Fee Schedule Guidelines

Inpatient Hospital

WSI
North Dakota Workforce Safety & Insurance

January 2020

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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.

Table of Contents

Inpatient Hospital Pricing Methodology	4
Inpatient Hospital Payment Parameters	7
Inpatient Hospital Billing Requirements	8
Inpatient Hospital Reimbursement Procedures	10
Inpatient Hospital Transfer Fee Schedule	11

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 2020, The Conversion Factor for Inpatient Hospital DRG rates is $9,930.00.

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 2020, the outlier threshold is $73,000.00.

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
AndexXa	Procedure:	XW03372, XW04372	$21,937.50
Aquabeam	Procedure:	XV508A4	$1,950.00
Axedra	Procedure:	XW033S5, XW043S5	$117,780.00
Balversa	Procedure:	XW0DXL5	$4,275.88
CABLIVI (caplacizumab)	Procedure:	XW013W5, XW033W5, XW043W5	$39,750.00
Elzonris	Procedure:	XW033Q5, XW043Q5	$150,537.66
ERLEADA	Procedure:	XW0DXJ5	$2,229.90
GIAPREZA	Procedure:	XW033H4, XW043H4	$2,340.00
Jakafi (ruxolitinib)	Procedure:	XW0DXT5	$4,772.47
Kymriah/Yescarta	Procedure:	XW033C3, XW043C3	$290,940.00
Remede System	Procedure:	0JH60DZ & 05H33MZ with 05H03MZ or 05H43MZ	$26,910.00
Sentinel Cerebral Protection	Procedure:	X2A5312	$2,184.00

New Technology (continued)	Qualifying Criteria		Payment Amount
Spravato (exketamine)	Procedure:	3E097GC	$1,217.75
T2 Bacteria Test Panel	Procedure:	XXE5XM5	$117.00
VABOMERE	Procedure: NDC:	XW033N5, XW043N5 70842012001, 65293000901	$9,979.20
VYXEOS	Procedure:	XW033B3, XW043B3	$56,823.00
Xospata	Procedure:	XW0DXV5	$8,775.00
ZEMDRI (Plazomicin)	Procedure:	XW033G4, XW043G4	$4,900.50

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.

North Dakota Workforce Safety & Insurance

Inpatient Hospital Payment Parameters

Inpatient Hospital Payment Parameters outlines 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 worker 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.

North Dakota Workforce Safety & Insurance

Inpatient Hospital Billing Requirements

Inpatient Hospital Billing Requirements outlines 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 hospital may submit medical charges via EDI through one of WSI's clearinghouses:

- **Carisk (fka iHCFA):** This option allows a provider to electronically submit professional (837p) and institutional (837i) charges along with supporting medical documentation. Contact Carisk EDI Support Services at 973-795-1641 (option 2) for additional information.
- **Noridian:** This option allows a provider to submit professional (837p) and institutional (837i) charges without medical documentation attachment. A provider must mail all supporting medical documentation to WSI at the address provided below or fax it to 701-328-3793. Contact Noridian EDI Support Services at 800-967-7902 for additional information.

Paper Billing- A hospital may submit bills in red and white paper format along with supporting medical documentation to WSI 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.

North Dakota Workforce Safety & Insurance

Inpatient Hospital Reimbursement Procedures

Inpatient Hospital Reimbursement Procedures outlines 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- A hospital must refer to the WSI Remittance Advice for bill status information when possible. WSI requests a hospital allow 2 months from the date of bill submission prior to contacting WSI for bill status, which permits adequate time for bill receipt, bill processing, and payment and/or remittance advice mailing. WSI will not process requests for bill status inquiries of large volume or repetitive requests for the status of processed medical bills that do not meet the above requirements.

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.

North Dakota Workforce Safety & Insurance

Inpatient Hospital Transfer Fee Schedule

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
001	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	29.1	$18,859.42	$9,429.71
002	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	15.1	$18,431.26	$9,215.63
003	ECMO OR TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	23.4	$16,086.52	$8,043.26
004	TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	19.5	$11,756.92	$5,878.46
005	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	14.6	$14,028.10	$7,014.05
006	LIVER TRANSPLANT W/O MCC	7.9	$12,247.59	$6,123.79
007	LUNG TRANSPLANT	16.7	$12,827.30	$6,413.65
008	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	8.9	$12,532.11	$6,266.05
010	PANCREAS TRANSPLANT	7.8	$10,123.76	$5,061.88
011	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W MCC	10.9	$9,007.69	$4,503.85
012	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W CC	8.7	$8,615.13	$4,307.57
013	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W/O CC/MCC	5.9	$8,163.81	$4,081.90
014	ALLOGENEIC BONE MARROW TRANSPLANT	24.1	$10,510.80	$5,255.40
016	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC OR T-CELL IMMUNOTHERAPY	17.1	$7,996.50	$3,998.25
017	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	7.9	$11,180.43	$5,590.21
020	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	13.6	$15,801.84	$7,900.92
021	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	12.1	$13,579.81	$6,789.90
022	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	6.3	$15,546.91	$7,773.46
023	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX W MCC OR CHEMOTHERAPY IMPLANT OR EPILEPSY W NEUROSTIMULATOR	7.3	$15,281.59	$7,640.79
024	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	4.3	$18,550.63	$9,275.31
025	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	6.7	$13,026.09	$6,513.04
026	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	4.3	$14,067.35	$7,033.67
027	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.1	$22,665.93	$11,332.97
028	SPINAL PROCEDURES W MCC	9	$12,336.15	$6,168.07
029	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	4.4	$14,475.23	$7,237.62
030	SPINAL PROCEDURES W/O CC/MCC	2.3	$19,619.09	$9,809.54
031	VENTRICULAR SHUNT PROCEDURES W MCC	7.2	$12,066.33	$6,033.16

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
032	VENTRICULAR SHUNT PROCEDURES W CC	3.3	$13,192.46	$6,596.23
033	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.8	$18,766.60	$9,383.30
034	CAROTID ARTERY STENT PROCEDURE W MCC	4.7	$15,861.38	$7,930.69
035	CAROTID ARTERY STENT PROCEDURE W CC	2.1	$21,772.23	$10,886.12
036	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.2	$28,979.05	$14,489.53
037	EXTRACRANIAL PROCEDURES W MCC	5.1	$12,629.79	$6,314.90
038	EXTRACRANIAL PROCEDURES W CC	2.2	$15,122.49	$7,561.24
039	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.3	$17,282.78	$8,641.39
040	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	7.6	$10,296.89	$5,148.44
041	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	4.2	$11,213.81	$5,606.90
042	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	2.5	$14,682.90	$7,341.45
052	SPINAL DISORDERS & INJURIES W CC/MCC	4.1	$7,890.23	$3,945.12
053	SPINAL DISORDERS & INJURIES W/O CC/MCC	2.7	$7,106.20	$3,553.10
054	NERVOUS SYSTEM NEOPLASMS W MCC	3.8	$7,003.79	$3,501.89
055	NERVOUS SYSTEM NEOPLASMS W/O MCC	3.1	$6,316.76	$3,158.38
056	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	5.5	$7,916.56	$3,958.28
057	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	3.9	$6,165.77	$3,082.88
058	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	5	$7,764.07	$3,882.03
059	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	3.7	$5,853.33	$2,926.67
060	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	3	$5,836.85	$2,918.43
061	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W MCC	5	$11,095.78	$5,547.89
062	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W CC	3.4	$11,747.77	$5,873.89
063	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W/O CC/MCC	2.4	$13,908.62	$6,954.31
064	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	4.4	$8,462.17	$4,231.08
065	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	3.1	$6,583.91	$3,291.96
066	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	2.1	$6,780.77	$3,390.39
067	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	3.6	$8,079.16	$4,039.58
068	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	2.3	$7,800.66	$3,900.33
069	TRANSIENT ISCHEMIA W/O THROMBOLYTIC	2.1	$7,379.41	$3,689.70

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
070	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	4.5	$7,383.07	$3,691.53
071	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	3.3	$5,986.29	$2,993.14
072	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	2.4	$6,111.09	$3,055.54
073	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	3.7	$7,598.33	$3,799.16
074	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	2.9	$6,766.78	$3,383.39
075	VIRAL MENINGITIS W CC/MCC	4.8	$6,653.93	$3,326.96
076	VIRAL MENINGITIS W/O CC/MCC	2.8	$6,401.30	$3,200.65
077	HYPERTENSIVE ENCEPHALOPATHY W MCC	4.1	$7,471.72	$3,735.86
078	HYPERTENSIVE ENCEPHALOPATHY W CC	3.1	$6,163.01	$3,081.50
079	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	2.1	$7,008.69	$3,504.34
080	NONTRAUMATIC STUPOR & COMA W MCC	4.5	$8,457.27	$4,228.64
081	NONTRAUMATIC STUPOR & COMA W/O MCC	2.7	$6,466.27	$3,233.13
082	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	3.8	$11,768.62	$5,884.31
083	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	3.2	$8,134.53	$4,067.27
084	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	2.2	$8,100.17	$4,050.09
085	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	4.7	$9,489.70	$4,744.85
086	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	3.2	$7,682.10	$3,841.05
087	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	2.1	$7,936.43	$3,968.22
088	CONCUSSION W MCC	3.6	$7,663.20	$3,831.60
089	CONCUSSION W CC	2.7	$7,254.78	$3,627.39
090	CONCUSSION W/O CC/MCC	1.9	$8,866.97	$4,433.48
091	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	4.2	$7,400.69	$3,700.34
092	OTHER DISORDERS OF NERVOUS SYSTEM W CC	3	$6,395.58	$3,197.79
093	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	2.2	$6,871.56	$3,435.78
094	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	8	$8,899.27	$4,449.63
095	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	5.7	$8,386.84	$4,193.42
096	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	4.4	$10,210.30	$5,105.15
097	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	8.4	$8,454.45	$4,227.22
098	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	5.4	$7,190.06	$3,595.03
099	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	3.7	$6,883.37	$3,441.68
100	SEIZURES W MCC	4.3	$8,406.78	$4,203.39

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
101	SEIZURES W/O MCC	2.7	$6,494.22	$3,247.11
102	HEADACHES W MCC	3	$7,895.01	$3,947.51
103	HEADACHES W/O MCC	2.3	$6,903.51	$3,451.75
113	ORBITAL PROCEDURES W CC/MCC	4.5	$9,409.67	$4,704.83
114	ORBITAL PROCEDURES W/O CC/MCC	2.3	$10,282.30	$5,141.15
115	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	3.5	$8,431.99	$4,215.99
116	INTRAOCULAR PROCEDURES W CC/MCC	4	$9,388.82	$4,694.41
117	INTRAOCULAR PROCEDURES W/O CC/MCC	2.3	$9,469.77	$4,734.88
121	ACUTE MAJOR EYE INFECTIONS W CC/MCC	4	$6,294.63	$3,147.31
122	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	3.2	$4,794.95	$2,397.47
123	NEUROLOGICAL EYE DISORDERS	2	$7,753.34	$3,876.67
124	OTHER DISORDERS OF THE EYE W MCC	3.6	$7,664.86	$3,832.43
125	OTHER DISORDERS OF THE EYE W/O MCC	2.6	$6,029.80	$3,014.90
129	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	3.7	$12,287.97	$6,143.99
130	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	2.3	$12,482.44	$6,241.22
131	CRANIAL/FACIAL PROCEDURES W CC/MCC	4.2	$12,716.55	$6,358.27
132	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	2	$15,783.74	$7,891.87
133	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	4	$10,659.36	$5,329.68
134	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	2	$12,006.36	$6,003.18
135	SINUS & MASTOID PROCEDURES W CC/MCC	4.4	$10,311.85	$5,155.93
136	SINUS & MASTOID PROCEDURES W/O CC/MCC	1.8	$13,129.67	$6,564.83
137	MOUTH PROCEDURES W CC/MCC	3.6	$7,355.37	$3,677.69
138	MOUTH PROCEDURES W/O CC/MCC	2	$8,553.70	$4,276.85
139	SALIVARY GLAND PROCEDURES	2.1	$11,672.95	$5,836.48
146	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	5.3	$7,226.79	$3,613.40
147	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	3.7	$6,660.61	$3,330.31
148	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	2.1	$7,191.21	$3,595.61
149	DYSEQUILIBRIUM	2	$7,253.87	$3,626.93
150	EPISTAXIS W MCC	3.5	$7,328.34	$3,664.17
151	EPISTAXIS W/O MCC	2.2	$6,310.97	$3,155.48
152	OTITIS MEDIA & URI W MCC	3.2	$6,448.29	$3,224.15
153	OTITIS MEDIA & URI W/O MCC	2.4	$5,845.46	$2,922.73

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	4	$7,134.71	$3,567.35
155	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	2.9	$6,170.98	$3,085.49
156	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	2.2	$5,908.35	$2,954.18
157	DENTAL & ORAL DISEASES W MCC	4.4	$7,054.36	$3,527.18
158	DENTAL & ORAL DISEASES W CC	2.8	$6,146.67	$3,073.34
159	DENTAL & ORAL DISEASES W/O CC/MCC	2.1	$6,363.71	$3,181.86
163	MAJOR CHEST PROCEDURES W MCC	9.7	$9,978.52	$4,989.26
164	MAJOR CHEST PROCEDURES W CC	4.8	$10,474.50	$5,237.25
165	MAJOR CHEST PROCEDURES W/O CC/MCC	2.9	$12,663.83	$6,331.92
166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	7.9	$9,378.70	$4,689.35
167	OTHER RESP SYSTEM O.R. PROCEDURES W CC	4.3	$8,841.86	$4,420.93
168	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	2.4	$10,978.44	$5,489.22
175	PULMONARY EMBOLISM W MCC OR ACUTE COR PULMONALE	4.3	$6,671.11	$3,335.56
176	PULMONARY EMBOLISM W/O MCC	2.8	$6,017.58	$3,008.79
177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	5.5	$6,828.95	$3,414.48
178	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	4.3	$5,742.31	$2,871.16
179	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	3.2	$5,375.23	$2,687.62
180	RESPIRATORY NEOPLASMS W MCC	4.9	$6,991.13	$3,495.56
181	RESPIRATORY NEOPLASMS W CC	3.4	$6,729.04	$3,364.52
182	RESPIRATORY NEOPLASMS W/O CC/MCC	2.2	$7,608.19	$3,804.09
183	MAJOR CHEST TRAUMA W MCC	4.4	$6,811.98	$3,405.99
184	MAJOR CHEST TRAUMA W CC	3.2	$6,319.20	$3,159.60
185	MAJOR CHEST TRAUMA W/O CC/MCC	2.4	$6,073.85	$3,036.93
186	PLEURAL EFFUSION W MCC	4.4	$6,964.09	$3,482.04
187	PLEURAL EFFUSION W CC	3.3	$6,186.09	$3,093.04
188	PLEURAL EFFUSION W/O CC/MCC	2.4	$6,048.20	$3,024.10
189	PULMONARY EDEMA & RESPIRATORY FAILURE	3.8	$6,353.63	$3,176.82
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	3.8	$5,978.91	$2,989.45
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	3.1	$5,719.68	$2,859.84
192	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	2.5	$5,633.88	$2,816.94

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
193	SIMPLE PNEUMONIA & PLEURISY W MCC	4.2	$6,305.55	$3,152.78
194	SIMPLE PNEUMONIA & PLEURISY W CC	3.3	$5,347.76	$2,673.88
195	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	2.6	$5,210.19	$2,605.10
196	INTERSTITIAL LUNG DISEASE W MCC	4.8	$6,931.97	$3,465.98
197	INTERSTITIAL LUNG DISEASE W CC	3.3	$6,147.57	$3,073.79
198	INTERSTITIAL LUNG DISEASE W/O CC/MCC	2.5	$5,997.72	$2,998.86
199	PNEUMOTHORAX W MCC	5.3	$6,722.80	$3,361.40
200	PNEUMOTHORAX W CC	3.4	$6,320.74	$3,160.37
201	PNEUMOTHORAX W/O CC/MCC	2.4	$5,941.45	$2,970.73
202	BRONCHITIS & ASTHMA W CC/MCC	3	$6,275.76	$3,137.88
203	BRONCHITIS & ASTHMA W/O CC/MCC	2.4	$5,741.20	$2,870.60
204	RESPIRATORY SIGNS & SYMPTOMS	2.2	$7,334.66	$3,667.33
205	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	4	$8,113.80	$4,056.90
206	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	2.5	$6,931.14	$3,465.57
207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT >96 HOURS	12	$9,492.42	$4,746.21
208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <=96 HOURS	4.9	$10,068.21	$5,034.10
215	OTHER HEART ASSIST SYSTEM IMPLANT	5.2	$49,214.99	$24,607.49
216	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	12.5	$15,955.37	$7,977.68
217	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	7.3	$18,096.00	$9,048.00
218	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	4.1	$26,163.85	$13,081.93
219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	9.1	$17,110.37	$8,555.19
220	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	6.1	$17,274.62	$8,637.31
221	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.2	$21,733.46	$10,866.73
222	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	9.2	$18,013.45	$9,006.73
223	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	5.3	$22,493.89	$11,246.94
224	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.7	$19,076.43	$9,538.22
225	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	4.1	$27,362.24	$13,681.12
226	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.5	$20,433.50	$10,216.75
227	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	3.1	$33,500.62	$16,750.31
228	OTHER CARDIOTHORACIC PROCEDURES W MCC	6.7	$18,633.72	$9,316.86

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
229	OTHER CARDIOTHORACIC PROCEDURES W/O MCC	3.4	$23,977.45	$11,988.72
231	CORONARY BYPASS W PTCA W MCC	10.3	$15,833.05	$7,916.52
232	CORONARY BYPASS W PTCA W/O MCC	8	$14,861.49	$7,430.74
233	CORONARY BYPASS W CARDIAC CATH W MCC	11.5	$13,416.55	$6,708.28
234	CORONARY BYPASS W CARDIAC CATH W/O MCC	8.1	$12,765.08	$6,382.54
235	CORONARY BYPASS W/O CARDIAC CATH W MCC	8.8	$13,280.47	$6,640.24
236	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	6	$13,336.32	$6,668.16
239	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	10.2	$9,092.18	$4,546.09
240	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	7	$7,830.51	$3,915.26
241	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	4.4	$6,844.03	$3,422.01
242	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	5.4	$13,648.60	$6,824.30
243	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	3.3	$15,222.39	$7,611.19
244	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.3	$17,920.63	$8,960.31
245	AICD GENERATOR PROCEDURES	4.4	$23,506.12	$11,753.06
246	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	4.1	$15,368.73	$7,684.37
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2.2	$18,367.79	$9,183.90
248	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W NON-DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	4.7	$13,084.36	$6,542.18
249	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	2.4	$15,859.87	$7,929.93
250	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	3.9	$12,985.89	$6,492.95
251	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	2.2	$15,192.90	$7,596.45
252	OTHER VASCULAR PROCEDURES W MCC	5.3	$12,292.22	$6,146.11
253	OTHER VASCULAR PROCEDURES W CC	4.1	$12,626.12	$6,313.06
254	OTHER VASCULAR PROCEDURES W/O CC/MCC	2.3	$15,716.17	$7,858.08
255	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	6.5	$8,095.55	$4,047.77
256	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	5.2	$6,555.71	$3,277.85
257	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	3.5	$6,436.91	$3,218.45
258	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	5	$12,149.16	$6,074.58
259	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	2.7	$15,318.68	$7,659.34
260	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	6.8	$10,805.01	$5,402.50

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
261	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	3.3	$11,726.43	$5,863.21
262	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	2.3	$14,485.71	$7,242.86
263	VEIN LIGATION & STRIPPING	4.2	$11,154.70	$5,577.35
264	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	6.5	$9,924.19	$4,962.10
265	AICD LEAD PROCEDURES	3.7	$16,753.79	$8,376.89
266	ENDOVASCULAR CARDIAC VALVE REPLACEMENT & SUPPLEMENT PROCEDURES W MCC	4	$35,357.75	$17,678.88
267	ENDOVASCULAR CARDIAC VALVE REPLACEMENT & SUPPLEMENT PROCEDURES W/O MCC	2.3	$49,007.57	$24,503.79
268	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W MCC	6.4	$21,047.26	$10,523.63
269	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W/O MCC	1.7	$49,841.59	$24,920.80
270	OTHER MAJOR CARDIOVASCULAR PROCEDURES W MCC	6.6	$15,377.06	$7,688.53
271	OTHER MAJOR CARDIOVASCULAR PROCEDURES W CC	4.3	$16,386.81	$8,193.40
272	OTHER MAJOR CARDIOVASCULAR PROCEDURES W/O CC/MCC	2.1	$24,600.87	$12,300.43
273	PERCUTANEOUS INTRACARDIAC PROCEDURES W MCC	5.3	$13,903.12	$6,951.56
274	PERCUTANEOUS INTRACARDIAC PROCEDURES W/O MCC	2	$31,376.81	$15,688.41
280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	4.2	$7,711.83	$3,855.91
281	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	2.6	$7,399.38	$3,699.69
282	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	1.8	$8,141.50	$4,070.75
283	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	3	$11,914.01	$5,957.01
284	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	1.7	$8,473.21	$4,236.61
285	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	1.3	$7,910.39	$3,955.20
286	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	5.2	$8,392.38	$4,196.19
287	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	2.4	$9,534.46	$4,767.23
288	ACUTE & SUBACUTE ENDOCARDITIS W MCC	7.3	$7,229.58	$3,614.79
289	ACUTE & SUBACUTE ENDOCARDITIS W CC	5.4	$6,119.09	$3,059.54
290	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	3.4	$5,844.68	$2,922.34
291	HEART FAILURE & SHOCK W MCC	4.1	$6,518.92	$3,259.46
292	HEART FAILURE & SHOCK W CC	3.3	$5,449.46	$2,724.73
293	HEART FAILURE & SHOCK W/O CC/MCC	2.4	$5,422.61	$2,711.30
294	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	3.4	$7,429.39	$3,714.70
295	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	2.3	$4,982.27	$2,491.13

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
296	CARDIAC ARREST, UNEXPLAINED W MCC	2	$15,594.07	$7,797.04
297	CARDIAC ARREST, UNEXPLAINED W CC	1.3	$11,045.22	$5,522.61
298	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	1.1	$9,085.05	$4,542.52
299	PERIPHERAL VASCULAR DISORDERS W MCC	3.9	$7,382.32	$3,691.16
300	PERIPHERAL VASCULAR DISORDERS W CC	3.3	$6,184.28	$3,092.14
301	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	2.3	$6,267.13	$3,133.56
302	ATHEROSCLEROSIS W MCC	2.7	$8,108.03	$4,054.01
303	ATHEROSCLEROSIS W/O MCC	1.9	$7,062.84	$3,531.42
304	HYPERTENSION W MCC	3	$7,225.73	$3,612.87
305	HYPERTENSION W/O MCC	2.2	$6,603.45	$3,301.73
306	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	3.8	$7,392.62	$3,696.31
307	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	2.4	$7,300.21	$3,650.10
308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	3.6	$6,552.15	$3,276.07
309	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	2.5	$6,008.05	$3,004.02
310	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	1.9	$5,846.16	$2,923.08
311	ANGINA PECTORIS	1.9	$7,160.05	$3,580.03
312	SYNCOPE & COLLAPSE	2.3	$7,051.16	$3,525.58
313	CHEST PAIN	1.7	$8,356.39	$4,178.19
314	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	4.8	$8,397.06	$4,198.53
315	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	2.8	$6,882.91	$3,441.45
316	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	2	$7,370.05	$3,685.02
319	OTHER ENDOVASCULAR CARDIAC VALVE PROCEDURES W MCC	10.1	$8,063.36	$4,031.68
320	OTHER ENDOVASCULAR CARDIAC VALVE PROCEDURES W/O MCC	4.9	$9,515.37	$4,757.69
326	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	2.2	$47,578.24	$23,789.12
327	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	10.8	$4,731.28	$2,365.64
328	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	6.2	$5,045.08	$2,522.54
329	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	3.7	$26,339.73	$13,169.86
330	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	6.9	$7,272.79	$3,636.39
331	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	4.4	$7,624.43	$3,812.22
332	RECTAL RESECTION W MCC	2.4	$28,895.47	$14,447.74
333	RECTAL RESECTION W CC	10.1	$4,450.21	$2,225.11

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
334	RECTAL RESECTION W/O CC/MCC	6.3	$4,855.61	$2,427.81
335	PERITONEAL ADHESIOLYSIS W MCC	3.9	$20,598.89	$10,299.45
336	PERITONEAL ADHESIOLYSIS W CC	6.6	$6,819.20	$3,409.60
337	PERITONEAL ADHESIOLYSIS W/O CC/MCC	4.3	$7,573.13	$3,786.56
338	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	2.4	$24,081.08	$12,040.54
339	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	4.6	$7,409.08	$3,704.54
340	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	2.7	$9,102.50	$4,551.25
341	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	1.7	$29,884.63	$14,942.31
342	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	7.6	$4,207.97	$2,103.98
343	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	4.6	$4,971.91	$2,485.95
344	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	3.2	$18,588.34	$9,294.17
345	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	5.7	$5,690.76	$2,845.38
346	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	3.6	$7,076.23	$3,538.11
347	ANAL & STOMAL PROCEDURES W MCC	2.1	$24,932.81	$12,466.41
348	ANAL & STOMAL PROCEDURES W CC	5.1	$5,487.98	$2,743.99
349	ANAL & STOMAL PROCEDURES W/O CC/MCC	3.4	$5,729.61	$2,864.81
350	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.1	$23,068.81	$11,534.40
351	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	6	$4,826.97	$2,413.49
352	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	3.8	$5,627.70	$2,813.85
353	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	2.5	$23,569.05	$11,784.53
354	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	7.8	$4,384.73	$2,192.37
355	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	4.7	$5,799.12	$2,899.56
356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	2.8	$28,919.00	$14,459.50
357	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	4.7	$9,509.14	$4,754.57
358	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	3.2	$8,512.49	$4,256.25
368	MAJOR ESOPHAGEAL DISORDERS W MCC	2.2	$17,184.32	$8,592.16
369	MAJOR ESOPHAGEAL DISORDERS W CC	5.4	$3,909.85	$1,954.92
370	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	4	$3,710.34	$1,855.17
371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	3.1	$11,054.33	$5,527.17
372	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	5.6	$3,626.22	$1,813.11

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
373	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	3.7	$3,981.66	$1,990.83
374	DIGESTIVE MALIGNANCY W MCC	2.5	$15,868.14	$7,934.07
375	DIGESTIVE MALIGNANCY W CC	4.5	$5,328.22	$2,664.11
376	DIGESTIVE MALIGNANCY W/O CC/MCC	3	$6,628.61	$3,314.30
377	G.I. HEMORRHAGE W MCC	2.1	$16,738.20	$8,369.10
378	G.I. HEMORRHAGE W CC	5.1	$3,847.78	$1,923.89
379	G.I. HEMORRHAGE W/O CC/MCC	3.3	$3,885.94	$1,942.97
380	COMPLICATED PEPTIC ULCER W MCC	2.5	$14,995.09	$7,497.55
381	COMPLICATED PEPTIC ULCER W CC	4	$5,345.82	$2,672.91
382	COMPLICATED PEPTIC ULCER W/O CC/MCC	2.6	$6,045.08	$3,022.54
383	UNCOMPLICATED PEPTIC ULCER W MCC	5.3	$4,969.87	$2,484.94
384	UNCOMPLICATED PEPTIC ULCER W/O MCC	3.5	$4,937.76	$2,468.88
385	INFLAMMATORY BOWEL DISEASE W MCC	2.8	$11,421.63	$5,710.81
386	INFLAMMATORY BOWEL DISEASE W CC	4.8	$4,076.27	$2,038.13
387	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	3.3	$4,216.94	$2,108.47
388	G.I. OBSTRUCTION W MCC	2.5	$12,115.39	$6,057.70
389	G.I. OBSTRUCTION W CC	3.7	$4,507.15	$2,253.57
390	G.I. OBSTRUCTION W/O CC/MCC	2.6	$4,427.25	$2,213.63
391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	4.4	$5,574.34	$2,787.17
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	3.1	$4,878.51	$2,439.26
393	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	2.3	$14,027.20	$7,013.60
394	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	9.6	$1,940.69	$970.35
395	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	5.6	$2,320.78	$1,160.39
405	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	3.8	$28,364.26	$14,182.13
406	PANCREAS, LIVER & SHUNT PROCEDURES W CC	9.2	$6,024.70	$3,012.35
407	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	5.6	$7,398.91	$3,699.46
408	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	3.7	$19,127.86	$9,563.93
409	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	8.3	$5,727.82	$2,863.91
410	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	5.5	$5,994.11	$2,997.05
411	CHOLECYSTECTOMY W C.D.E. W MCC	3.5	$21,734.78	$10,867.39
412	CHOLECYSTECTOMY W C.D.E. W CC	8	$5,900.90	$2,950.45

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
413	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	5.2	$6,176.84	$3,088.42
414	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.2	$21,203.03	$10,601.52
415	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	5.4	$7,545.70	$3,772.85
416	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	3.7	$7,247.83	$3,623.91
417	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.5	$19,150.60	$9,575.30
418	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	7.7	$4,304.46	$2,152.23
419	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	4.1	$6,330.01	$3,165.01
420	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	2.8	$24,362.55	$12,181.27
421	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	8.6	$4,251.89	$2,125.94
422	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	5.6	$4,980.96	$2,490.48
423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	3.4	$24,756.07	$12,378.04
424	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	4.7	$9,513.36	$4,756.68
425	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	3.3	$8,795.57	$4,397.79
432	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	2.3	$15,744.66	$7,872.33
433	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	4.8	$4,269.90	$2,134.95
434	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	3.5	$3,630.98	$1,815.49
435	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	2.4	$14,043.50	$7,021.75
436	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	4.6	$4,860.09	$2,430.04
437	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	3.2	$5,448.47	$2,724.23
438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	2.5	$13,014.66	$6,507.33
439	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	4.7	$3,579.87	$1,789.94
440	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	3.2	$3,820.57	$1,910.28
441	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W MCC	2.5	$14,700.37	$7,350.19
442	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	4.4	$4,213.03	$2,106.51
443	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC/MCC	3.2	$4,222.11	$2,111.06
444	DISORDERS OF THE BILIARY TRACT W MCC	2.3	$14,041.02	$7,020.51
445	DISORDERS OF THE BILIARY TRACT W CC	7.6	$2,807.84	$1,403.92
446	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	4	$4,035.06	$2,017.53
453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	2.6	$71,855.01	$35,927.50

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
454	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	9.5	$12,804.47	$6,402.24
455	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.3	$18,036.25	$9,018.13
456	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W MCC	3.2	$56,360.20	$28,180.10
457	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W CC	6.3	$20,532.40	$10,266.20
458	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W/O CC/MCC	2.9	$32,145.12	$16,072.56
459	SPINAL FUSION EXCEPT CERVICAL W MCC	5.6	$24,300.13	$12,150.06
460	SPINAL FUSION EXCEPT CERVICAL W/O MCC	2.9	$27,121.91	$13,560.96
461	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	9.8	$10,900.30	$5,450.15
462	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	5.5	$11,325.26	$5,662.63
463	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	2.7	$38,453.37	$19,226.69
464	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	6.6	$8,884.94	$4,442.47
465	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	3.4	$11,187.02	$5,593.51
466	REVISION OF HIP OR KNEE REPLACEMENT W MCC	2.2	$46,030.97	$23,015.48
467	REVISION OF HIP OR KNEE REPLACEMENT W CC	4.9	$14,234.76	$7,117.38
468	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.2	$25,385.59	$12,692.80
469	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC OR TOTAL ANKLE REPLACEMENT	6.3	$9,898.16	$4,949.08
470	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.4	$16,288.51	$8,144.26
471	CERVICAL SPINAL FUSION W MCC	1.5	$66,125.86	$33,062.93
472	CERVICAL SPINAL FUSION W CC	8.9	$6,786.99	$3,393.49
473	CERVICAL SPINAL FUSION W/O CC/MCC	5.8	$8,602.80	$4,301.40
474	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.1	$24,824.36	$12,412.18
475	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	8.2	$5,088.52	$2,544.26
476	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	5.3	$4,364.33	$2,182.16
477	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.4	$19,014.78	$9,507.39
478	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	6.4	$7,190.25	$3,595.13
479	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	4.4	$8,043.75	$4,021.88
480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.5	$17,127.83	$8,563.92
481	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	1.6	$25,914.82	$12,957.41
482	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	8	$4,084.46	$2,042.23

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
483	MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES	5.3	$8,963.60	$4,481.80
485	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.7	$17,600.25	$8,800.13
486	KNEE PROCEDURES W PDX OF INFECTION W CC	3.8	$11,239.71	$5,619.86
487	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	2.1	$15,199.52	$7,599.76
488	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	6.1	$6,411.20	$3,205.60
489	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	4	$6,250.94	$3,125.47
492	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR W MCC	2.7	$25,342.10	$12,671.05
493	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR W CC	7.3	$6,262.70	$3,131.35
494	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR W/O CC/MCC	3.5	$10,278.40	$5,139.20
495	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	1.9	$35,879.70	$17,939.85
496	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	5.1	$7,945.95	$3,972.97
497	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	2.1	$13,895.38	$6,947.69
498	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	7.3	$6,660.17	$3,330.09
499	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	4.2	$5,442.11	$2,721.06
500	SOFT TISSUE PROCEDURES W MCC	2.5	$23,952.75	$11,976.37
501	SOFT TISSUE PROCEDURES W CC	6.8	$4,900.75	$2,450.37
502	SOFT TISSUE PROCEDURES W/O CC/MCC	4.8	$5,464.40	$2,732.20
503	FOOT PROCEDURES W MCC	2.8	$19,268.46	$9,634.23
504	FOOT PROCEDURES W CC	3.8	$9,075.50	$4,537.75
505	FOOT PROCEDURES W/O CC/MCC	4.5	$7,421.02	$3,710.51
506	MAJOR THUMB OR JOINT PROCEDURES	2.1	$12,659.33	$6,329.67
507	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	4.4	$9,478.64	$4,739.32
508	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	5	$6,189.96	$3,094.98
509	ARTHROSCOPY	3.4	$8,129.17	$4,064.58
510	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC W MCC	2.2	$25,168.04	$12,584.02
511	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC W CC	4.1	$9,126.88	$4,563.44
512	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC W/O CC/MCC	2.3	$13,071.33	$6,535.67
513	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	6.4	$4,893.94	$2,446.97
514	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	3.8	$5,575.43	$2,787.72
515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	2.2	$28,472.02	$14,236.01

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
516	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	3.4	$11,326.63	$5,663.31
517	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	3.1	$9,067.05	$4,533.53
518	BACK & NECK PROC EXC SPINAL FUSION W MCC OR DISC DEVICE/NEUROSTIM	1.9	$35,628.84	$17,814.42
519	BACK & NECK PROC EXC SPINAL FUSION W CC	4.2	$9,025.42	$4,512.71
520	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	2.9	$9,162.99	$4,581.50
533	FRACTURES OF FEMUR W MCC	3.8	$7,627.29	$3,813.64
534	FRACTURES OF FEMUR W/O MCC	2.9	$5,326.59	$2,663.29
535	FRACTURES OF HIP & PELVIS W MCC	3.1	$7,861.36	$3,930.68
536	FRACTURES OF HIP & PELVIS W/O MCC	2.5	$6,025.52	$3,012.76
537	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	6.1	$2,965.65	$1,482.83
538	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	4.5	$3,182.01	$1,591.01
539	OSTEOMYELITIS W MCC	3.2	$11,700.02	$5,850.01
540	OSTEOMYELITIS W CC	5.2	$4,965.00	$2,482.50
541	OSTEOMYELITIS W/O CC/MCC	3.7	$4,866.77	$2,433.39
542	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	2.8	$12,943.05	$6,471.52
543	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	5.6	$3,746.09	$1,873.05
544	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	3.6	$4,183.84	$2,091.92
545	CONNECTIVE TISSUE DISORDERS W MCC	2.7	$18,594.84	$9,297.42
546	CONNECTIVE TISSUE DISORDERS W CC	6.1	$3,917.95	$1,958.98
547	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	4.1	$3,924.05	$1,962.02
548	SEPTIC ARTHRITIS W MCC	3	$13,129.45	$6,564.72
549	SEPTIC ARTHRITIS W CC	4.4	$5,385.22	$2,692.61
550	SEPTIC ARTHRITIS W/O CC/MCC	3	$5,719.68	$2,859.84
551	MEDICAL BACK PROBLEMS W MCC	3.9	$8,093.71	$4,046.86
552	MEDICAL BACK PROBLEMS W/O MCC	2.8	$6,467.98	$3,233.99
553	BONE DISEASES & ARTHROPATHIES W MCC	3.7	$6,900.01	$3,450.00
554	BONE DISEASES & ARTHROPATHIES W/O MCC	2.7	$5,790.29	$2,895.15
555	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	4.6	$5,678.66	$2,839.33
556	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	3.2	$4,914.11	$2,457.05
557	TENDONITIS, MYOSITIS & BURSITIS W MCC	4.8	$6,033.30	$3,016.65
558	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	3.6	$4,752.06	$2,376.03

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	2.7	$13,253.24	$6,626.62
560	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	4.1	$5,054.61	$2,527.31
561	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	3	$4,947.79	$2,473.89
562	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	4.7	$5,692.21	$2,846.11
563	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	3.4	$4,988.36	$2,494.18
564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	2.6	$11,549.35	$5,774.68
565	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	7.6	$2,562.20	$1,281.10
566	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	5.2	$2,893.83	$1,446.92
570	SKIN DEBRIDEMENT W MCC	3.4	$16,782.87	$8,391.43
571	SKIN DEBRIDEMENT W CC	10.7	$3,103.91	$1,551.96
572	SKIN DEBRIDEMENT W/O CC/MCC	7.5	$2,970.26	$1,485.13
573	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	4.8	$21,992.05	$10,996.03
574	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	8.4	$7,380.83	$3,690.41
575	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	4.7	$7,424.26	$3,712.13
576	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	2.7	$35,667.82	$17,833.91
577	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	6.5	$7,380.59	$3,690.29
578	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	4.1	$7,882.97	$3,941.48
579	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.4	$24,709.98	$12,354.99
580	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	2.4	$13,311.99	$6,656.00
581	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	1.7	$14,659.02	$7,329.51
582	MASTECTOMY FOR MALIGNANCY W CC/MCC	3.6	$8,709.16	$4,354.58
583	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	2.2	$13,192.46	$6,596.23
584	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	5.4	$6,724.45	$3,362.22
585	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	4.2	$8,025.80	$4,012.90
592	SKIN ULCERS W MCC	3.2	$11,073.81	$5,536.91
593	SKIN ULCERS W CC	5.2	$4,383.71	$2,191.86
594	SKIN ULCERS W/O CC/MCC	3.5	$4,594.47	$2,297.23
595	MAJOR SKIN DISORDERS W MCC	4.9	$8,238.25	$4,119.13
596	MAJOR SKIN DISORDERS W/O MCC	3.5	$5,527.32	$2,763.66
597	MALIGNANT BREAST DISORDERS W MCC	2.2	$15,282.27	$7,641.14

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
598	MALIGNANT BREAST DISORDERS W CC	3.5	$6,177.03	$3,088.51
599	MALIGNANT BREAST DISORDERS W/O CC/MCC	2.7	$5,115.05	$2,557.53
600	NON-MALIGNANT BREAST DISORDERS W CC/MCC	4.7	$4,053.13	$2,026.57
601	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	3.3	$3,724.05	$1,862.03
602	CELLULITIS W MCC	3.9	$7,280.98	$3,640.49
603	CELLULITIS W/O MCC	2.7	$6,204.41	$3,102.21
604	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	4.2	$6,924.99	$3,462.50
605	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	2.8	$6,211.22	$3,105.61
606	MINOR SKIN DISORDERS W MCC	3.5	$8,485.89	$4,242.95
607	MINOR SKIN DISORDERS W/O MCC	2	$8,203.17	$4,101.59
614	ADRENAL & PITUITARY PROCEDURES W CC/MCC	10.1	$4,784.69	$2,392.34
615	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	5.9	$4,995.63	$2,497.82
616	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DIS W MCC	3.5	$22,701.68	$11,350.84
617	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DIS W CC	3	$13,579.61	$6,789.80
618	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DIS W/O CC/MCC	2	$12,457.19	$6,228.59
619	O.R. PROCEDURES FOR OBESITY W MCC	1.5	$40,759.34	$20,379.67
620	O.R. PROCEDURES FOR OBESITY W CC	8.7	$4,096.64	$2,048.32
621	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	5.5	$5,676.35	$2,838.17
622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.3	$22,721.65	$11,360.82
623	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	4.8	$8,078.88	$4,039.44
624	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	2.5	$8,754.29	$4,377.14
625	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	1.4	$41,494.63	$20,747.32
626	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	7.3	$4,578.14	$2,289.07
627	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	6	$3,779.03	$1,889.51
628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	2.9	$25,265.34	$12,632.67
629	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	3.9	$11,828.41	$5,914.21
630	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	2.9	$9,921.78	$4,960.89
637	DIABETES W MCC	2.1	$13,104.76	$6,552.38
638	DIABETES W CC	3.3	$5,320.67	$2,660.34
639	DIABETES W/O CC/MCC	2.6	$4,683.90	$2,341.95

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
640	MISC DISORDERS OF NUTRITION, METABOLISM, FLUIDS/ELECTROLYTES W MCC	3.2	$7,535.63	$3,767.81
641	MISC DISORDERS OF NUTRITION, METABOLISM, FLUIDS/ELECTROLYTES W/O MCC	5	$3,005.22	$1,502.61
642	INBORN AND OTHER DISORDERS OF METABOLISM	3.5	$6,898.80	$3,449.40
643	ENDOCRINE DISORDERS W MCC	2.7	$11,956.46	$5,978.23
644	ENDOCRINE DISORDERS W CC	5.3	$3,852.47	$1,926.23
645	ENDOCRINE DISORDERS W/O CC/MCC	10.5	$1,447.32	$723.66
652	KIDNEY TRANSPLANT	6.2	$10,842.60	$5,421.30
653	MAJOR BLADDER PROCEDURES W MCC	3.7	$29,717.54	$14,858.77
654	MAJOR BLADDER PROCEDURES W CC	6	$9,308.38	$4,654.19
655	MAJOR BLADDER PROCEDURES W/O CC/MCC	3.6	$11,377.57	$5,688.79
656	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	2.3	$28,154.57	$14,077.29
657	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	6.1	$6,297.25	$3,148.62
658	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	3.2	$9,743.19	$4,871.60
659	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	2	$26,610.41	$13,305.21
660	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	7.3	$3,865.08	$1,932.54
661	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	3.9	$5,551.12	$2,775.56
662	MINOR BLADDER PROCEDURES W MCC	2	$31,425.47	$15,712.74
663	MINOR BLADDER PROCEDURES W CC	8.2	$3,689.60	$1,844.80
664	MINOR BLADDER PROCEDURES W/O CC/MCC	4.2	$5,232.64	$2,616.32
665	PROSTATECTOMY W MCC	2.2	$26,797.46	$13,398.73
666	PROSTATECTOMY W CC	7.1	$4,948.50	$2,474.25
667	PROSTATECTOMY W/O CC/MCC	4	$4,660.65	$2,330.32
668	TRANSURETHRAL PROCEDURES W MCC	2.1	$26,369.35	$13,184.68
669	TRANSURETHRAL PROCEDURES W CC	3.9	$7,871.18	$3,935.59
670	TRANSURETHRAL PROCEDURES W/O CC/MCC	1.9	$10,229.99	$5,115.00
671	URETHRAL PROCEDURES W CC/MCC	7.9	$4,594.45	$2,297.22
672	URETHRAL PROCEDURES W/O CC/MCC	5.3	$3,871.58	$1,935.79
673	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	2.8	$25,354.13	$12,677.06
674	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	4.5	$10,787.07	$5,393.53
675	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	3.2	$10,128.60	$5,064.30
682	RENAL FAILURE W MCC	2.3	$12,762.21	$6,381.10

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
683	RENAL FAILURE W CC	5.1	$3,494.19	$1,747.10
684	RENAL FAILURE W/O CC/MCC	3.3	$3,702.99	$1,851.49
686	KIDNEY & URINARY TRACT NEOPLASMS W MCC	2	$17,438.07	$8,719.04
687	KIDNEY & URINARY TRACT NEOPLASMS W CC	3.9	$5,360.16	$2,680.08
688	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	3	$5,106.01	$2,553.00
689	KIDNEY & URINARY TRACT INFECTIONS W MCC	3	$7,405.13	$3,702.57
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	2	$7,852.64	$3,926.32
693	URINARY STONES W MCC	3.8	$7,072.77	$3,536.39
694	URINARY STONES W/O MCC	2.1	$7,002.07	$3,501.03
695	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	3.6	$6,467.19	$3,233.59
696	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	2.4	$5,622.04	$2,811.02
697	URETHRAL STRICTURE	2.5	$7,736.66	$3,868.33
698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	4.9	$6,560.28	$3,280.14
699	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	3.4	$6,032.18	$3,016.09
700	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	2.5	$5,892.06	$2,946.03
707	MAJOR MALE PELVIC PROCEDURES W CC/MCC	2.3	$16,146.18	$8,073.09
708	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.3	$22,182.09	$11,091.05
709	PENIS PROCEDURES W CC/MCC	3.6	$13,270.89	$6,635.45
710	PENIS PROCEDURES W/O CC/MCC	1.7	$17,941.76	$8,970.88
711	TESTES PROCEDURES W CC/MCC	5.2	$8,185.38	$4,092.69
712	TESTES PROCEDURES W/O CC/MCC	2.4	$8,442.16	$4,221.08
713	TRANSURETHRAL PROSTATECTOMY W CC/MCC	2.9	$10,012.18	$5,006.09
714	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	1.7	$10,694.03	$5,347.01
715	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	5.4	$7,857.57	$3,928.79
716	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	1.5	$19,403.22	$9,701.61
717	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	4.2	$8,342.62	$4,171.31
718	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	2.5	$9,686.91	$4,843.46
722	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	5.1	$7,028.49	$3,514.25
723	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	3.5	$6,283.70	$3,141.85
724	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	1.9	$6,171.23	$3,085.62
725	BENIGN PROSTATIC HYPERTROPHY W MCC	4	$6,233.06	$3,116.53

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
726	BENIGN PROSTATIC HYPERTROPHY W/O MCC	2.6	$5,841.13	$2,920.57
727	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	4.7	$6,031.10	$3,015.55
728	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	3	$5,312.55	$2,656.28
729	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	3.3	$6,462.93	$3,231.46
730	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	1.9	$6,601.88	$3,300.94
734	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	3.7	$11,765.17	$5,882.59
735	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.8	$15,162.01	$7,581.00
736	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	8.9	$9,641.92	$4,820.96
737	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	4.6	$8,579.09	$4,289.54
738	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	2.8	$9,780.34	$4,890.17
739	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	6.6	$11,267.54	$5,633.77
740	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	3	$11,816.04	$5,908.02
741	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.7	$15,531.69	$7,765.84
742	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	3	$11,184.49	$5,592.25
743	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	1.8	$12,671.78	$6,335.89
744	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	4.1	$8,430.81	$4,215.41
745	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	2.1	$10,074.69	$5,037.35
746	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	3.5	$9,254.76	$4,627.38
747	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	1.6	$11,570.93	$5,785.47
748	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.6	$16,405.60	$8,202.80
749	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	5.7	$9,031.42	$4,515.71
750	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	2.4	$11,015.68	$5,507.84
754	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	5.2	$6,729.10	$3,364.55
755	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	3.3	$6,161.41	$3,080.71
756	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	2.2	$7,915.11	$3,957.56
757	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	4.9	$5,756.56	$2,878.28
758	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	3.7	$5,181.85	$2,590.92
759	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	2.6	$5,043.68	$2,521.84
760	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	2.6	$6,893.71	$3,446.86

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
761	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	1.8	$6,238.25	$3,119.12
768	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	2.7	$7,410.72	$3,705.36
769	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	3.2	$8,955.62	$4,477.81
770	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	1.8	$8,675.51	$4,337.76
776	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	2.5	$5,639.45	$2,819.72
779	ABORTION W/O D&C	1.7	$13,338.91	$6,669.46
783	CESAREAN SECTION W STERILIZATION W MCC	4.6	$9,259.94	$4,629.97
784	CESAREAN SECTION W STERILIZATION W CC	3.4	$6,105.20	$3,052.60
785	CESAREAN SECTION W STERILIZATION W/O CC/MCC	2.7	$6,314.01	$3,157.00
786	CESAREAN SECTION W/O STERILIZATION W MCC	4.4	$7,738.63	$3,869.31
787	CESAREAN SECTION W/O STERILIZATION W CC	3.5	$5,932.47	$2,966.23
788	CESAREAN SECTION W/O STERILIZATION W/O CC/MCC	3	$5,999.04	$2,999.52
789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.8	$18,646.33	$9,323.17
790	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	17.9	$6,183.23	$3,091.61
791	PREMATURITY W MAJOR PROBLEMS	13.3	$5,683.54	$2,841.77
792	PREMATURITY W/O MAJOR PROBLEMS	8.6	$5,303.31	$2,651.66
793	FULL TERM NEONATE W MAJOR PROBLEMS	4.7	$16,520.56	$8,260.28
794	NEONATE W OTHER SIGNIFICANT PROBLEMS	3.4	$8,083.02	$4,041.51
795	NORMAL NEWBORN	3.1	$1,199.93	$599.96
796	VAGINAL DELIVERY W STERILIZATION/D&C W MCC	3.4	$11,520.55	$5,760.28
797	VAGINAL DELIVERY W STERILIZATION/D&C W CC	2.2	$7,788.73	$3,894.37
798	VAGINAL DELIVERY W STERILIZATION/D&C W/O CC/MCC	2.2	$7,788.73	$3,894.37
799	SPLENECTOMY W MCC	8.3	$11,830.58	$5,915.29
800	SPLENECTOMY W CC	4.7	$12,008.96	$6,004.48
801	SPLENECTOMY W/O CC/MCC	2.5	$14,880.70	$7,440.35
802	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	7.4	$8,460.36	$4,230.18
803	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	4.1	$8,629.90	$4,314.95
804	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	2.1	$12,886.30	$6,443.15
805	VAGINAL DELIVERY W/O STERILIZATION/D&C W MCC	3	$6,889.43	$3,444.72
806	VAGINAL DELIVERY W/O STERILIZATION/D&C W CC	2.4	$5,868.63	$2,934.32
807	VAGINAL DELIVERY W/O STERILIZATION/D&C W/O CC/MCC	2.1	$5,927.74	$2,963.87

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
808	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	5.5	$7,689.79	$3,844.90
809	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	3.6	$6,707.72	$3,353.86
810	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	2.6	$7,145.02	$3,572.51
811	RED BLOOD CELL DISORDERS W MCC	3.7	$7,194.15	$3,597.08
812	RED BLOOD CELL DISORDERS W/O MCC	2.7	$6,404.48	$3,202.24
813	COAGULATION DISORDERS	3.7	$8,508.67	$4,254.33
814	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	4.5	$7,719.36	$3,859.68
815	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	3.1	$6,488.45	$3,244.23
816	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	2.2	$6,462.62	$3,231.31
817	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W MCC	3.8	$13,150.46	$6,575.23
818	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W CC	2.8	$9,035.59	$4,517.80
819	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W/O CC/MCC	1.6	$9,903.93	$4,951.97
820	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	10.9	$10,415.93	$5,207.97
821	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	4.3	$10,310.11	$5,155.06
822	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.9	$13,216.31	$6,608.15
823	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W MCC	10.4	$8,078.06	$4,039.03
824	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W CC	5.3	$8,712.54	$4,356.27
825	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W/O CC/MCC	2.5	$10,760.15	$5,380.07
826	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	9.9	$10,060.39	$5,030.20
827	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	4.7	$9,787.18	$4,893.59
828	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	3	$10,930.94	$5,465.47
829	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W CC/MCC	6.4	$9,743.50	$4,871.75
830	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W/O CC/MCC	2.6	$10,531.91	$5,265.96
831	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W MCC	3.2	$6,693.44	$3,346.72
832	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W CC	2.5	$5,683.93	$2,841.97
833	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W/O CC/MCC	1.9	$5,561.85	$2,780.92
834	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	10	$11,603.21	$5,801.60
835	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	4.5	$8,951.12	$4,475.56

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
836	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	2.6	$10,064.44	$5,032.22
837	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	12.8	$9,295.10	$4,647.55
838	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	5.8	$7,491.67	$3,745.84
839	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	4.5	$5,632.30	$2,816.15
840	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	7	$9,065.24	$4,532.62
841	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	4.2	$7,621.04	$3,810.52
842	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	2.9	$7,852.23	$3,926.12
843	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	5.3	$7,148.85	$3,574.43
844	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	3.7	$6,484.02	$3,242.01
845	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	2.6	$6,614.14	$3,307.07
846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	6.2	$8,413.59	$4,206.80
847	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	3.6	$7,259.38	$3,629.69
848	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	2.9	$6,720.90	$3,360.45
849	RADIOTHERAPY	5	$8,443.68	$4,221.84
853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	9.9	$10,228.10	$5,114.05
854	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	5.7	$7,530.08	$3,765.04
855	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	3.6	$8,844.87	$4,422.44
856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	8.9	$9,875.78	$4,937.89
857	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	5.4	$7,478.03	$3,739.01
858	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	3.7	$7,387.92	$3,693.96
862	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	5	$7,350.58	$3,675.29
863	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	3.5	$5,606.19	$2,803.10
864	FEVER AND INFLAMMATORY CONDITIONS	2.8	$6,010.49	$3,005.24
865	VIRAL ILLNESS W MCC	3.9	$7,095.11	$3,547.56
866	VIRAL ILLNESS W/O MCC	2.7	$6,021.99	$3,011.00
867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	5.6	$7,749.66	$3,874.83
868	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	3.6	$6,051.78	$3,025.89
869	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	2.7	$5,461.50	$2,730.75
870	SEPTICEMIA OR SEVERE SEPSIS W MV >96 HOURS	12.4	$10,129.08	$5,064.54

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	4.8	$7,721.82	$3,860.91
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	3.7	$5,578.51	$2,789.26
876	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	7.2	$10,040.33	$5,020.17
880	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	2.6	$6,545.40	$3,272.70
881	DEPRESSIVE NEUROSES	3.8	$4,281.92	$2,140.96
882	NEUROSES EXCEPT DEPRESSIVE	3.2	$4,901.70	$2,450.85
883	DISORDERS OF PERSONALITY & IMPULSE CONTROL	4.8	$5,530.18	$2,765.09
884	ORGANIC DISTURBANCES & INTELLECTUAL DISABILITY	4.3	$6,641.55	$3,320.78
885	PSYCHOSES	5.8	$4,161.70	$2,080.85
886	BEHAVIORAL & DEVELOPMENTAL DISORDERS	3.7	$7,222.60	$3,611.30
887	OTHER MENTAL DISORDER DIAGNOSES	3	$7,203.22	$3,601.61
894	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	2.1	$5,488.93	$2,744.46
895	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	8.6	$3,757.00	$1,878.50
896	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	4.9	$6,970.05	$3,485.02
897	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	3.4	$4,800.28	$2,400.14
901	WOUND DEBRIDEMENTS FOR INJURIES W MCC	9.2	$9,341.11	$4,670.55
902	WOUND DEBRIDEMENTS FOR INJURIES W CC	4.9	$7,971.97	$3,985.98
903	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	2.9	$7,834.43	$3,917.21
904	SKIN GRAFTS FOR INJURIES W CC/MCC	6.7	$10,485.49	$5,242.74
905	SKIN GRAFTS FOR INJURIES W/O CC/MCC	3.5	$9,444.28	$4,722.14
906	HAND PROCEDURES FOR INJURIES	2.8	$12,347.96	$6,173.98
907	OTHER O.R. PROCEDURES FOR INJURIES W MCC	7.2	$11,004.65	$5,502.32
908	OTHER O.R. PROCEDURES FOR INJURIES W CC	4	$10,243.29	$5,121.65
909	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	2.5	$10,475.75	$5,237.88
913	TRAUMATIC INJURY W MCC	3.6	$8,144.26	$4,072.13
914	TRAUMATIC INJURY W/O MCC	2.5	$6,845.34	$3,422.67
915	ALLERGIC REACTIONS W MCC	3.7	$9,120.03	$4,560.02
916	ALLERGIC REACTIONS W/O MCC	1.8	$6,986.31	$3,493.15
917	POISONING & TOXIC EFFECTS OF DRUGS W MCC	3.5	$8,302.61	$4,151.31
918	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	2.3	$6,769.67	$3,384.83
919	COMPLICATIONS OF TREATMENT W MCC	4.3	$8,430.34	$4,215.17

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
920	COMPLICATIONS OF TREATMENT W CC	2.9	$6,899.64	$3,449.82
921	COMPLICATIONS OF TREATMENT W/O CC/MCC	2.2	$6,234.23	$3,117.12
922	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	3.8	$8,380.92	$4,190.46
923	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	2.7	$6,366.23	$3,183.12
927	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W SKIN GRAFT	22.2	$17,841.35	$8,920.67
928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	10.7	$11,498.20	$5,749.10
929	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	5.8	$10,072.10	$5,036.05
933	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W/O SKIN GRAFT	2.6	$23,986.30	$11,993.15
934	FULL THICKNESS BURN W/O SKIN GRAFT OR INHAL INJ	4.2	$8,557.77	$4,278.88
935	NON-EXTENSIVE BURNS	3.4	$11,286.91	$5,643.45
939	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	6.5	$11,165.60	$5,582.80
940	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	3.7	$12,194.04	$6,097.02
941	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	2.3	$16,671.17	$8,335.59
945	REHABILITATION W CC/MCC	9.4	$3,074.50	$1,537.25
946	REHABILITATION W/O CC/MCC	7.1	$3,040.54	$1,520.27
947	SIGNS & SYMPTOMS W MCC	3.5	$6,793.82	$3,396.91
948	SIGNS & SYMPTOMS W/O MCC	2.6	$5,954.94	$2,977.47
949	AFTERCARE W CC/MCC	4.5	$4,805.68	$2,402.84
950	AFTERCARE W/O CC/MCC	3.4	$4,327.73	$2,163.86
951	OTHER FACTORS INFLUENCING HEALTH STATUS	2.5	$4,659.16	$2,329.58
955	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	7.4	$16,318.75	$8,159.37
956	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	6.1	$12,773.24	$6,386.62
957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	9.7	$15,424.67	$7,712.33
958	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	7	$11,890.18	$5,945.09
959	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	3.8	$14,636.30	$7,318.15
963	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	5.3	$10,211.41	$5,105.71
964	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	4	$7,415.23	$3,707.61
965	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.7	$6,745.78	$3,372.89
969	HIV W EXTENSIVE O.R. PROCEDURE W MCC	11.7	$9,849.71	$4,924.86
970	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	6.5	$8,912.56	$4,456.28

DRG	DRG Description	GMLOS	Day 1	Day ≥ 2
974	HIV W MAJOR RELATED CONDITION W MCC	6.4	$8,297.45	$4,148.72
975	HIV W MAJOR RELATED CONDITION W CC	4.1	$6,500.52	$3,250.26
976	HIV W MAJOR RELATED CONDITION W/O CC/MCC	3.1	$5,856.78	$2,928.39
977	HIV W OR W/O OTHER RELATED CONDITION	3.4	$7,596.45	$3,798.23
981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	8.4	$10,644.01	$5,322.01
982	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	8.4	$5,764.13	$2,882.06
983	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	4.9	$6,635.27	$3,317.63
987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	2.5	$26,482.91	$13,241.46
988	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	8.1	$4,213.02	$2,106.51
989	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	4.4	$5,201.51	$2,600.76
998	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	2.1	$0.00	$0.00
999	UNGROUPABLE	8.4	$0.00	$0.00

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