American Hospital Association

Member Advisory

March 3, 2008

Recovery Audit Contractors (RACs): Preparing for RAC Audits

At A Glance

The Issue:

The Medicare Recovery Audit Contractor (RAC) program is authorized by Congress to identify improper Medicare payments – both overpayments and underpayments. The RAC program began operation in three states (California, Florida and New York) under a demonstration program and has since been expanded to two additional states (Massachusetts and South Carolina). The Centers for Medicare & Medicaid Services (CMS) plans to roll out a permanent, nationwide RAC program by 2010. As part of its rollout strategy, CMS intends to award contracts to four regional RACs by this April and begin review activity in all states by January 2009. The *Medicare Recovery Audit Contractor Program Moratorium Act of 2007* (H.R. 4105), which would establish a one-year moratorium on the RAC program, was introduced last year in the House, but no action has yet been taken.

CMS recently reported that RACs collected $357 million in overpayments from Medicare providers in the three early demonstration states during fiscal year 2007, with 92 to 94 percent of these funds collected from hospitals. To avoid RAC denials under the fully implemented program, hospitals should pay special attention to ensure appropriate admissions, coding and documentation practices, which are likely to be scrutinized by RACs.

This advisory highlights the types of inpatient claims that were targeted during the RAC demonstration and some strategies and tools your organization can implement to minimize the impact of future RAC audits. *This information is provided only as a guideline. Consult with legal counsel and your financial experts before finalizing any policy or practice*.

What You Can Do:

Although we are urging Congress and CMS to make changes to the RAC program, the AHA is advising hospitals to begin preparing for RAC reviews. Hospitals should start by assembling an internal RAC team to plan and implement process improvements to reduce RAC vulnerabilities, including a self-audit to identify RAC risks. Please share this advisory with other hospital leaders and your RAC team to learn about likely targets under the national RAC program and to determine which tools and strategies in this advisory would be most effective in helping your hospital ensure Medicare claims accuracy.

Further Questions:

Please contact AHA Member Relations at 1 (800) 424-4301 or email RACinfo@aha.org.

AHA's Member Advisories are produced whenever there are significant developments that affect the job you do in your community. A 13-page, in-depth examination of this issue follows.

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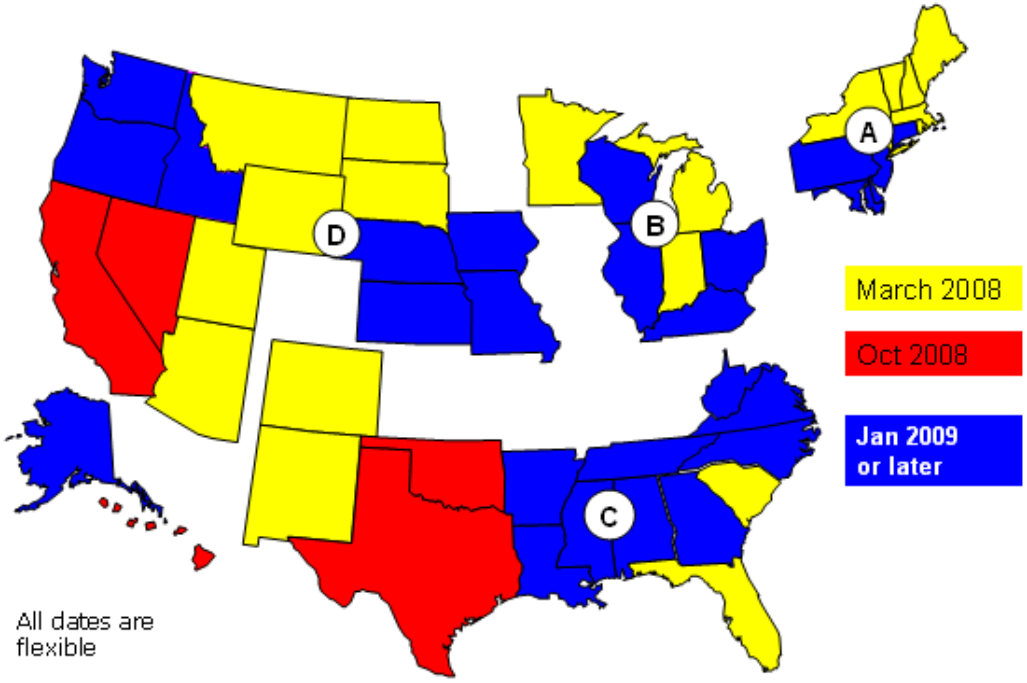
RECOVERY AUDIT CONTRACTORS (RACS): PREPARING FOR RAC AUDITS

BACKGROUND

In the *Medicare Modernization Act of 2003,* Congress established the Medicare Recovery Audit Contractor (RAC) program as a demonstration program in California, Florida and New York to identify improper Medicare payments – both overpayments and underpayments.[1] RACs are paid on a contingency fee basis, receiving a percentage of the improper payments they identify. In the *Tax Relief and Health Care Act of 2006*, Congress authorized the expansion of the RAC program to all 50 states by 2010. This was done before the demonstration program was complete or a thorough evaluation of its appropriateness and problems was made. So far, the Centers for Medicare & Medicaid Services (CMS) has expanded the program to Massachusetts and South Carolina. The national expansion will roll out in three stages beginning in March 2008.

CMS' RAC Expansion Schedule



Although CA was a RAC demo state, California claims will not be available for RAC review from March 2008- Oct. 2008 due to a MAC transition.

[1] For additional background information on the RACs, download the AHA's December 4, 2007 RAC Advisory and other resources at http://www.aha.org/aha/issues/Medicare/RAC/resources.html.

RACs use automated proprietary software programs to identify potential payment errors, such as duplicate payments, fiscal intermediary (FI) mistakes and coding errors. For "complex reviews," RACs request medical charts to review admissions and documentation to identify services that are not covered by Medicare or are miscoded. The demonstration program is scheduled to end on March 27, 2008, and the last day for RACs to request medical records from a provider in the five states was December 1, 2007. The last day for RACs to issue denials under the demonstration was February 15, 2008.

Late last year, Reps. Lois Capps (D-CA) and Devin Nunes (R-CA) introduced H.R. 4105, the *Medicare Recovery Audit Contractor Program Moratorium Act of 2007*, which would place a one-year moratorium on RAC activities in states in which RACs are currently operating and prevent CMS from entering into new, permanent RAC contracts. By delaying implementation, the moratorium would allow time for program evaluation and time to address serious problems with RACs, including more appropriate payment incentives, and greater oversight and transparency. The AHA is actively seeking co-sponsors for H.R. 4105.

This advisory – the fourth in a series – summarizes experiences from the RAC demonstration that can help you and your staff focus on those inpatient areas most likely to be audited by RACs when the rollout of the national program begins. In particular, it highlights the types of inpatient claims that were targeted during the RAC demonstration, and strategies and tools your organization can implement to minimize the impact of future RAC audits. **This information is provided only as a guideline. Consult with legal counsel and your financial experts before finalizing any policy or practice.**

RAC DEMONSTRATION AUDITS AND DENIALS

CMS recently reported to the AHA that during fiscal year 2007 RACs collected $357.2 million in overpayments and repaid $14.3 million in underpayments. Hospitals accounted for approximately 92 to 94 percent of overpayments collected by RACs. According to CMS, the improper payments fell into the following categories:

- 42 percent – Incorrect coding;
- 41 percent – Medically unnecessary, or no or insufficient documentation; and
- 17 percent – Other.

You have an opportunity to pay special attention now to prepare for RAC reviews that will ultimately affect hospitals in every state. RACs will be able to review claims that are up to three years old, but in no case may they review claims with a paid date prior to October 1, 2007. Therefore, **today hospitals have a valuable opportunity to proactively ensure the accuracy of their admission, documentation, coding and billing practices to minimize the risk of RAC denials.**

Hospitals across the country can benefit from lessons learned in the five demonstration states. Common examples of inpatient acute services that were the subject of significant review and denial activity by RACs during the demonstration, which varied by state, are summarized below.

Short-stay Claims. Short-stay claims were targeted by the RACs in Florida and New York. These RACs specifically sought out short-stay claims in an attempt to validate whether the admissions met Medicare's medical necessity criteria. Some hospitals affected by a high rate of short-stay claims denials experienced significant Medicare recoupments. Large numbers of one-day stays were denied based on RAC determinations that the cases should not have been admitted for inpatient care because they were clinically appropriate for outpatient observation or other less-intensive care. One-day stays by chest pain patients are an example of a short-stay condition targeted by RACs.

Many three-day stays were denied based on RAC findings that they were inappropriately extended in order to qualify a beneficiary for Medicare Part A coverage of post-acute skilled nursing care. Medicare rules allow patients to qualify for up to 100 days of skilled nursing care after at least three days as a medically necessary inpatient in an acute-care hospital. Observation days do not count toward the three-day requirement.

Debridement. RACs have targeted several debridement diagnosis-related groups (DRGs). Skin graft and/or debridement for skin ulcer or cellulitis cases (DRG 263/MS-DRG 573) were cited for incorrect coding as "excisional" debridement, which was either not documented in the chart or the RAC believed was not justified by the medical chart. Cases of wound debridement and skin graft, exc. hand for musculoskeletal and connective tissue disease (DRG 217/MS-DRGs 463, 464 and 465) also were denied for being incorrectly coded at the "excisional" debridement level.

Back Pain. RACs found certain claims for medical back problems (DRG 243/MS-DRG 551) to be medically unnecessary if they determined the care could be provided on an outpatient basis and the patient was primarily admitted for three days in order to qualify for skilled nursing coverage. Substantiating the medical necessity of an inpatient admission for treatment of back pain requires comprehensive documentation of all clinical and other complicating factors that require inpatient-level care.

Outpatient vs. Inpatient Surgeries. RACs are denying a host of procedures that are not found on Medicare's "inpatient-only list." If a procedure is on Medicare's inpatient list, the patient must be an inpatient at the time the procedure is performed in order to qualify for payment. For procedures not on Medicare's inpatient-only list, the physician must document a medical reason for performing the procedure on an inpatient basis. This documentation, including lab results, X-rays and any failed outpatient procedures, must become part of the patient's permanent medical record to justify the medical necessity of inpatient surgery.

Transfer Patients. RACs also have targeted inpatients discharged to another hospital or post-acute provider where the hospital received a full DRG payment rather than the per-diem payment associated with transfers.

TOOLS TO ADDRESS RAC INPATIENT TARGET AREAS

To minimize the risk of RAC audit, hospitals should take steps today to ensure the highest level of admissions and claims accuracy. We suggest the methods below, which have been used successfully by hospitals to conduct process improvements to minimize Medicare denials. Your hospital may already have some of these systems and protocols in place. However, we suggest that you revisit them with a focus on the patterns of denials that emerged during the RAC demonstrations.

Conduct a Self-assessment of RAC Risk. We urge hospitals to conduct a risk self-assessment to identify error-prone claims identified by the RACs. This process and other RAC activities should be overseen by an interdisciplinary RAC team. The process improvements outlined below can help you identify and correct the root causes of any identified errors:

- Review available data on claims, admissions, documentation and coding to identify any patterns of errors related to, for example, specific DRGs, time of admission, particular specialties or groups of contract providers.
- Audit a sample of cases associated with patterns of errors to identify the scope of the problems.
- Use a cross-department team to review the findings of your audit to identify the root causes for any identified errors.
- Share the findings of your audit with key clinical, financial, compliance, legal counsel, coding, billing and medical records staff.
- Develop and implement internal protocol changes to correct the root causes and thereby prevent avoidable errors.
- Monitor new or revised protocols periodically to assess their effectiveness, and modify as needed.

QIO Resources for RAC Preparation. CMS-contracted quality improvement organizations (QIOs) have developed a wide array of resources to help hospitals improve claims and payment accuracy. While it appears their role is changing under a new CMS contract that begins in August 2008, QIOs remain a valuable source of online materials and recommendations related to payment accuracy. To learn about QIO provider education materials available through July or longer, contact your QIO at http://www.ahqa.org under "QIO Locator."

Examples of resources available to address areas targeted by the RACs include several tools developed by the Texas QIO, TMF Health Quality Institute (TMF). These tools are available free of charge as part of the Medicare program at http://hpmp.tmfhqi.net. In addition, the CMS Web site, http://www.hpmpresources.org, provides a list of successful

payment accuracy improvement initiatives in 25 states, which can be replicated by other hospitals.

Utilization Review and Case Management. Utilization review committees and case management teams play critical compliance and process improvement roles. We encourage you to consider these both for proactive and ongoing RAC preparation. While many of the methods summarized below are based on common process improvement principles, they should be given special consideration as RAC tools since they have been successful in reducing Medicare denials. Some of these strategies may be appropriate for your hospital depending on the outcome of your RAC self-audit:

- Develop a watch list of particular error-prone DRGs, such as short-stay cases and cases that are eligible for both outlier and inpatient payment.
- Use special forms, such as TMF's "One-Day Stay Inpatient Audit Tool" (Appendix A), a one-page audit checklist that helps validate whether a patient's admission is medically necessary. This tool helps hospitals route patients to the medically appropriate setting, highlights key admission screening criteria, and includes guidance on appropriate medical necessity documentation, billing and coding.
- Authorize case management to assess incoming patients at all entry points into the hospital, including the emergency department, day surgery units and direct admissions on a 24-hour-a-day, seven-days-per-week basis. Under this model, admission screening criteria such as Interqual can be used to assess medical necessity for all incoming patients.
- Communicate changes in patient status through appropriate documentation that justifies the changes. This has reduced RAC denials related to documentation and medical necessity. The TMF "Status Change Matrix Tool" (Appendix B) highlights necessary clinical criteria, signatures, dated orders, medical record documentation, billing/payment changes and other necessary actions that must be reviewed if a patient's status changes.
- Implement an "admit-to-case management" program to reduce one-day stays through closer monitoring of admissions. As part of this effort, some hospitals include clinical vignettes in each medical chart to support a patient's correct admission status.

Physician Education on RAC Risks. As physicians play a critical role in referring and admitting patients, hospitals must ensure they are educated about RACs, including the top admission and documentation problems identified by your RAC self-assessment. Consider these RAC resources for physicians:

- The "Medicare Outpatient Observation: Physician Guidelines" tool (Appendix C) clarifies for physicians the Medicare rules distinguishing inpatient admissions from outpatient observations. This tool can be customized by hospitals to match their priorities and state regulations.

- The “Chest Pain: Observation vs. Inpatient” decision tree (Appendix D) helps physicians determine if chest pain patients need observation only or a full inpatient admission. The tool highlights key risk factors that tend to influence the admission versus observation decision for chest pain patients. It is consistent with Medicare compliance guidelines and includes reminders for appropriate medical necessity documentation.

To decrease the rate of Medicare denials, the process improvement tools and methods above have been used to target common causes of claims and admissions errors, including:

- The lack of seven-day-per-week/24-hour availability of case management to review medical necessity of hospital admissions.
- The lack of seven-day-per-week/24-hour availability of a physician to support admission screening.
- Inadequate training and re-training of physicians and other clinicians reviewing admissions.
- The lack of periodic quality assessment of admission review protocols to ensure effectiveness and consistency across hospital departments.

IDENTIFYING OTHER POTENTIAL RAC VULNERABILITIES FOR YOUR HOSPITAL

Thus far, CMS has failed to conduct provider education based on experience of the RAC program and how to prevent payment errors identified in the demonstration. Therefore, it is critical that hospitals proactively use the data resources available to assess and mitigate risk. RACs use several data resources, including the tools summarized below, to focus their audit activities on the most error-prone claims. Your hospital can use the same data to focus your self-audit on your greatest risks related to coding, medically unnecessary admissions or documentation, and to prioritize any resulting performance improvement efforts.

PEPPER. A key tool to assess your hospital’s claims accuracy is the Program for Evaluating Payment Patterns Report (PEPPER), a provider-specific report (Appendix E). Today, each QIO prepares and distributes a PEPPER to each hospital in its state. It remains unclear which CMS entity will generate PEPPERs upon completion of the current CMS-QIO contract. The AHA will seek clarification from CMS on this important transition.

PEPPERs identify claims patterns that are outliers relative to other hospitals in the state, a “Top 20” list of DRGs that are prone to certain billing errors, and other problem areas, which vary by state. If your hospital is not accessing its PEPPER on a regular basis, contact your QIO immediately for assistance.

PEPPER data can be assessed in combination with additional hospital data for the same period. This additional information helps hospitals understand the scope of problem areas relative to the hospital's total operations. Tracking such data over time would be helpful to identify seasonal or other patterns and deviations, including:

- Total medical inpatient admissions;
- Total outpatient observation admissions;
- Observation admissions as a percent of total admissions;
- Number of DRGs in the 75th or greater percentile for all hospital admissions; and
- Number of DRGs that have shifted more than 25 percentile points over the prior two periods.

CMS Payment Reports. Every year, CMS studies a national sample of Medicare claims to identify the most common types of billing errors made by hospitals and other providers. The most recent data[2] indicate that CMS contractors overpaid almost $10 billion in Medicare claims in the 12-month period ending March 31, 2007. The table below highlights the diagnoses with the highest rates of medically unnecessary admissions, which accounted for $3.5 billion of the errors identified by CMS contractors in 2007.

Most Frequent Medically Unnecessary Errors

DRG / MS-DRG	Paid Claims Error Rate	Projected Improper Payments
DRG 143 / MS-DRG 313: CHEST PAIN	20.1%	$118,194,148
DRG 243 / MS-DRG 551: MEDICAL BACK PROB	15.5%	$58,879,136
DRG 182 / MS-DRG 391: ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W CC	11.9%	$164,182,142
DRG 296 / MS-DRG 640: NUTR & MISC METAB DISOR AGE >17 W CC	10.7%	$99,252,860
DRG 125 / MS-DRG 287: CIRC DISOR EXC AMI, W CAR CATH W/O COMPL DIAG	9.8%	$45,758,977
DRG 120 / MS-DRG 264: OTH CIRC SYS OR PROC	9.6%	$42,310,159
DRG 294 / MS-DRG 637: DIABETES AGE >35	9.2%	$35,996,770
DRG 141 / MS-DRG 312: SYNCOPE & COLLAPSE W CC	8.1%	$39,879,723
All DRGs	**1.3%**	**$3,553,336,758**

[2] January 28, 2008. "Improper Medicare Fee-For-Service Payments Report – November 2007 Long Report." Report available at http://www.cms.hhs.gov/CERT/ under "CERT Reports."

NEXT STEPS

The AHA will continue to urge CMS to make further improvements to the RAC program before the program is expanded nationwide. We also will continue to seek a moratorium on the phase-in of the RAC program. In addition, we will seek clarification from CMS on the entities that will be assuming the hospital education and data functions currently being provided by the QIOs, which are critical tools for RAC preparation.

We urge hospitals to begin to prepare for RAC audits today using the strategies and resources outlined in this advisory. Please share this advisory with the following staff members to aid your preparation:

- Hospital leadership, including executive, medical and financial leaders, corporate compliance officers and legal counsel;
- Physicians, nurses, therapists and others making clinical decisions who will need to address medical record documentation; and
- Coding, billing and medical records staff.

In addition, we suggest you assemble an inter-disciplinary RAC team and designate a primary RAC contact for both internal and external parties. You also may choose to work with an external consultant to design and guide your RAC campaign.

FURTHER QUESTIONS

Please contact AHA Member Relations at 1 (800) 424-4301 or email RACinfo@aha.org.

TMF QIO's
One-Day Stay Inpatient Audit Tool

TMF Health Quality Institute

ONE-DAY INPATIENT STAY AUDIT TOOL					
Patient:		**Admitting Diagnosis:**	**DOB:**		
Attending Physician:		**Reviewer:**	**MR #:**		
Dates of Service:		**Coder:**	**Date Reviewed:**		
	Was the patient initially admitted to observation status? If NO, skip to questions 5.		**YES**	**NO**	**N/A**	**Measure**
1	Does the medical record contain an order for observation status?					
2	Was the patient's condition/treatment appropriate for observation status (as opposed to outpatient or inpatient) at the time the patient was placed into observation?					
3	Does the medical record contain a physician's order to change the patient status to inpatient?					A2
4	If yes, does the order contain a time and date?					
5	Does the medical record contain an inpatient admission order for the date of admission?					A3
6	Was admission-screening criteria applied?					
	Was admission-screening criteria applied in a timely manner?					B2
7	Did the patient's **condition/symptoms** require treatment in an inpatient setting at the time of inpatient admission? If yes, describe the condition:					B1
8	Did the patient require **treatment** that could only be performed in the inpatient setting? If yes, list the treatment:					B1
9	Does the medical record contain physician documentation to support medical necessity of admission?					E1
10	If admitted for an inpatient procedure, list procedure:					
	Was the procedure medically necessary?					
	If no, did the patient have other conditions and treatment requiring admission?					
11	Per non-physician review, did this appear to be an appropriate one-day inpatient stay? **(If YES, stop here)** **(If NO, review case with physician and complete Question #13)**					R1
12	Was the discharge billed with the appropriate status (observation vs one-day inpatient admission)?					D1
	Physician Utilization Review		**YES**	**NO**	**N/A**	**Measure**
13	Per physician review, was this an appropriate one-day **inpatient** stay?					R1
	If NO, was outpatient observation status appropriate for this patient?					C1

This material was prepared by the TMF Health Quality Institute, The Medicare Quality Improvement Organization for Texas, under contract with the Centers for Medicare & Medicaid Services (CMS, an agency of the U.S. Department of Health and Human Services. The Contents presented do not necessarily reflect CMS policy. 8SOW-TX-HPPE-06-21

TMF QIO's
Status Change Matrix

TMF Health Quality Institute

STATUS CHANGE MATRIX

This tool is intended to be used as a guide for determining patient admission status, documentation needed, and potential effect on payment only and does not address all possible situations that may arise.

Status change	Criteria Required	Signed/ Dated Order Required?	Additional Medical Record Documentation Required	Payment Affected by Status Change?	Notes
Observation to Inpatient	IP screening criteria	Yes	Medical necessity for IP admission	[1]Yes	[1]CMS Claims Processing Manual, Ch. 3, Sec. 40.3
Observation to Outpatient Surgery/Procedure	Medical necessity for OP procedure	Yes	Medical necessity for procedure	Yes	
Outpatient to Inpatient	IP screening criteria	Yes	Medical necessity for IP admission	Yes	
Outpatient (ER, chemo, PT, etc.) **to Observation**	Observation criteria	Yes	[2]Support for need for observation	[3]Maybe	[2]FR vol. 69, No 219, p. 65828-31, Sec. D [3]Additional payment for observation dx of asthma, CP, or CHF
Outpatient (ER, chemo, PT, etc.) **to Outpatient Surgery/Procedure**	Medical necessity for OP procedure	Yes	Medical necessity for procedure	[4]Yes	[4]CMS Manual 100-4, Ch. 4, Sec. 10.5
Outpatient Surgery to Inpatient	IP screening criteria (surgery complication)	Yes	Medical necessity for IP admission	[1]Yes	[1]CMS Claims Processing Manual, Ch. 3, Sec. 40.3
Outpatient Surgery to Observation	Observation criteria	Yes	Support for need for observation	[5]No	[5] Elective documentation on claim for CMS info
Inpatient to Observation	Condition Code 44 Obs criteria (did not meet IP criteria)	Yes	[6]Need for Obs UR Committee notes Physician concurrence with UR decision	[7]Yes	[6]MLN Matters #SE 0622 [7]CMS Change Request CR 3444

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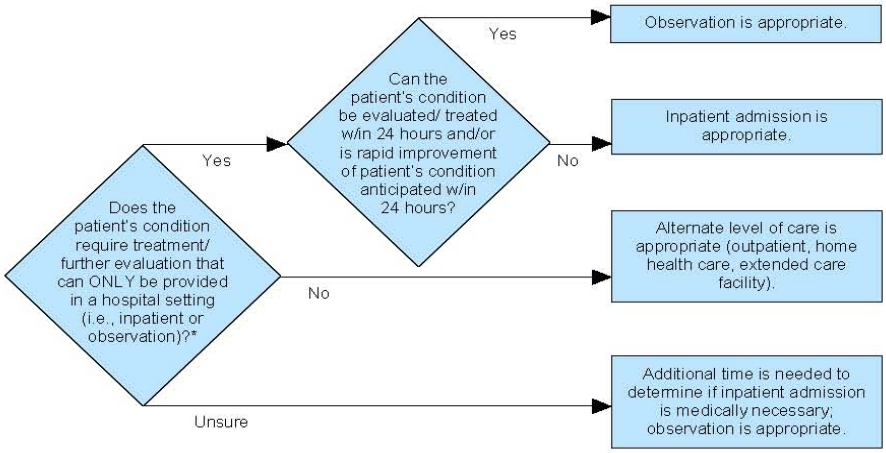
TMF QIO Physician Tool:
Medicare Observation vs. Inpatient Admission

MEDICARE PATIENTS:
Observation or Inpatient Admission?

TMF Health Quality Institute

To aid the physician in determining when observation may be appropriate, TMF Health Quality Institute (TMF) has developed a decision tree outlining the thought process for determining whether observation or inpatient admission is appropriate. TMF hopes that this tool will be valuable to physicians when having to make this decision.



* The decision to admit a patient as an inpatient requires complex medical judgment including consideration of the patient's medical history and current medical needs, the medical predictability of something adverse happening to the patient, and the availability of diagnostic services/procedures when and where the patient presents.

Key Points to Remember:

- Outpatient observation services are reimbursed under the Outpatient Prospective Payment System.
- Using outpatient observation as an alternative to admission will allow you time to determine if admission is necessary, reduce denials for unnecessary admissions and ensure that some payment is received for services rendered.
- Care in outpatient observation can be the same as inpatient care, but reimbursement is different. Patients with chest pain, CHF and asthma are paid under specific observation Ambulatory Payment Classifications (APCs). Payment for all other conditions is bundled into the APC package.
- An order simply documented as "admit" will be treated as an inpatient admission. A clearly worded order such as "inpatient admission" or "place patient in outpatient observation" will ensure appropriate patient care and prevent hospital billing errors.
- Medicare coverage for observation services requires at least eight hours of monitoring and is limited to no more than 48 hours unless the fiscal intermediary grants an exception. The hospital is only reimbursed for 24 hours. The clock starts with the nurse's note reflecting initiation of observation care/arrival to observation site. The clock ends with staff sign-off of the discharge order and when all clinical or medical interventions have been completed.
- An outpatient observation patient may be progressed to inpatient status when it is determined the patient's condition requires an inpatient level of care.
- **Hospitals can convert and bill an inpatient case as an outpatient if the hospital utilization review committee determines before the patient is discharged and prior to billing that this setting would have been more appropriate.** A physician must concur with the decision of the committee, and the physician's concurrence and status change must be documented in the medical record.
- Services that do not qualify for outpatient observation include services for convenience reasons, routine prep for and recovery after diagnostic testing, certain therapeutic services, normal post-procedure recovery time (4-6 hours) and procedures designated as "inpatient only" or that are inappropriate as inpatient.
- Documentation must support the level of care provided (inpatient admission versus outpatient observation).

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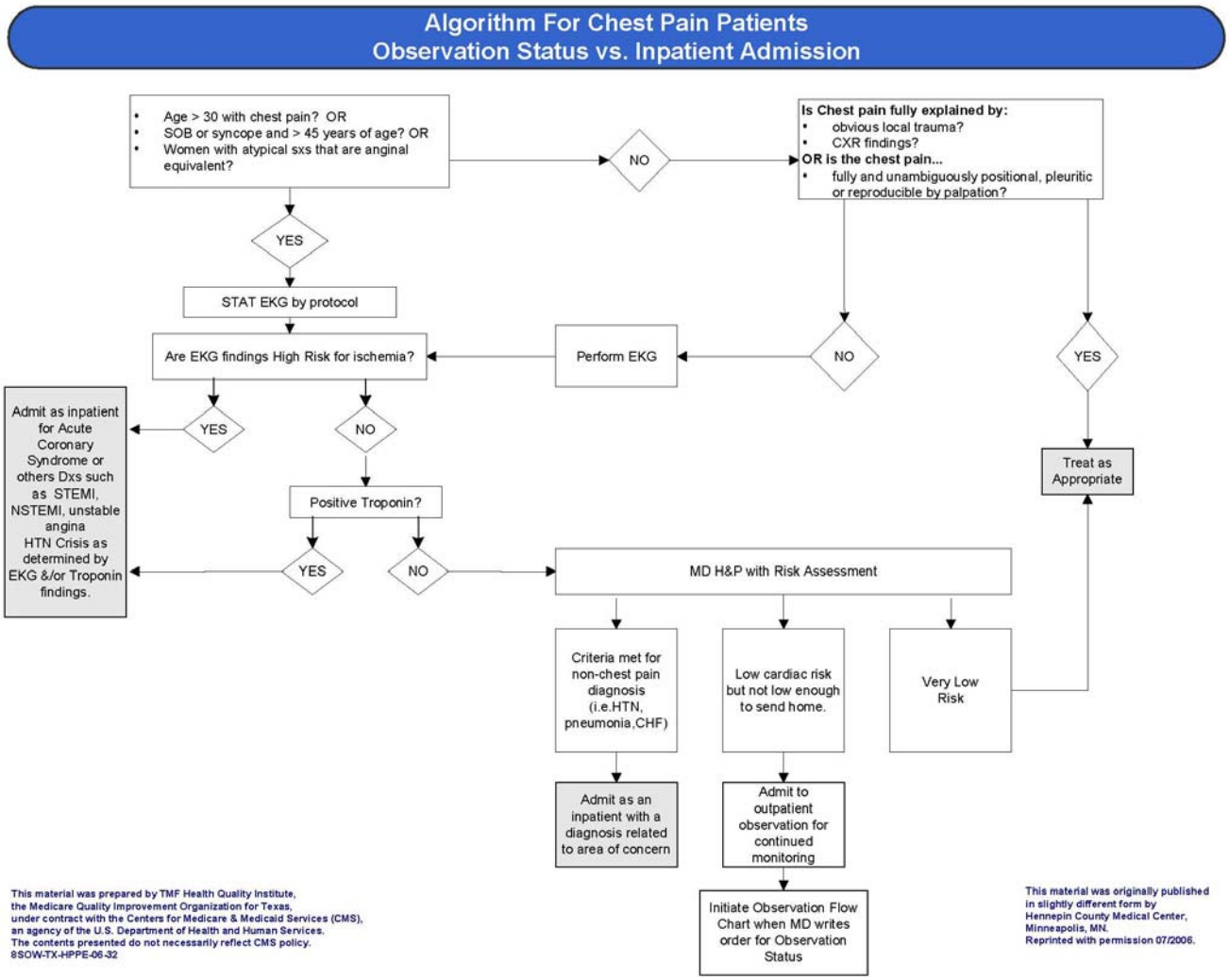
TMF QIO Decision Tree:
Observation vs. Inpatient Admission



Sample State PEPPER Report

HPMP Administrative Reports of
X X Any State PPS Hospitals for
One-Day Stay Top 20 DRGs

Statewide Top 20 DRGs for One-Day Stay Discharges* in Q3 FY 2005

In Descending Order by One-Day Stay Totals Per DRG

DRG	DRG Description	One-Day Stay Count	Total Discharges for DRG	Proportion of One-Day Stays to Total Discharges	Statewide Average Length of Stay for DRG
527	Percutaneous cardiovascular proc w drug-eluting stent w/o	6,930	10,565	65.6%	2.1
143	Chest pain	5,061	13,141	38.5%	2.4
127	Heart failure & shock	1,473	31,820	4.6%	6.2
125	Circulatory disorders except AMI, w card cath w/o complex	1,205	3,258	37.0%	2.9
182	Esophagitis, gastroent & misc digest disorders age >17 w	1,202	13,256	9.1%	5.5
142	Syncope & collapse w/o CC	1,137	4,488	25.3%	3.0
534	Extracranial procedures w/o CC	1,136	1,643	69.1%	1.8
116	Other permanent cardiac pacemaker implant	1,112	4,906	22.7%	5.4
141	Syncope & collapse w CC	1,097	8,255	13.3%	4.3
139	Cardiac arrhythmia & conduction disorders w/o CC	1,072	4,022	26.7%	2.9
183	Esophagitis, gastroent & misc digest disorders age >17 w/o	1,006	4,461	22.6%	3.3
088	Chronic obstructive pulmonary disease	953	19,367	4.9%	5.7
138	Cardiac arrhythmia & conduction disorders w CC	947	9,429	10.0%	5.0
395	Red blood cell disorders age >17	927	5,625	16.5%	4.9
294	Diabetes age >35	804	6,484	12.4%	5.0
296	Nutritional & misc metabolic disorders age >17 w CC	793	11,661	6.8%	6.2
518	Percutaneous cardiovasc proc w/o coronary artery stent or	749	2,112	35.5%	4.4
132	Atherosclerosis w CC	722	5,615	12.9%	3.3
124	Circulatory disorders except AMI, w card cath & complex	691	4,347	15.9%	5.2
524	Transient ischemia	688	5,538	12.4%	4.1
Top 20 DRGs Statewide		29,705	169,993	17.5%	4.7
All DRGs Statewide		61,263	561,945	10.9%	6.7

* Excludes deaths, transfers and leaves against medical advice.

Note that some DRGs changed for FY 2005. The User's Guide cites source for more detailed