAFT EXCEPT FOR SKIN ULCER OR CELLULITIS WITHOUT CC/MCC	2.7	$13,750.74	$6,875.37
579	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITH MCC	7.2	$9,490.12	$4,745.06
580	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITH CC	4.0	$9,410.21	$4,705.10
581	OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITHOUT CC/MCC	2.0	$15,300.66	$7,650.33
582	MASTECTOMY FOR MALIGNANCY WITH CC/MCC	2.4	$17,477.69	$8,738.85
583	MASTECTOMY FOR MALIGNANCY WITHOUT CC/MCC	1.7	$19,267.14	$9,633.57

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
584	BREAST BIOPSY, LOCAL EXCISION AND OTHER BREAST PROCEDURES WITH CC/MCC	3.5	$13,229.75	$6,614.88
585	BREAST BIOPSY, LOCAL EXCISION AND OTHER BREAST PROCEDURES WITHOUT CC/MCC	2.1	$19,007.16	$9,503.58
592	SKIN ULCERS WITH MCC	5.5	$7,032.20	$3,516.10
593	SKIN ULCERS WITH CC	4.1	$6,091.02	$3,045.51
594	SKIN ULCERS WITHOUT CC/MCC	3.0	$5,592.72	$2,796.36
595	MAJOR SKIN DISORDERS WITH MCC	5.4	$8,597.33	$4,298.66
596	MAJOR SKIN DISORDERS WITHOUT MCC	3.5	$6,762.92	$3,381.46
597	MALIGNANT BREAST DISORDERS WITH MCC	4.8	$7,606.07	$3,803.03
598	MALIGNANT BREAST DISORDERS WITH CC	3.3	$7,017.09	$3,508.55
599	MALIGNANT BREAST DISORDERS WITHOUT CC/MCC	2.1	$7,718.08	$3,859.04
600	NON-MALIGNANT BREAST DISORDERS WITH CC/MCC	3.4	$6,638.54	$3,319.27
601	NON-MALIGNANT BREAST DISORDERS WITHOUT CC/MCC	2.6	$5,869.45	$2,934.72
602	CELLULITIS WITH MCC	4.6	$6,792.44	$3,396.22
603	CELLULITIS WITHOUT MCC	3.2	$5,974.19	$2,987.10
604	TRAUMA TO THE SKIN, SUBCUTANEOUS TISSUE AND BREAST WITH MCC	3.8	$8,610.38	$4,305.19
605	TRAUMA TO THE SKIN, SUBCUTANEOUS TISSUE AND BREAST WITHOUT MCC	2.5	$7,894.99	$3,947.50
606	MINOR SKIN DISORDERS WITH MCC	4.4	$7,562.87	$3,781.44
607	MINOR SKIN DISORDERS WITHOUT MCC	2.9	$6,341.03	$3,170.51
614	ADRENAL AND PITUITARY PROCEDURES WITH CC/MCC	3.0	$16,981.95	$8,490.97
615	ADRENAL AND PITUITARY PROCEDURES WITHOUT CC/MCC	1.6	$19,997.09	$9,998.54
616	AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH MCC	9.7	$8,413.85	$4,206.93
617	AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH CC	5.6	$7,526.06	$3,763.03
618	AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITHOUT CC/MCC	3.5	$7,265.28	$3,632.64
619	O.R. PROCEDURES FOR OBESITY WITH MCC	2.8	$22,390.02	$11,195.01
620	O.R. PROCEDURES FOR OBESITY WITH CC	1.7	$21,496.35	$10,748.18
621	O.R. PROCEDURES FOR OBESITY WITHOUT CC/MCC	1.3	$25,932.62	$12,966.31
622	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH MCC	8.6	$9,128.54	$4,564.27

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
623	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH CC	5.4	$7,566.32	$3,783.16
624	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITHOUT CC/MCC	2.6	$8,246.74	$4,123.37
625	THYROID, PARATHYROID AND THYROGLOSSAL PROCEDURES WITH MCC	4.7	$13,271.85	$6,635.93
626	THYROID, PARATHYROID AND THYROGLOSSAL PROCEDURES WITH CC	2.1	$16,716.31	$8,358.16
627	THYROID, PARATHYROID AND THYROGLOSSAL PROCEDURES WITHOUT CC/MCC	1.4	$19,758.23	$9,879.11
628	OTHER ENDOCRINE, NUTRITIONAL AND METABOLIC O.R. PROCEDURES WITH MCC	7.7	$10,262.24	$5,131.12
629	OTHER ENDOCRINE, NUTRITIONAL AND METABOLIC O.R. PROCEDURES WITH CC	5.9	$8,245.01	$4,122.51
630	OTHER ENDOCRINE, NUTRITIONAL AND METABOLIC O.R. PROCEDURES WITHOUT CC/MCC	2.2	$13,837.75	$6,918.88
637	DIABETES WITH MCC	3.9	$7,758.66	$3,879.33
638	DIABETES WITH CC	2.9	$6,548.86	$3,274.43
639	DIABETES WITHOUT CC/MCC	2.0	$6,512.67	$3,256.34
640	MISCELLANEOUS DISORDERS OF NUTRITION, METABOLISM, FLUIDS AND ELECTROLYTES WITH MCC	3.4	$8,068.15	$4,034.07
641	MISCELLANEOUS DISORDERS OF NUTRITION, METABOLISM, FLUIDS AND ELECTROLYTES WITHOUT MCC	2.6	$6,422.28	$3,211.14
642	INBORN AND OTHER DISORDERS OF METABOLISM	3.3	$9,219.25	$4,609.63
643	ENDOCRINE DISORDERS WITH MCC	5.1	$6,987.34	$3,493.67
644	ENDOCRINE DISORDERS WITH CC	3.5	$6,312.59	$3,156.30
645	ENDOCRINE DISORDERS WITHOUT CC/MCC	2.6	$6,192.14	$3,096.07
650	KIDNEY TRANSPLANT WITH HEMODIALYSIS WITH MCC	6.6	$15,254.51	$7,627.25
651	KIDNEY TRANSPLANT WITH HEMODIALYSIS WITHOUT MCC	5.6	$13,728.86	$6,864.43
652	KIDNEY TRANSPLANT	4.5	$14,863.32	$7,431.66
653	MAJOR BLADDER PROCEDURES WITH MCC	10.1	$11,927.65	$5,963.82
654	MAJOR BLADDER PROCEDURES WITH CC	5.4	$11,412.11	$5,706.06
655	MAJOR BLADDER PROCEDURES WITHOUT CC/MCC	3.4	$13,764.89	$6,882.44
656	KIDNEY AND URETER PROCEDURES FOR NEOPLASM WITH MCC	5.3	$13,520.55	$6,760.27
657	KIDNEY AND URETER PROCEDURES FOR NEOPLASM WITH CC	2.8	$14,541.09	$7,270.54
658	KIDNEY AND URETER PROCEDURES FOR NEOPLASM WITHOUT CC/MCC	1.8	$19,018.18	$9,509.09
659	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITH MCC	5.9	$9,469.02	$4,734.51

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
660	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITH CC	3.0	$10,198.27	$5,099.14
661	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITHOUT CC/MCC	1.8	$12,982.71	$6,491.36
662	MINOR BLADDER PROCEDURES WITH MCC	7.0	$9,411.29	$4,705.64
663	MINOR BLADDER PROCEDURES WITH CC	3.5	$9,446.29	$4,723.14
664	MINOR BLADDER PROCEDURES WITHOUT CC/MCC	1.8	$13,570.48	$6,785.24
665	PROSTATECTOMY WITH MCC	7.4	$8,965.85	$4,482.93
666	PROSTATECTOMY WITH CC	3.6	$10,369.67	$5,184.83
667	PROSTATECTOMY WITHOUT CC/MCC	1.9	$11,226.82	$5,613.41
668	TRANSURETHRAL PROCEDURES WITH MCC	7.0	$8,742.93	$4,371.46
669	TRANSURETHRAL PROCEDURES WITH CC	3.7	$9,223.96	$4,611.98
670	TRANSURETHRAL PROCEDURES WITHOUT CC/MCC	2.0	$10,704.50	$5,352.25
671	URETHRAL PROCEDURES WITH CC/MCC	3.7	$10,731.60	$5,365.80
672	URETHRAL PROCEDURES WITHOUT CC/MCC	1.6	$14,115.04	$7,057.52
673	OTHER KIDNEY AND URINARY TRACT PROCEDURES WITH MCC	8.0	$9,468.74	$4,734.37
674	OTHER KIDNEY AND URINARY TRACT PROCEDURES WITH CC	6.0	$8,565.41	$4,282.70
675	OTHER KIDNEY AND URINARY TRACT PROCEDURES WITHOUT CC/MCC	3.0	$12,187.05	$6,093.53
682	RENAL FAILURE WITH MCC	4.3	$7,495.23	$3,747.61
683	RENAL FAILURE WITH CC	3.1	$6,258.53	$3,129.26
684	RENAL FAILURE WITHOUT CC/MCC	2.2	$5,960.03	$2,980.01
686	KIDNEY AND URINARY TRACT NEOPLASMS WITH MCC	4.7	$7,831.55	$3,915.78
687	KIDNEY AND URINARY TRACT NEOPLASMS WITH CC	3.2	$7,044.64	$3,522.32
688	KIDNEY AND URINARY TRACT NEOPLASMS WITHOUT CC/MCC	2.0	$9,391.78	$4,695.89
689	KIDNEY AND URINARY TRACT INFECTIONS WITH MCC	3.8	$6,544.51	$3,272.25
690	KIDNEY AND URINARY TRACT INFECTIONS WITHOUT MCC	2.8	$6,160.21	$3,080.11
693	URINARY STONES WITH MCC	3.7	$8,383.71	$4,191.86
694	URINARY STONES WITHOUT MCC	2.0	$8,640.56	$4,320.28
695	KIDNEY AND URINARY TRACT SIGNS AND SYMPTOMS WITH MCC	3.6	$6,915.32	$3,457.66
696	KIDNEY AND URINARY TRACT SIGNS AND SYMPTOMS WITHOUT MCC	2.3	$6,532.28	$3,266.14
697	URETHRAL STRICTURE	2.6	$8,275.09	$4,137.55
698	OTHER KIDNEY AND URINARY TRACT DIAGNOSES WITH MCC	4.8	$7,237.96	$3,618.98

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
699	OTHER KIDNEY AND URINARY TRACT DIAGNOSES WITH CC	3.2	$6,856.98	$3,428.49
700	OTHER KIDNEY AND URINARY TRACT DIAGNOSES WITHOUT CC/MCC	2.3	$6,982.84	$3,491.42
707	MAJOR MALE PELVIC PROCEDURES WITH CC/MCC	2.3	$18,807.87	$9,403.93
708	MAJOR MALE PELVIC PROCEDURES WITHOUT CC/MCC	1.4	$22,991.64	$11,495.82
709	PENIS PROCEDURES WITH CC/MCC	4.3	$12,160.97	$6,080.48
710	PENIS PROCEDURES WITHOUT CC/MCC	1.9	$16,447.14	$8,223.57
711	TESTES PROCEDURES WITH CC/MCC	5.1	$8,686.45	$4,343.23
712	TESTES PROCEDURES WITHOUT CC/MCC	2.5	$10,767.15	$5,383.58
713	TRANSURETHRAL PROSTATECTOMY WITH CC/MCC	2.6	$12,356.77	$6,178.38
714	TRANSURETHRAL PROSTATECTOMY WITHOUT CC/MCC	1.5	$13,849.19	$6,924.59
715	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY WITH CC/MCC	5.2	$9,310.73	$4,655.36
716	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY WITHOUT CC/MCC	1.5	$18,996.01	$9,498.01
717	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES EXCEPT MALIGNANCY WITH CC/MCC	3.4	$11,288.26	$5,644.13
718	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES EXCEPT MALIGNANCY WITHOUT CC/MCC	1.9	$14,479.96	$7,239.98
722	MALIGNANCY, MALE REPRODUCTIVE SYSTEM WITH MCC	4.9	$7,511.46	$3,755.73
723	MALIGNANCY, MALE REPRODUCTIVE SYSTEM WITH CC	3.3	$7,570.92	$3,785.46
724	MALIGNANCY, MALE REPRODUCTIVE SYSTEM WITHOUT CC/MCC	1.8	$9,215.20	$4,607.60
725	BENIGN PROSTATIC HYPERTROPHY WITH MCC	4.0	$6,771.21	$3,385.60
726	BENIGN PROSTATIC HYPERTROPHY WITHOUT MCC	2.5	$6,691.31	$3,345.66
727	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM WITH MCC	4.6	$6,771.70	$3,385.85
728	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM WITHOUT MCC	2.9	$6,142.92	$3,071.46
729	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES WITH CC/MCC	3.3	$7,080.82	$3,540.41
730	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES WITHOUT CC/MCC	2.0	$7,108.87	$3,554.44
734	PELVIC EVISCERATION, RADICAL HYSTERECTOMY AND RADICAL VULVECTOMY WITH CC/MCC	3.4	$13,933.86	$6,966.93
735	PELVIC EVISCERATION, RADICAL HYSTERECTOMY AND RADICAL VULVECTOMY WITHOUT CC/MCC	1.7	$16,224.29	$8,112.15
736	UTERINE AND ADNEXA PROCEDURES FOR OVARIAN OR ADNEXAL MALIGNANCY WITH MCC	8.0	$11,558.69	$5,779.35
737	UTERINE AND ADNEXA PROCEDURES FOR OVARIAN OR ADNEXAL MALIGNANCY WITH CC	4.0	$10,967.37	$5,483.69

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
738	UTERINE AND ADNEXA PROCEDURES FOR OVARIAN OR ADNEXAL MALIGNANCY WITHOUT CC/MCC	2.3	$13,232.34	$6,616.17
739	UTERINE AND ADNEXA PROCEDURES FOR NON-OVARIAN AND NON-ADNEXAL MALIGNANCY WITH MCC	6.5	$13,015.67	$6,507.84
740	UTERINE AND ADNEXA PROCEDURES FOR NON-OVARIAN AND NON-ADNEXAL MALIGNANCY WITH CC	2.7	$14,472.61	$7,236.30
741	UTERINE AND ADNEXA PROCEDURES FOR NON-OVARIAN AND NON-ADNEXAL MALIGNANCY WITHOUT CC/MCC	1.6	$17,789.80	$8,894.90
742	UTERINE AND ADNEXA PROCEDURES FOR NON-MALIGNANCY WITH CC/MCC	2.8	$13,953.40	$6,976.70
743	UTERINE AND ADNEXA PROCEDURES FOR NON-MALIGNANCY WITHOUT CC/MCC	1.6	$15,861.63	$7,930.81
744	D&C, CONIZATION, LAPAROSCOPY AND TUBAL INTERRUPTION WITH CC/MCC	4.4	$9,353.44	$4,676.72
745	D&C, CONIZATION, LAPAROSCOPY AND TUBAL INTERRUPTION WITHOUT CC/MCC	2.0	$12,474.67	$6,237.34
746	VAGINA, CERVIX AND VULVA PROCEDURES WITH CC/MCC	3.3	$10,271.07	$5,135.53
747	VAGINA, CERVIX AND VULVA PROCEDURES WITHOUT CC/MCC	1.5	$14,144.03	$7,072.01
748	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.5	$20,483.27	$10,241.63
749	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES WITH CC/MCC	5.3	$10,333.59	$5,166.79
750	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES WITHOUT CC/MCC	2.1	$14,732.08	$7,366.04
754	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH MCC	4.8	$7,845.00	$3,922.50
755	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC	3.1	$7,560.72	$3,780.36
756	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITHOUT CC/MCC	2.1	$10,290.77	$5,145.39
757	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM WITH MCC	4.7	$6,329.64	$3,164.82
758	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM WITH CC	3.5	$5,918.64	$2,959.32
759	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM WITHOUT CC/MCC	2.5	$5,380.11	$2,690.06
760	MENSTRUAL AND OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS WITH CC/MCC	2.6	$8,059.95	$4,029.98
761	MENSTRUAL AND OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS WITHOUT CC/MCC	1.5	$8,176.25	$4,088.13
768	VAGINAL DELIVERY WITH O.R. PROCEDURES EXCEPT STERILIZATION AND/OR D&C	2.8	$8,879.51	$4,439.75
769	POSTPARTUM AND POST ABORTION DIAGNOSES WITH O.R. PROCEDURES	2.9	$12,419.65	$6,209.82
770	ABORTION WITH D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	1.6	$11,731.59	$5,865.79
776	POSTPARTUM AND POST ABORTION DIAGNOSES WITHOUT O.R. PROCEDURES	2.2	$6,869.60	$3,434.80

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
779	ABORTION WITHOUT D&C	2.2	$10,037.84	$5,018.92
783	CESAREAN SECTION WITH STERILIZATION WITH MCC	4.7	$8,901.26	$4,450.63
784	CESAREAN SECTION WITH STERILIZATION WITH CC	3.1	$7,301.26	$3,650.63
785	CESAREAN SECTION WITH STERILIZATION WITHOUT CC/MCC	2.6	$7,605.51	$3,802.75
786	CESAREAN SECTION WITHOUT STERILIZATION WITH MCC	4.2	$8,336.48	$4,168.24
787	CESAREAN SECTION WITHOUT STERILIZATION WITH CC	3.2	$7,217.41	$3,608.70
788	CESAREAN SECTION WITHOUT STERILIZATION WITHOUT CC/MCC	2.7	$7,005.05	$3,502.53
789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.8	$21,990.74	$10,995.37
790	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	17.9	$7,292.59	$3,646.30
791	PREMATURITY WITH MAJOR PROBLEMS	13.3	$6,703.03	$3,351.52
792	PREMATURITY WITHOUT MAJOR PROBLEMS	8.6	$6,254.93	$3,127.47
793	FULL TERM NEONATE WITH MAJOR PROBLEMS	4.7	$19,484.32	$9,742.16
794	NEONATE WITH OTHER SIGNIFICANT PROBLEMS	3.4	$9,533.46	$4,766.73
795	NORMAL NEWBORN	3.1	$1,415.50	$707.75
796	VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITH MCC	3.6	$7,907.18	$3,953.59
797	VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITH CC	2.1	$9,579.47	$4,789.73
798	VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITHOUT CC/MCC	2.1	$9,579.47	$4,789.73
799	SPLENECTOMY WITH MCC	7.6	$14,855.65	$7,427.83
800	SPLENECTOMY WITH CC	4.4	$13,099.15	$6,549.58
801	SPLENECTOMY WITHOUT CC/MCC	2.6	$14,975.88	$7,487.94
802	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS WITH MCC	8.2	$10,078.56	$5,039.28
803	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS WITH CC	4.1	$10,857.45	$5,428.72
804	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS WITHOUT CC/MCC	1.8	$15,197.68	$7,598.84
805	VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITH MCC	2.8	$7,786.21	$3,893.11
806	VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITH CC	2.3	$6,577.52	$3,288.76
807	VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITHOUT CC/MCC	2.0	$6,844.38	$3,422.19
808	MAJOR HEMATOLOGICAL AND IMMUNOLOGICAL DIAGNOSES EXCEPT SICKLE CELL CRISIS AND COAGULATION DISORDERS WITH MCC	5.1	$9,101.35	$4,550.67

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
809	MAJOR HEMATOLOGICAL AND IMMUNOLOGICAL DIAGNOSES EXCEPT SICKLE CELL CRISIS AND COAGULATION DISORDERS WITH CC	3.4	$7,751.88	$3,875.94
810	MAJOR HEMATOLOGICAL AND IMMUNOLOGICAL DIAGNOSES EXCEPT SICKLE CELL CRISIS AND COAGULATION DISORDERS WITHOUT CC/MCC	2.5	$8,141.27	$4,070.64
811	RED BLOOD CELL DISORDERS WITH MCC	3.6	$8,372.69	$4,186.35
812	RED BLOOD CELL DISORDERS WITHOUT MCC	2.7	$7,210.61	$3,605.30
813	COAGULATION DISORDERS	3.6	$9,425.38	$4,712.69
814	RETICULOENDOTHELIAL AND IMMUNITY DISORDERS WITH MCC	4.6	$8,856.28	$4,428.14
815	RETICULOENDOTHELIAL AND IMMUNITY DISORDERS WITH CC	3.0	$7,451.41	$3,725.71
816	RETICULOENDOTHELIAL AND IMMUNITY DISORDERS WITHOUT CC/MCC	2.2	$7,183.96	$3,591.98
817	OTHER ANTEPARTUM DIAGNOSES WITH O.R. PROCEDURES WITH MCC	3.7	$18,338.94	$9,169.47
818	OTHER ANTEPARTUM DIAGNOSES WITH O.R. PROCEDURES WITH CC	3.6	$9,575.93	$4,787.97
819	OTHER ANTEPARTUM DIAGNOSES WITH O.R. PROCEDURES WITHOUT CC/MCC	1.6	$12,039.18	$6,019.59
820	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURES WITH MCC	10.3	$11,192.77	$5,596.39
821	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURES WITH CC	3.4	$13,788.48	$6,894.24
822	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURES WITHOUT CC/MCC	1.6	$16,327.75	$8,163.88
823	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH OTHER PROCEDURES WITH MCC	9.9	$9,474.38	$4,737.19
824	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH OTHER PROCEDURES WITH CC	5.1	$9,736.02	$4,868.01
825	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH OTHER PROCEDURES WITHOUT CC/MCC	2.3	$12,410.38	$6,205.19
826	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WITH MAJOR O.R. PROCEDURES WITH MCC	9.4	$11,859.19	$5,929.60
827	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WITH MAJOR O.R. PROCEDURES WITH CC	4.3	$12,275.42	$6,137.71
828	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WITH MAJOR O.R. PROCEDURES WITHOUT CC/MCC	2.6	$14,501.42	$7,250.71
829	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WITH OTHER PROCEDURES WITH CC/MCC	5.9	$11,628.93	$5,814.47
830	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WITH OTHER PROCEDURES WITHOUT CC/MCC	2.2	$14,491.11	$7,245.55
831	OTHER ANTEPARTUM DIAGNOSES WITHOUT O.R. PROCEDURES WITH MCC	3.4	$7,618.61	$3,809.30

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
832	OTHER ANTEPARTUM DIAGNOSES WITHOUT O.R. PROCEDURES WITH CC	2.5	$6,074.74	$3,037.37
833	OTHER ANTEPARTUM DIAGNOSES WITHOUT O.R. PROCEDURES WITHOUT CC/MCC	1.9	$5,750.91	$2,875.45
834	ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURES WITH MCC	9.4	$12,754.30	$6,377.15
835	ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURES WITH CC	4.3	$10,573.28	$5,286.64
836	ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURES WITHOUT CC/MCC	2.8	$12,146.99	$6,073.50
837	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS OR WITH HIGH DOSE CHEMOTHERAPY AGENT WITH MCC	11.2	$10,418.40	$5,209.20
838	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITH CC OR HIGH DOSE CHEMOTHERAPY AGENT	5.3	$9,097.83	$4,548.91
839	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITHOUT CC/MCC	4.5	$6,623.00	$3,311.50
840	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH MCC	6.6	$10,206.02	$5,103.01
841	LYMPHOMA AND NON-ACUTE LEUKEMIA WITH CC	4.0	$8,643.82	$4,321.91
842	LYMPHOMA AND NON-ACUTE LEUKEMIA WITHOUT CC/MCC	2.6	$9,203.16	$4,601.58
843	OTHER MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASTIC DIAGNOSES WITH MCC	5.4	$7,778.30	$3,889.15
844	OTHER MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASTIC DIAGNOSES WITH CC	3.5	$7,065.20	$3,532.60
845	OTHER MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASTIC DIAGNOSES WITHOUT CC/MCC	2.5	$7,332.18	$3,666.09
846	CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITH MCC	5.7	$9,162.65	$4,581.33
847	CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITH CC	3.6	$7,335.67	$3,667.83
848	CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITHOUT CC/MCC	2.7	$7,460.33	$3,730.16
849	RADIOTHERAPY	6.4	$7,923.03	$3,961.51
853	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH MCC	9.6	$11,068.09	$5,534.05
854	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH CC	5.1	$8,738.31	$4,369.16
855	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITHOUT CC/MCC	3.2	$10,350.17	$5,175.08
856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS WITH O.R. PROCEDURES WITH MCC	9.0	$10,629.70	$5,314.85
857	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS WITH O.R. PROCEDURES WITH CC	5.3	$8,627.00	$4,313.50
858	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS WITH O.R. PROCEDURES WITHOUT CC/MCC	3.5	$8,762.43	$4,381.22

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
862	POSTOPERATIVE AND POST-TRAUMATIC INFECTIONS WITH MCC	5.0	$7,930.98	$3,965.49
863	POSTOPERATIVE AND POST-TRAUMATIC INFECTIONS WITHOUT MCC	3.4	$6,414.09	$3,207.05
864	FEVER AND INFLAMMATORY CONDITIONS	2.6	$7,072.68	$3,536.34
865	VIRAL ILLNESS WITH MCC	4.2	$8,634.83	$4,317.42
866	VIRAL ILLNESS WITHOUT MCC	2.8	$6,966.25	$3,483.13
867	OTHER INFECTIOUS AND PARASITIC DISEASES DIAGNOSES WITH MCC	5.5	$8,330.64	$4,165.32
868	OTHER INFECTIOUS AND PARASITIC DISEASES DIAGNOSES WITH CC	3.5	$6,539.31	$3,269.65
869	OTHER INFECTIOUS AND PARASITIC DISEASES DIAGNOSES WITHOUT CC/MCC	2.5	$6,424.22	$3,212.11
870	SEPTICEMIA OR SEVERE SEPSIS WITH MV >96 HOURS	13.2	$11,153.54	$5,576.77
871	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	5.0	$8,486.42	$4,243.21
872	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOUT MCC	3.5	$6,367.73	$3,183.86
876	O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS	6.2	$11,176.74	$5,588.37
880	ACUTE ADJUSTMENT REACTION AND PSYCHOSOCIAL DYSFUNCTION	2.7	$7,276.45	$3,638.23
881	DEPRESSIVE NEUROSES	3.9	$4,755.70	$2,377.85
882	NEUROSES EXCEPT DEPRESSIVE	3.3	$5,738.63	$2,869.32
883	DISORDERS OF PERSONALITY AND IMPULSE CONTROL	5.2	$6,731.22	$3,365.61
884	ORGANIC DISTURBANCES AND INTELLECTUAL DISABILITY	4.7	$7,242.04	$3,621.02
885	PSYCHOSES	6.2	$4,530.07	$2,265.04
886	BEHAVIORAL AND DEVELOPMENTAL DISORDERS	4.6	$6,433.30	$3,216.65
887	OTHER MENTAL DISORDER DIAGNOSES	3.3	$8,517.61	$4,258.81
894	ALCOHOL, DRUG ABUSE OR DEPENDENCE, LEFT AMA	2.0	$6,198.31	$3,099.16
895	ALCOHOL, DRUG ABUSE OR DEPENDENCE WITH REHABILITATION THERAPY	8.4	$4,022.93	$2,011.47
896	ALCOHOL, DRUG ABUSE OR DEPENDENCE WITHOUT REHABILITATION THERAPY WITH MCC	5.0	$7,612.28	$3,806.14
897	ALCOHOL, DRUG ABUSE OR DEPENDENCE WITHOUT REHABILITATION THERAPY WITHOUT MCC	3.3	$5,592.78	$2,796.39
901	WOUND DEBRIDEMENTS FOR INJURIES WITH MCC	9.1	$10,479.30	$5,239.65
902	WOUND DEBRIDEMENTS FOR INJURIES WITH CC	4.7	$9,141.58	$4,570.79
903	WOUND DEBRIDEMENTS FOR INJURIES WITHOUT CC/MCC	2.7	$9,760.81	$4,880.41
904	SKIN GRAFTS FOR INJURIES WITH CC/MCC	6.7	$11,493.31	$5,746.66

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
905	SKIN GRAFTS FOR INJURIES WITHOUT CC/MCC	3.1	$10,909.24	$5,454.62
906	HAND PROCEDURES FOR INJURIES	2.9	$13,365.34	$6,682.67
907	OTHER O.R. PROCEDURES FOR INJURIES WITH MCC	6.8	$12,324.76	$6,162.38
908	OTHER O.R. PROCEDURES FOR INJURIES WITH CC	3.8	$11,732.87	$5,866.44
909	OTHER O.R. PROCEDURES FOR INJURIES WITHOUT CC/MCC	2.3	$12,863.78	$6,431.89
913	TRAUMATIC INJURY WITH MCC	3.9	$8,416.84	$4,208.42
914	TRAUMATIC INJURY WITHOUT MCC	2.4	$8,031.53	$4,015.77
915	ALLERGIC REACTIONS WITH MCC	3.8	$10,384.15	$5,192.07
916	ALLERGIC REACTIONS WITHOUT MCC	1.8	$7,999.92	$3,999.96
917	POISONING AND TOXIC EFFECTS OF DRUGS WITH MCC	3.6	$9,168.83	$4,584.42
918	POISONING AND TOXIC EFFECTS OF DRUGS WITHOUT MCC	2.4	$7,386.56	$3,693.28
919	COMPLICATIONS OF TREATMENT WITH MCC	4.3	$9,043.08	$4,521.54
920	COMPLICATIONS OF TREATMENT WITH CC	2.9	$7,638.83	$3,819.42
921	COMPLICATIONS OF TREATMENT WITHOUT CC/MCC	2.1	$7,514.70	$3,757.35
922	OTHER INJURY, POISONING AND TOXIC EFFECT DIAGNOSES WITH MCC	4.1	$8,226.77	$4,113.38
923	OTHER INJURY, POISONING AND TOXIC EFFECT DIAGNOSES WITHOUT MCC	2.8	$7,303.06	$3,651.53
927	EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITH SKIN GRAFT	23.3	$17,662.41	$8,831.20
928	FULL THICKNESS BURN WITH SKIN GRAFT OR INHALATION INJURY WITH CC/MCC	12.1	$11,093.17	$5,546.59
929	FULL THICKNESS BURN WITH SKIN GRAFT OR INHALATION INJURY WITHOUT CC/MCC	6.1	$10,444.78	$5,222.39
933	EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITHOUT SKIN GRAFT	2.3	$28,589.32	$14,294.66
934	FULL THICKNESS BURN WITHOUT SKIN GRAFT OR INHALATION INJURY	4.5	$9,038.15	$4,519.08
935	NON-EXTENSIVE BURNS	3.7	$11,860.13	$5,930.06
939	O.R. PROCEDURES WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES WITH MCC	6.1	$11,007.40	$5,503.70
940	O.R. PROCEDURES WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES WITH CC	3.2	$14,927.36	$7,463.68
941	O.R. PROCEDURES WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES WITHOUT CC/MCC	2.0	$20,459.42	$10,229.71
945	REHABILITATION WITH CC/MCC	4.4	$7,416.53	$3,708.27
946	REHABILITATION WITHOUT CC/MCC	3.1	$7,850.95	$3,925.48
947	SIGNS AND SYMPTOMS WITH MCC	3.5	$7,529.77	$3,764.89
948	SIGNS AND SYMPTOMS WITHOUT MCC	2.5	$6,743.34	$3,371.67

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
949	AFTERCARE WITH CC/MCC	4.9	$5,273.99	$2,637.00
950	AFTERCARE WITHOUT CC/MCC	3.3	$4,661.20	$2,330.60
951	OTHER FACTORS INFLUENCING HEALTH STATUS	1.8	$6,855.70	$3,427.85
955	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	8.1	$18,029.20	$9,014.60
956	LIMB REATTACHMENT, HIP AND FEMUR PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	6.1	$13,520.50	$6,760.25
957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITH MCC	9.7	$16,562.85	$8,281.42
958	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITH CC	6.6	$13,699.46	$6,849.73
959	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITHOUT CC/MCC	3.8	$14,655.11	$7,327.56
963	OTHER MULTIPLE SIGNIFICANT TRAUMA WITH MCC	5.3	$11,343.96	$5,671.98
964	OTHER MULTIPLE SIGNIFICANT TRAUMA WITH CC	3.9	$8,141.12	$4,070.56
965	OTHER MULTIPLE SIGNIFICANT TRAUMA WITHOUT CC/MCC	2.5	$7,890.66	$3,945.33
969	HIV WITH EXTENSIVE O.R. PROCEDURES WITH MCC	13.2	$11,903.63	$5,951.82
970	HIV WITH EXTENSIVE O.R. PROCEDURES WITHOUT MCC	6.2	$10,799.44	$5,399.72
974	HIV WITH MAJOR RELATED CONDITION WITH MCC	6.9	$9,027.05	$4,513.52
975	HIV WITH MAJOR RELATED CONDITION WITH CC	4.2	$7,101.23	$3,550.62
976	HIV WITH MAJOR RELATED CONDITION WITHOUT CC/MCC	3.3	$6,062.52	$3,031.26
977	HIV WITH OR WITHOUT OTHER RELATED CONDITION	3.6	$7,828.29	$3,914.14
981	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC	8.5	$11,682.72	$5,841.36
982	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH CC	4.3	$12,646.00	$6,323.00
983	EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITHOUT CC/MCC	2.1	$17,242.83	$8,621.41
987	NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC	7.8	$9,223.45	$4,611.73
988	NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH CC	4.2	$8,756.66	$4,378.33
989	NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITHOUT CC/MCC	2.1	$11,380.97	$5,690.49
998	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.	$0	$0
999	UNGROUPABLE	.	$0	$0

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