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February 13, 2015

Sean Cavanaugh
Deputy Administrator & Director
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Two-Midnight Policy and Potential Short Stay Payment Solutions

Dear Mr. Cavanaugh:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) writes to urge the Centers for Medicare & Medicaid Services (CMS) to offer potential payment solutions for hospital stays of less than two-midnights in its proposed rule for the fiscal year (FY) 2016 inpatient prospective payment system (PPS). We also ask CMS to extend the partial enforcement delay of the "two-midnight" policy until the later of Oct. 1, 2015 or the agency's implementation date of a short stay payment (SSP) policy. Currently, CMS prohibits the recovery audit contractors (RACs) from conducting post-payment patient status reviews for claims with dates of admission from Oct. 1, 2013 through March 31, 2015. Additionally, we ask the agency to repeal the unlawful 0.2 percent reduction to the standardized amount that was implemented in FY 2014.

We strongly urge CMS to undertake comprehensive reform of the RAC program to improve its management and fairness. RAC reform should go hand-in-hand with an SSP solution; without such changes, implementation of the two-midnight policy will continue to be problematic. However, changes to the RAC program can be made – and are made – independently from the two-midnight policy. While we appreciate the changes to the RAC program that the agency made on Dec. 30, 2014, these modifications are modest at best. We believe that additional, more significant reforms are necessary – such as realigning the financial incentives that drive RACs to deny claims inappropriately and excessively – to address the systemic issues that have resulted in tremendous burden on hospitals and the appeals process.

Since the agency first mentioned, in its calendar year (CY) 2013 proposed rule for the outpatient PPS, the option of a payment solution to address patient status, the AHA has considered the design of a potential SSP policy and discussed some possible solutions with its members. We believe that an SSP policy, supplementing the existing two-midnight policy, could reimburse hospitals more accurately for the resources used to treat patients who stay in the hospital less than two midnights.

As you know, under the two-midnight policy, CMS generally considers hospital admissions spanning two midnights appropriate for payment under the inpatient PPS. In contrast, hospital stays of less than two midnights are generally considered outpatient cases by CMS, regardless of clinical severity. We appreciate CMS's attempt to clarify what is required for payment of inpatient hospital services under Medicare Part A, but the two-midnight policy results in inadequate reimbursement to hospitals for beneficiaries who require an inpatient level of care, but who stay in the hospital less than two midnights.

The AHA has modeled and analyzed several potential SSP policy approaches. While our analysis leaves many questions unanswered, we want to share it with you in the attachment. Our results show that creating a SSP policy is technically feasible and can be done in different ways, each of which has strengths and weaknesses. We hope that it will help inform the work of the agency related to potential SSP solutions as it formulates the FY 2016 inpatient PPS proposed rule.

We appreciate your consideration of these issues and look forward to continuing to work with CMS on matters of great importance to hospitals, beneficiaries and the Medicare program. If you have any questions, please feel free to contact me or Priya Bathija, senior associate director, policy, at (202) 626-2678 or pbathija@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President for Public Policy
Analysis and Development

AMERICAN HOSPITAL ASSOCIATION (AHA) DETAILED COMMENTS

THE TWO-MIDNIGHT POLICY & THE NEED FOR A SHORT STAY PAYMENT SOLUTION

The Centers for Medicare & Medicaid Services (CMS) formalized its "two-midnight" policy in the fiscal year (FY) 2014 inpatient prospective payment system (PPS) final rule. Under this policy, CMS generally considers hospital admissions spanning two midnights appropriate for payment under the inpatient PPS. In contrast, hospital stays of less than two midnights are generally considered outpatient cases, regardless of clinical severity.

We believe the two-midnight policy has many shortcomings, which we have addressed in previous communications to the agency. One of the most significant, however, is that it introduces an arbitrary time-based benchmark that results in inadequate reimbursement for beneficiaries who require an inpatient level of care, but who stay in the hospital less than two midnights. **We believe that a short stay payment (SSP) policy, supplementing the existing two-midnight policy, could reimburse hospitals more accurately for the resources they use to treat beneficiaries during short stays.**

In our comment letter on the FY 2015 inpatient PPS proposed rule, the AHA offered a set of principles for CMS to consider in crafting an SSP policy. We have since continued our work on an SSP policy and discuss our findings below.

THE AHA'S POTENTIAL SSP POLICY MODELS

The AHA modeled six potential SSP approaches using 2013 Medicare Provider Analysis and Review (MedPAR) claims data. Our results show that creating a SSP policy is technically feasible and can be done in many different ways, each of which has strengths and weaknesses. Below, we describe each of our models and findings.

Transfer Policy-based SSP Policy. The AHA began its analysis of potential SSP models by reviewing CMS's existing transfer policy, an option mentioned by CMS in its FY 2015 inpatient PPS proposed rule. Under the existing transfer policy, CMS provides a payment of two times the per-diem rate for the first day of the stay and one times the per-diem rate for each additional day, up to the otherwise applicable Medicare-severity diagnosis-related group (MS-DRG or DRG) payment. Initially, it seemed that such a per-diem approach would allow for administrative simplicity because it was based on existing policy and the same per-diem multiplier would be used for each short-stay case.

However, further research indicates that using a fixed multiplier of two times the per diem for the first day of the stay would not reimburse hospitals appropriately. Rather, a wide range of per-diem multipliers – from 0.9 to 7.9 – would be required, depending on the DRG, in order to account appropriately for resource use. **Given these findings, our members concluded that a**

transfer policy-based SSP policy is not a viable option for reimbursing short inpatient hospital stays.

Five Additional SSP Policy Models. The AHA also analyzed five additional SSP models that create new short-stay DRGs for inpatient hospital stays spanning less than two midnights. Each of the five models uses CMS's current weight-setting methodology and is budget neutral to the inpatient PPS. As previously stated, each model uses final 2013 MedPAR claims data.[1] These data include claims from FY 2013 – the year prior to the implementation of the two-midnight policy. These data do not reflect behavioral changes made by hospitals as a result of implementation of the two-midnight policy or actions taken by CMS (i.e., partial enforcement delay of the two-midnight policy).

Under each model, we created a set of short-stay DRGs that included only inpatient stays of less than two days – those listed as one-day stays in MedPAR. Accordingly, non-short stays are defined as cases with stays of two days or more. We used MedPAR's "length of stay" variable, as opposed to the "covered days" variable to be consistent with the general inpatient PPS methodology, which uses length of stay even if it includes days not covered by Medicare. It is also important to note that by using this definition of short-stays, we do not fully account for the "two-midnight benchmark" or the "two-midnight expectation." That is, in our analysis we considered as short stays certain cases that CMS might consider as non-short stays. For example, if a patient stay included one midnight of outpatient time and one midnight of inpatient time, we considered this a short stay, but CMS might consider this case a non-short stay since the combination of outpatient and inpatient time met the "two-midnight benchmark." In addition, if a physician expected a patient stay to span two midnights, but it actually spanned only one midnight, we considered this a short stay, but CMS might consider this a non-short stay case since there was an expectation of a two-midnight stay.

A description of the five models follows. Table 1 displays the number of short-stay DRGs created for each model.

- **Major Diagnostic Category (MDC).** Under this model, we created one short-stay DRG that included all the DRGs within one of 27 MDCs.[2] An inpatient stay spanning at least two days was assigned to the same DRG to which it is currently assigned, but an admission spanning less than two days was assigned to a new short-stay DRG created for the MDC to which that DRG is assigned. For example, all short stays from all DRGs in MDC 5 (Diseases and Disorders of the Circulatory System) were assigned to the MDC 5 Short-stay DRG. Although there are a total of 27 MDCs, only 26 new DRGs were created in this model because MDC 15 (Newborns and Other Neonates) has no short stays.

- **MDC Medical/Surgical (M/S).** Under this model, we created one short-stay DRG for all of the medical DRGs within an MDC and another short-stay DRG was created for all of the surgical DRGs within that MDC. Although there are a total of 27 MDCs, which could

[1] Maryland and Indian Health Service hospitals are excluded from this analysis.
[2] We considered the "pre-MDC" and "non-MDC" categories as distinct MDCs.

potentially be divided into 54 new MDC M/S DRGs, only 49 new DRGs were created in this model because not all MDCs contain both medical and surgical DRGs.

- **Targeted DRGs.** Under this model, we created a short-stay DRG for the 61 DRGs listed in Exhibit A. These DRGs had the highest percentage of short stays, number of short stays or number of RAC denials.[3] Specifically, the top 25 DRGs in each of these categories were determined, then all duplicate DRGs were removed, and a list of 61 DRGs remained. An inpatient stay spanning at least two days was assigned to the same DRG to which it is currently assigned. An inpatient stay spanning less than two days and belonging to one of the 61 DRGs was assigned to the new short-stay DRG created for that DRG. An inpatient stay spanning less than two days and *not* belonging to one of the 61 DRGs was assigned to the same DRG to which it is currently assigned. This model is similar to an option presented at a recent meeting of the Medicare Payment Advisory Commission (MedPAC).

- **Base DRG.** Many base DRGs are split into two or three DRGs based on differences in severity. Levels of severity are defined by whether any one of the secondary diagnoses has been categorized as a major complicating or comorbid condition (MCC), a complicating or comorbid condition (CC), or neither. For example, the Carotid Artery Stent Procedure base DRG is split into three severity levels – DRGs 34, 35, and 36, Carotid Artery Stent Procedure w/o CC/MCC, w/CC, and w/MCC, respectively. Under the Base DRG model, we created one short-stay DRG that combined all the DRG severity levels for a base DRG. An inpatient stay spanning at least two days was assigned to the same DRG to which it is currently assigned. An inpatient stay spanning less than two days was assigned to the new short-stay DRG created for the base DRG to which that DRG belongs. For example, all short stays from DRGs 34, 35 and 36 were assigned to the Carotid Artery Stent Procedure Short-stay DRG. There are a total of 336 base DRGs; however, three of these do not have any short stays. As a result, a total of 333 short-stay DRGs were created for this model.

- **DRG Refinement.** Under this model, we created two separate sets of DRG weights. Specifically, we split each current DRG into two – one for short-stay cases and one for non-short-stay cases, essentially doubling the current number of DRGs.

[3] The DRGs associated with the number of RAC denials was based on RAC denials from October 2010 through June 2014.

Table 1: AHA SSP Policy Models

Model Name	Description	Short-stay DRGs Created
MDC	One short-stay DRG for each MDC	26
MDC M/S	One short-stay DRG for all of the medical DRGs within an MDC and another short-stay DRG for all of the surgical DRGs within an MDC	49
Targeted DRGs	One short-stay and one non-short-stay DRG for the DRGs with the most short stays or RAC denials	61
Base DRG	One short-stay DRG for each base DRG	333
DRG Refinement	One short-stay DRG for each DRG	739

IMPACT OF SSP POLICY MODELS

Our analysis of the five SSP models is limited by the fact that the most recent publicly available MedPAR data are from FY 2013, which is before the two-midnight policy was implemented in FY 2014. Because of this limitation, we chose to focus our efforts on the extent to which each SSP model redistributes payments across hospitals, rather than the extent to which each model improves payment accuracy.

In general, the one-year redistributive impact of many of our models is fairly comparable (see Table 2). The two exceptions are the MDC model and the Targeted DRG model. The MDC model redistributes more hospital payments than the other models; we believe this is because the MDC model aggregates a broader range of short-stay cases into one DRG than the other models do. In contrast, the Targeted DRG model redistributes substantially fewer hospital payments than the other models; this is not surprising, given that most DRG assignments would remain unchanged under this model.

Table 2: Total Payments Redistributed by SSP Model, in Millions of Dollars

MDC	$631
MDC M/S	492
Targeted DRGS	206
Base DRG	487
DRG Refinement	486

The impact of each of our models on individual hospitals' payments was also fairly comparable, again with the exception of the MDC and Targeted DRG models (see Table 3). Under the MDC model, a higher percentage of hospitals tended to gain and a lower percentage of hospitals tended

to lose payments than other models. Under the Targeted DRG model, fewer hospitals have gains or losses of 3 percent or more.

Table 3: Percentage of Hospitals by Percentage Change in Payment, by SSP Model

	MDC	MDC M/S	Targeted DRGS	Base DRG	DRG Refinement
Loss of 3% or more	6.4%	6.4%	0.8%	6.5%	6.4%
Loss of 0.1 to 2.9%	31.0	40.6	48.0	42.1	42.2
Gain of 0.1 to 2.9%	53.6	48.0	50.5	46.6	46.7
Gain of 3% or more	9.0	4.9	0.7	4.8	4.7

Changes in payment by hospital type are also fairly comparable across models, as indicated in Table 4. Again, the MDC model is a slight outlier in that it redistributes slightly more payments than the other models and the Targeted DRG model redistributes the least amount of hospital payments. Additionally, the data indicate that major teaching hospitals experience losses in each of the models, with the total loss ranging from negative $8 million (the Targeted DRGs) to negative $115 million (the MDC model). We believe this is because those hospitals have the most short stay cases.

Table 4: Percentage Change in Payment by Hospital Type and SSP Model

	MDC	MDC M/S	Targeted DRGS	Base DRG	DRG Refinement
Rural	1.0%	0.1%	0.1%	0.0%	0.0%
Urban	0.0	0.0	0.0	0.0	0.0
Major Teaching	-0.4	-0.2	0.0	-0.1	-0.1
Minor Teaching	0.0	0.0	0.0	0.0	0.0
Non-Teaching	0.3	0.1	0.0	0.1	0.1
For-Profit	0.1	0.1	0.0	0.1	0.1
Non-Profit	0.0	0.0	0.0	0.0	0.0
Government	-0.1	-0.2	0.0	-0.2	-0.2

Although the Targeted DRG model redistributes the least amount of payments, we believe it is the least workable of the five models. This model could be the most disruptive in terms of administrative burden and year-to-year change. Specifically, the DRGs in this model would need to be reviewed periodically because the conditions that have a high percentage of short stays, number of short stays, or number of RAC denials change over time due to changes in

technology, medical practice, and RAC activity. While we could not review how the conditions with a high number of RAC denials change over time, we did review how the conditions with a high percentage or number of short stays change over time. We found that, of the 25 DRGs with the highest percentage of short stays in FY 2013, only 18 were in the top 25 in FY 2008. Of the 25 DRGs with the highest number of short stays in FY 2013, only 17 of these were in the top 25 in FY 2008.

In addition, while this model targets the DRGs with the highest percentage or number of short stays, our analysis shows that short-stay cases are widely distributed across the DRGs. Specifically, nearly all DRGs have short-stay cases and approximately half of the DRGs (377) have at least 10 percent short-stay cases. We are not confident that the Targeted DRG model will appropriately address the short, resource-intensive stays that span less than two midnights.

Finally, while our models reduced payment differentials between inpatient stays and similar outpatient stays, one goal of an SSP policy, we found that new payment differentials between short-stay and non-short stay inpatient cases were created. We were not able to analyze systematically payment differentials for all DRGs in all models because of the difficulty in determining a comparable outpatient payment for each inpatient stay. However, we reviewed some DRGs that demonstrate this trend. For example, as seen in Figure 1, under the current system, we estimated that the payment differential between an inpatient and outpatient stay for DRG 69, Transient Ischemia, is $2,599. Under each of our models, that differential decreased, but a new payment differential between the short stay and non-short stay payment rates was created. This payment differential ranged from $1,064 to $2,280 depending on the model. Similar results were found when reviewing DRG 343, as seen in Figure 2, Appendectomy without Complicated Principal Diagnosis without CC/MCC. Although these differentials are less than the current inpatient-outpatient differential, they are not always substantially less.

Figure 1: Payment Differentials between Inpatient and Outpatient Services for Transient Ischemia (DRG 69, MDC 1 – Nervous System)

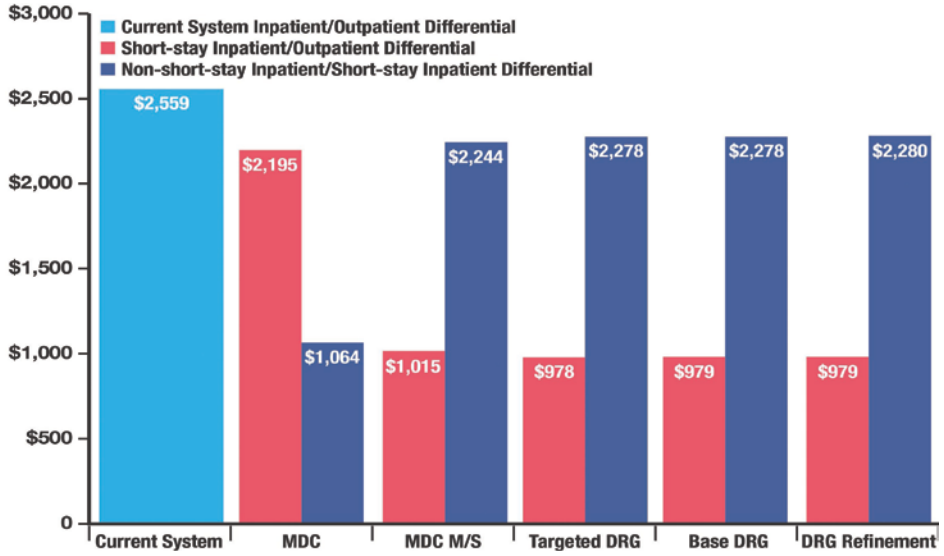
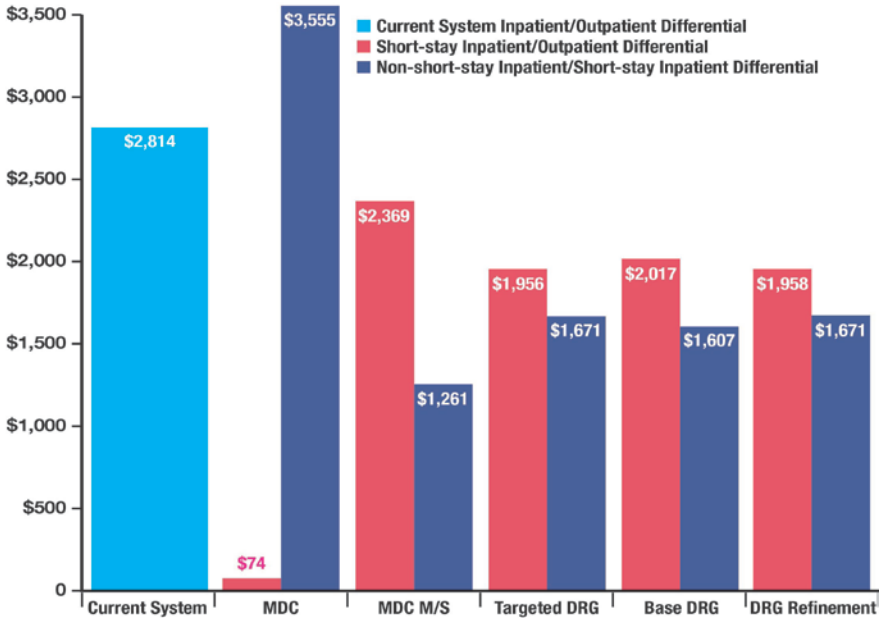


Figure 2: Payment Differentials between Inpatient and Outpatient Services for Appendectomy without Complicated Principal Diagnoses without CC/MCC (DRG 343, MDC 6 – Digestive System)



SSP POLICY METHODOLOGICAL CONSIDERATIONS

In the course of our analysis, we encountered certain methodological issues that required further consideration. Below we describe these issues and how we addressed them in our modeling.

Non-Monotonicity. Because the DRG Refinement model creates short-stay DRGs for each level of severity within a base DRG, we encountered issues with non-monotonicity. Non-monotonicity occurs when, within a base DRG, the DRG weight decreases as the DRG severity level increases. It often occurs as a result of a small number of cases being available to calculate the weights for a given DRG. For example, this occurred when the DRG weight decreased when moving from the short-stay Heart Transplant or Implant of Heart Assist System w/o MCC DRG to the short-stay Heart Transplant or Implant of Heart Assist System w/MCC DRG. The DRG weight should always increase as the DRG severity increases – otherwise, cases that are more severe and require greater expenditure of medical care resources would be paid based on a lower relative weight than cases that are less severe and require lower resource use.

We corrected for the issue of non-monotonicity using a methodology similar to how CMS corrects for it in the long-term care hospital PPS. Specifically, if we found a situation where a lower-severity DRG had a higher weight than a higher-severity DRG, we created a single weighted average of the weights for the DRGs with the exception, and assigned the same weight

to both DRGs. After our initial round of correction, we re-checked and re-weighted where necessary.

Finally, we checked the DRG Refinement model (739 DRGs) for another type of non-monotonocity – where the short-stay version of a DRG had a higher weight than the non-short-stay version of the DRG. Only one short-stay DRG (DRG 710) had this characteristic; we made no adjustment for that DRG. We did not systematically check the other models for this problem given that there is not a clear way to solve it without creating large numbers of distortions. However, we expected and found several instances of this problem in the other models. For example, in the MDC model, for DRG 313, Chest Pain, the short-stay weight is higher than the non-short stay weight. We did not correct or otherwise account for this irregularity in our other models. This issue warrants further study.

Outpatient Payment Higher than Inpatient Payment. One of the AHA's guiding principles on potential SSP policies is that the payment for a short-stay inpatient case should be higher than the payment for a comparable outpatient case, but should not exceed the applicable full inpatient DRG payment. We were not able to identify systematically the extent to which our models adhere to this principle because of the difficulty in determining a comparable outpatient payment for each inpatient stay. However, we were able to review some specific examples. We found one exception to this principle and surmise that others exist. Specifically, under the MDC model, for DRG 247, Percutaneous Cardiovascular Procedure with Drug-eluting Stent w/o MCC, the short-stay weight results in a payment that is $4,889 lower than the estimated outpatient payment amount. This phenomenon needs to be studied and addressed in formulating a potential SSP policy. It also raises the question of whether the MDC model aggregates too many different short-stay cases into one DRG and is, therefore, a less acceptable model.

Deaths, Transfers and Left against Medical Advice (DTL) Cases. Another methodological consideration is how to handle DTL cases. These cases are not insignificant – they accounted for about 3 percent of all inpatient PPS cases and about 2 percent of total inpatient PPS payments in our dataset. In all of our models, we chose to subject all DTL cases to the SSP policy (i.e., these cases were classified as short stay or non-short stay based entirely on the length of stay listed in MedPAR.) For example, if a beneficiary was at the hospital for one day before leaving against medical advice, the case was treated as a short stay; in turn, if the patient was at the hospital for longer than two days, the case was considered a non-short stay. In the case of transfers, we did the same – we did not subject them to the existing transfer policy. This issue also warrants further study.

Inpatient-Only List. MedPAR does not specifically identify those cases involving procedures on the inpatient-only list. Therefore, we classified these cases as short stay or non-short stay based entirely on the length of stay listed in MedPAR. **However, the AHA recommends, consistent with the current two-midnight policy and our guiding principles, that these procedures continue to be paid under the full, non-short stay inpatient PPS payment rate.**

Outlier Policy. With all models, there is also a choice about how to construct the outlier policy. There are at least three possibilities for handling outlier payments: (1) outlier payments for short-

stay cases could be determined in the same manner as for all other inpatient PPS cases (i.e., same outlier offset and same threshold); (2) outlier payments for short-stay cases could be based on a separate outlier offset and threshold specifically for these cases and a different outlier offset and threshold for all other inpatient PPS cases; or (3) there could be no outlier payments (and no outlier offset) for short-stay cases. In our modeling, we applied the first option, calculating outlier payments for short-stay cases in the same manner as for all other cases. However, this issue also warrants further consideration.

EVALUATION OF THE ADEQUACY OF OBSERVATION PAYMENT RATES

In addition to implementing an SSP policy, we encourage CMS to evaluate the adequacy of the outpatient PPS rates Medicare pays for observation care, which is the type of care hospitals often provide while making a determination of whether an inpatient admission is appropriate. Current observation care rates, which have been quite low historically, do not cover hospitals' costs. Specifically, the CY 2015 payment rate for eight or more hours of observation services (furnished in conjunction with a hospital clinic visit and certain high-level emergency department visits) is $1,234.70. This payment rate is the same whether a patient requires eight hours of observation care, or 48 hours of observation care. Hospitals receive the same reimbursement, regardless of the length, level or intensity of observation services (e.g., nursing and monitoring services) they actually provide to a patient and, in many cases, the payment rates are far less than the costs incurred by the hospital. CMS could, for example, consider allowing hospitals to record a room and board charge associated with these services, thereby more accurately reflecting their costs.

Exhibit A: DRGs for which Short-stay DRG was Created under Targeted DRG Model

DRG Number	Title
35	CAROTID ARTERY STENT PROCEDURE W CC
36	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC
39	EXTRACRANIAL PROCEDURES W/O CC/MCC
66	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC
69	TRANSIENT ISCHEMIA
117	INTRAOCULAR PROCEDURES W/O CC/MCC
136	SINUS & MASTOID PROCEDURES W/O CC/MCC
139	SALIVARY GLAND PROCEDURES
149	DYSEQUILIBRIUM
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC
192	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC
194	SIMPLE PNEUMONIA & PLEURISY W CC
204	RESPIRATORY SIGNS & SYMPTOMS
238	MAJOR CARDIOVASC PROCEDURES W/O MCC
246	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC
249	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC
251	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC
253	OTHER VASCULAR PROCEDURES W CC
254	OTHER VASCULAR PROCEDURES W/O CC/MCC
284	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC
285	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC
287	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC
291	HEART FAILURE & SHOCK W MCC
292	HEART FAILURE & SHOCK W CC
293	HEART FAILURE & SHOCK W/O CC/MCC
296	CARDIAC ARREST, UNEXPLAINED W MCC
297	CARDIAC ARREST, UNEXPLAINED W CC
298	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC
303	ATHEROSCLEROSIS W/O MCC
305	HYPERTENSION W/O MCC
309	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC
310	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC
312	SYNCOPE & COLLAPSE
313	CHEST PAIN
343	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC

378	G.I. HEMORRHAGE W CC
379	G.I. HEMORRHAGE W/O CC/MCC
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC
419	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC
473	CERVICAL SPINAL FUSION W/O CC/MCC
491	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC
512	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC
552	MEDICAL BACK PROBLEMS W/O MCC
627	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC
641	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC
670	TRANSURETHRAL PROCEDURES W/O CC/MCC
683	RENAL FAILURE W CC
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC
708	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC
710	PENIS PROCEDURES W/O CC/MCC
714	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC
716	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC
747	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC
748	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES
812	RED BLOOD CELL DISORDERS W/O MCC
847	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC
916	ALLERGIC REACTIONS W/O MCC
933	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT