Short-Term Acute Care
Program for Evaluating Payment Patterns Electronic Report (ST PEPPER) User's Guide

April 2007

Contents

I. What is PEPPER?

II. How Can Hospitals Use PEPPER?

III. Interpreting PEPPER Findings

IV. Installation Instructions for PEPPER

V. Glossary

VI. Assistance with PEPPER

Appendix: DRG Pair Listing

This material was prepared by TMF Health Quality Institute, the Quality Improvement Organization Support Center for the Hospital Payment Monitoring Program, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. 8SOW-TX-HPMPQ-07-13

I. What is PEPPER?

The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is an electronic data report developed under contract with the Centers for Medicare & Medicaid Services (CMS) by the Hospital Payment Monitoring Program (HPMP) Quality Improvement Organization Support Center (QIOSC), which is TMF Health Quality Institute (TMF). PEPPER contains hospital-specific, Medicare inpatient Prospective Payment System (PPS) discharge data for 14 target areas—specific Diagnosis Related Groups (DRGs) and discharges that have been identified as at high risk for payment errors in the short-term acute care hospital setting.

In general, target areas are constructed such that the discharges in the numerator have been identified as problematic. For example, admission necessity-focused target areas generally include in the numerator the DRG(s) that have been identified as prone to unnecessary admissions, and the denominator generally includes all discharges for that DRG, or all discharges. DRG-coding related target areas generally include in the numerator the DRGs that have been identified as prone to DRG coding errors, and the denominator includes these DRGs as well as DRGs to which the original DRG is frequently changed.

TMF provides all Quality Improvement Organizations (QIOs) with hospital-specific data for short-term acute care inpatient PPS hospitals within their states quarterly. These data are intended to assist QIOs and hospitals in their HPMP efforts to identify and prevent payment errors. The overall goal of HPMP is to reduce the Medicare payment error rate within each state, as well as nationally.

Your QIO may have decided to give you a report on a smaller group of these target areas for your hospital. The target areas are defined as follows:

DRGs 014 and 559	Numerator: count of discharges for DRGs 014 (intracranial hemorrhage or cerebral infarction) and 559 (acute ischemic stroke with use of thrombolytic agent) Denominator: count of discharges for DRGs 014, 015 (nonspecific CVA and precerebral occlusion without infarct), 524 (transient ischemia), or 559 *IMPORTANT: DRGs 014 and 015 were redefined and DRG 524 was added effective with discharges starting October 1, 2002. The coding of CVAs and strokes changed with discharges starting October 1, 2002. These coding changes resulted in these conditions grouping to DRG 014 rather than to DRG 015. Because of the number of discharges involving these conditions, the impact of the coding changes can be readily seen in data for DRGs 014 and 015. DRG 559 was added effective with discharges starting October 1, 2005. These DRG 559 discharges would previously have been included in DRG 014. Therefore, hospitals are encouraged to evaluate these DRGs on a fiscal year basis in terms of DRG and coding changes.*

DRG 079	Numerator: count of discharges for DRG 079 (respiratory infections and inflammations age > 17 with complication or comorbidity) Denominator: count of discharges for DRGs 079, 080 (respiratory infections and inflammations age > 17 without complication or comorbidity), 089 (simple pneumonia and pleurisy age > 17 with complication or comorbidity), or 090 (simple pneumonia and pleurisy age > 17 without complication or comorbidity)
DRG 089	Numerator: count of discharges for DRG 089 Denominator: count of discharges for DRGs 089, 090, or 088 (chronic obstructive pulmonary disease)
DRG 127 one-day stays	Numerator: count of discharges for DRG 127 (heart failure and shock) with length of stay less than or equal to one day excluding patient status of 20 (expired), 07 (left against medical advice or discontinued care), or 02 (discharged/transferred to a short-term general hospital for inpatient care), and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours Denominator: count of all DRG 127 discharges
DRG 143 one-day stays	Numerator: count of discharges for DRG 143 (chest pain) with length of stay less than or equal to one day excluding patient status of 20 (expired), 07 (left against medical advice or discontinued care), or 02 (discharged/transferred to a short-term general hospital for inpatient care) and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours Denominator: count of all DRG 143 discharges
DRGs 182 and 183 one-day stays	Numerator: count of discharges for DRGs 182 (esophagitis, gastroenteritis and miscellaneous digestive disorders age > 17 with complication or comorbidity) or 183 (esophagitis, gastroenteritis and miscellaneous digestive disorders age > 17 without complication or comorbidity) with length of stay less than or equal to one day excluding patient status of 20 (expired), 07 (left against medical advice or discontinued care), or 02 (discharged/transferred to a short-term general hospital for inpatient care) and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours Denominator: count of discharges for DRGs 182 or 183 *IMPORTANT: Effective October 1, 2006, some diagnoses that were previously included in DRGs 182 and 183 are now included in DRGs 571 (major esophageal disorders) and 572 (major gastrointestinal disorders and peritoneal infections). This may result in changes to the proportions for this target area. Therefore, hospitals are encouraged to evaluate these DRGs on a fiscal year basis in terms of DRG and coding changes.*
DRG 243	Numerator: count of discharges for DRG 243 (medical back problems) Denominator: count of all discharges

<table>
<tr><td>DRGs 296 and 297 one-day stays</td><td>Numerator: count of discharges for DRGs 296 (nutritional and miscellaneous metabolic disorders age > 17 with complication or comorbidity) or 297 (nutritional and miscellaneous metabolic disorders age > 17 without complication or comorbidity) with length of stay less than or equal to one day excluding patient status of 20 (expired), 07 (left against medical advice or discontinued care), or 02 (discharged/transferred to a short-term general hospital for inpatient care) and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours
Denominator: count of discharges for DRGs 296 or 297</td></tr>
<tr><td>DRGs 575 and 576</td><td>Numerator: count of discharges for DRGs 575 (septicemia with mechanical ventilation 96+ hours age > 17) and 576 (septicemia without mechanical ventilation 96+ hours age > 17)
Denominator: count of discharges for DRGs 575, 576, 320 (kidney and urinary tract infections age > 17 with complication or comorbidity), or 321 (kidney and urinary tract infections age > 17 without complication or comorbidity)
IMPORTANT: DRGs 575 and 576 became effective October 1, 2006, and replace DRG 416 (septicemia age > 17).</td></tr>
<tr><td>Seven-day readmit to same facility or elsewhere</td><td>Numerator: count of index (first) admissions for which a readmission occurred within seven days to the same hospital or to another short-term acute care PPS hospital for the same beneficiary (identified using the Health Insurance Claim number); patient status of the index admission is not equal to 02 (discharged/transferred to a short-term general hospital for inpatient care)
Denominator: count of all discharges</td></tr>
<tr><td>One-day stays excluding transfers</td><td>Numerator: count of discharges with length of stay less than or equal to one day excluding patient status of 20 (expired), 07 (left against medical advice or discontinued care), or 02 (discharged/transferred to a short-term general hospital for inpatient care) and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours
Denominator: count of all discharges excluding patient status 02</td></tr>
<tr><td>One-day stays for medical DRGs</td><td>Numerator: count of discharges for medical DRGs with length of stay less than or equal to one day excluding patient status of 20 (expired), 07 (left against medical advice or discontinued care), or 02 (discharged/transferred to a short-term general hospital for inpatient care) and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours
Denominator: count of all discharges for medical DRGs</td></tr>
<tr><td>Three-day skilled nursing facility (SNF)-qualifying admissions</td><td>Numerator: count of discharges to a SNF with a three-day length of stay
Denominator: count of all discharges to a SNF (identified by patient status code of 03 (discharged or transferred to a SNF) or 61 (discharged or transferred to a swing bed))</td></tr>
<tr><td>Complication/ comorbidity (CC) pairs (Note: see Appendix for DRG pair listing)</td><td>Numerator: count of discharges for medical DRGs with a CC, excluding DRGs 079/089
Denominator: count of discharges for all medical DRG pairs, excluding DRGs 079/080/089/090</td></tr>
</table>

These target areas were selected by CMS because a national analysis of payment errors identified that they were high in either dollars in error or proportion of payment errors. In fiscal year 2005, thirty-nine percent of all admission denials were for admissions with a length of stay of one day, while seventy-eight percent of all admission denials were for admissions of three or fewer days. DRGs 079 and 575 and 576 (formerly DRG 416) were selected due to the high dollars in error for DRG changes. DRG 089 was also selected due to high dollars and volume of error for DRG changes; DRG 088 is included in the denominator for this target area as data analysis found that DRG 089 was frequently changed to DRG 088, a lower-weighted DRG.

Several target areas were high in dollars in error or number of payment errors for both DRG changes and admission denials (DRGs 014, 127, 243, 182/183, 296/297 and 143). Readmissions have been associated with payment errors due to billing errors, premature discharge, incomplete care and/or inappropriate readmission. Three-day SNF-qualifying admissions have been found to have issues with medical necessity in several states, and data indicate that three-day SNF-qualifying admissions have a higher incidence of unnecessary admissions than other three-day admissions. The May 4, 2005 *Federal Register* (Vol. 70, No. 85, pages 23332-23333) describes the increase in discharges billed to the DRG with a CC in a pair from 61.9 percent in 1986 to 79.9 percent in 2004; additionally, QIO reviews have indicated that there have been coding errors related to the addition of a CC that was not substantiated in the medical record. Therefore, a target area focusing on the medical DRG CC pairs was added.

Four additional worksheets are included. The first, titled 'One Day Stay Top 20 DRGs', lists the top 20 DRGs for one-day stays in the current fiscal year, updated quarterly (excluding patient status codes 02, 07, 20, and excluding claims with prior observation of 24 hours or greater) for your hospital. The second worksheet shows the Statewide Top 20 DRGs for One-Day Stay Discharges in the current fiscal year, updated quarterly. Please note there are changes in DRGs and DRG definitions from year to year that should be considered. For example, for FY 2006, the changes are documented in the *Federal Register* dated August 12, 2005, pages 47278-47707, and for FY 2007, the changes are documented in the *Federal Register* dated August 18, 2006, pages 47870-48351.

II. How Can Hospitals use PEPPER?

"The Office of Inspector General's Compliance Program Guidance for Hospitals," (http://oig.hhs.gov/authorities/docs/cpghosp.pdf), released in 1998, and Supplemental Compliance Program Guidance for Hospitals published in the *Federal Register*, Vol. 70, No. 19, January 31, 2005, encourages hospitals to develop and implement a compliance program. One aspect of a compliance program involves ensuring that charges for Medicare services are correctly documented and billed. Hospitals should conduct regular audits to ensure that the medical necessity for admission and treatment is documented and that bills for Medicare services are correct. Hospitals can use PEPPER to guide their auditing and monitoring activities related to the identification and prevention of payment errors. PEPPER provides statewide comparative data that enables hospitals to identify where they differ from other short-term acute care hospitals, with regards to the above-noted high-risk areas. The data can assist hospitals in identifying both potential overpayments as well as potential underpayments.

PEPPER defines outliers based on control limits that are determined by each QIO. The PEPPER default upper control limit is the 75th percentile, and the default lower control limit is the 10th percentile. PEPPER identifies target area report findings that are at or above the upper control limit, or at or below the lower control limit. PEPPER cannot be used to identify the presence of payment errors, but it can be used as a guide for auditing and monitoring efforts to help hospitals identify and prevent payment errors.

Hospitals may receive all or some of the following reports from PEPPER at the discretion of the QIO:

A. Data Tables
PEPPER provides data tables that include a variety of statistics for a target area summarized over fiscal year or quarter time period. Statistics in each data table include the total number of discharges for the target area (target area discharge count, which is the numerator), the denominator count of discharges, the proportion of the numerator and denominator, average length of stay, and Medicare payment data.

B. Graphs
The PEPPER graph provides a visual representation of the proportion for each target area over time. The graphs can assist in the identification of significant changes from one time period to the next, which could be a result of changes in the medical staff, coding staff, utilization review processes, or hospital services. Hospitals are encouraged to identify root causes of major changes to ensure that payment errors are prevented.

C. Compare Worksheet
The Compare Worksheet assists hospitals with prioritizing areas for auditing and monitoring by using two factors: 1) the number of discharges for a target area, and 2) the hospital's "outlier value" for that target area, which is a measure of how unusual the finding for your hospital is relative to all PPS hospitals in your state. Please note that the PEPPER-defined outlier value is not related to DRG outliers. Generally, positive outlier value findings identify possible over-coding errors, while negative values generally identify possible under-coding errors. The data displayed in the Compare Worksheet represents the most recent time period included in PEPPER.

Hospitals can navigate through PEPPER by clicking on the worksheet tabs at the bottom of the screen. Each tab is labeled to identify the contents of each worksheet (i.e., target area tables, graphs, Compare Worksheet).

III. Interpreting PEPPER Findings

PEPPER provides hospitals with their percentile value for each target area. The following table is intended to assist hospitals with interpreting these values. Please note that these are generalized suggestions and will not apply to all situations. For all areas, assess whether there is sufficient volume (10 to 30 cases for the fiscal year, depending on the hospital's total discharges for the fiscal year) to warrant a review of cases.

Target Area	Suggested Interventions If At/Above 75th Percentile	Suggested Interventions If At/Below 10th Percentile
One-day stay areas	This could indicate that there are unnecessary admissions related to inappropriate use of	A low proportion of one-day stays does not indicate a

	admission screening criteria or outpatient observation. A sample of one-day stay cases should be reviewed to determine if inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation). Hospitals may generate data profiles to identify one-day stays sorted by DRG, physician, or admission source to assist in identification of any patterns related to one-day stays. Hospitals may wish to evaluate whether one-day stays are identified for procedures that are designated by CMS as "inpatient only." *IMPORTANT: Effective October 1, 2006, some diagnoses that were previously included in DRGs 182 and 183 are now included in DRGs 571 (major esophageal disorders) and 572 (major gastrointestinal disorders and peritoneal infections). This may result in changes to the proportions for this target area. Therefore, hospitals are encouraged to evaluate these DRGs on a fiscal year basis in terms of DRG and coding changes.*	problem; therefore, additional review is not necessary.
DRG 079	This could indicate that there are coding or billing errors related to over-coding for DRG 079. A sample of medical records for DRG 079 should be reviewed to determine if coding errors exist. Hospitals may generate data profiles to identify DRG 079 cases with principal diagnosis codes of 507.x (aspiration pneumonia), 482.83 (pneumonia due to other gram negative pneumonia), or 482.89 (pneumonia due to other specified bacteria) to ensure that documentation supports the principal diagnosis.	This could indicate that there are coding or billing errors related to under-coding for DRG 079. A sample of medical records for other DRGs, such as DRGs 089/090, should be reviewed to determine if coding errors exist. Remember that a diagnosis of pneumonia must be determined by the physician and that a coder should not code based on a laboratory or radiological finding without seeking clarification from the physician.
DRGs 014 and 559	This could indicate potential over-coding. A sample of medical records for DRGs 014 and 559 should be reviewed to determine if coding errors exist. *Note that DRGs 014 and 015 were redefined and DRG 524 was added effective with discharges starting October 1, 2002. The coding of CVAs and strokes changed with discharges starting October 1, 2002. These*	This could indicate that there are coding or billing errors related to under-coding of DRGs 014 and 559. A sample of medical records for other DRGs, such as DRG 015 or 524, should be reviewed to determine if coding errors exist. Remember that a diagnosis

	coding changes resulted in these conditions grouping to DRG 014 rather than to DRG 015. Because of the number of discharges involving these conditions, the impact of the coding changes can be readily seen in data for DRGs 014 and 015. DRG 559 was added effective with discharges starting October 1, 2005. These DRG 559 discharges would previously have been included in DRG 014. Therefore, hospitals are encouraged to evaluate these DRGs on a fiscal year basis in terms of DRG and coding changes.	of cerebro-vascular accident must be determined by the physician and that a coder should not code based on laboratory or radiological findings without seeking clarification from the physician.
DRG 243	This could indicate that there are unnecessary admissions related to inappropriate use of admission screening criteria or outpatient observation. A sample of medical records for DRG 243 should be reviewed to determine if inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation).	A low proportion for this DRG does not indicate a problem; therefore, additional review is not necessary.
DRGs 575 and 576	This could indicate that there are coding or billing errors related to over-coding of DRGs 575 or 576. A sample of medical records for DRGs 575 or 576 should be reviewed to determine if coding errors exist. Hospitals may generate data profiles to identify DRG 575 or 576 cases with a principal diagnosis code of 038.9 (unspecified septicemia) to ensure documentation supports the principal diagnosis.	This could indicate that there are coding or billing errors related to under-coding of DRGs 575 or 576. A sample of medical records for other DRGs, such as DRG 320 (urinary tract infection), should be reviewed to determine if coding errors exist. Remember that a diagnosis of septicemia must be determined by the physician and that a coder should not code based on a laboratory finding without seeking clarification from the physician.
Seven-day Readmissions to the same or elsewhere	This could indicate that there are inappropriate admissions or discharges, quality of care issues, or billing errors. A sample of readmission cases should be reviewed to identify appropriateness of admission, discharge, quality of care and DRG assignment and billing errors. The hospital is encouraged to generate data profiles for patients readmitted the same day or next day after discharge. Suggested data elements to include in these profiles are: patient identifier, date of admission, date of discharge, discharge destination code, principal and secondary	A low proportion of readmissions does not indicate a problem; therefore, additional review is not necessary.

	diagnoses, procedure code(s) and DRG. Evaluate these profiles for the following indications of potential payment errors: • When patients are discharged home (patient status code 01) and readmitted on the same or next day, this may indicate a potential premature discharge or incomplete care. • When a patient is readmitted for the same principal diagnosis as for the first admission, this may indicate a potential premature discharge or incomplete care. • Hospitals that have exempt units (i.e., swing beds, rehabilitation units, or psychiatric units) should take special note of patient status codes and same-day readmissions. In these situations, the second admission is usually billed to an incorrect provider number, rather than a true readmission to the acute care PPS hospital. There is a very high probability of billing errors when the following patient status codes are billed on the first admission of a same-day readmission: 03 (discharged/transferred to SNF); 05 (discharged/transferred to another type of institution, including distinct parts); 61 (discharged/transferred within the institution to a hospital-based Medicare approved swing bed, effective 10-01-01); or 62 (discharged/transferred to another rehabilitation facility including rehabilitation distinct part units of a hospital, effective 01-01-02).	
DRG 089	This could indicate that there are coding or billing errors related to DRG 089. A sample of medical records for DRG 089 should be reviewed to determine if coding errors exist. Hospitals should ensure documentation supports the principal diagnosis.	This could indicate that there are coding or billing errors related to undercoding for DRG 089. A sample of medical records for other DRGs, such as DRG 079, or 087 (pulmonary edema and respiratory failure), should be reviewed to determine if coding errors exist. Remember that a diagnosis of pneumonia must be determined by the physician and that a coder should not

		code based on a laboratory or radiological finding without seeking clarification from the physician.
CC pairs	This could indicate that there are coding or billing errors related to over-coding due to unsubstantiated CCs. A sample of medical records for DRGs with CCs should be reviewed to determine if coding errors exist. Hospitals may generate data profiles to identify proportions of their DRG CC pairs to determine if there are any particular DRG pairs on which to focus. Remember that a diagnosis of a CC must be determined by the physician, and that a coder should not code based on laboratory or radiology findings without seeking physician determination of the clinical significance of the abnormal finding.	This could indicate that there are coding or billing errors related to under-coding for CCs. A sample of medical records for DRGs without a CC should be reviewed to determine if coding errors exist. Remember that in order for a diagnosis to be coded as a CC, it must be substantiated by documentation. Remember that a coder should not code based on a laboratory or radiological findings without seeking physician determination of the clinical significance of the abnormal finding.
Three-day SNF-qualifying admissions	This could indicate that there are medical necessity issues related to unnecessary admissions to qualify patients for a SNF admission. A sample of medical records with three-day lengths of stay and patient status codes of “03” or “61” should be reviewed to determine if the admission was medically necessary.	A low proportion for this target area does not indicate a problem; therefore, additional review is not necessary.

Comparative data for several consecutive years can be used to identify whether the hospital’s proportions changed significantly in either direction from one year to the next. This could be an indication of a procedural change in admitting, coding or billing practices, staff turnover, or a change in medical staff.

IV. Installation Instructions for PEPPER

PEPPER is a Microsoft Excel spreadsheet program that can be opened and saved to a PC. It is not intended for use on a network but may be saved to as many PCs as necessary.

Installation of PEPPER will depend upon the distribution method utilized by each QIO. Please follow any instructions received from your QIO with regards to accessing and installing PEPPER.

V. Glossary

Average Length of Stay	The Average Length of Stay (ALOS) is calculated as an arithmetic average or mean. It is computed by dividing the total number of hospital (or inpatient) days by the total number of discharges within a given time period. Hospital (or inpatient) days are calculated by counting the difference between admission and discharge dates for each discharge. Same day admission and discharges are counted as one hospital (or inpatient) day.
Data Table	The statistical findings for a hospital are presented in tabular form, labeled by time period and indicator. These are referred to as Data Tables.
Excel	Microsoft Excel 2000 or later is a spreadsheet program used to distribute PEPPER.
Fiscal Year	As used in describing Medicare data, the fiscal year starts October 1 and ends September 30.
Graph	In PEPPER, the graph shows a hospital's percentages for the last four time periods. The hospital's percentages are compared to statewide data that include the 10th, median (50th), 75th and 90th percentiles. See *Percentile*.
Outlier Value	As used in the PEPPER program, the value (number) assigned to a hospital's proportion in each target area that indicates the unusualness of the hospital's proportion relative to all short-term acute care Prospective Payment System hospitals in the state. In the PEPPER program outliers are defined as those findings that are at or above the statewide 75th percentile statewide or at or below the statewide 10th percentile. The program uses the term outlier in the sense of 'PEPPER-defined outliers' to distinguish them from other kinds of outliers, such as the DRG cost outliers. In the context of this program, 'outlier' will mean 'PEPPER-defined outlier.' In the PEPPER program outlier values can range from –10 to –3.2, at the low end and from 2 to 10 at the high end. Negative outlier values represent percentile values at or below the 10th percentile. For DRG-related findings, these generally represent possible under-coding instances. Positive outlier values represent percentile values at or above the 75th percentile. For DRG-related findings, these generally represent possible instances of over-coding or over-utilization.
Percentile	A number that corresponds to one of 100 equal divisions of a range of values in a sample. In PEPPER, the percentile represents the hospital's percentile value compared to all values in the state for that target area. For example, suppose we calculate that the 75th percentile value of a hospital is the proportion 2.3%; this means that 75 percent of the

hospitals in the state have a proportion for that target area that is *less* than 2.3%.

Percentiles in PEPPER are calculated from the hospitals' proportions, so that each hospital proportion can be compared to the statewide distribution of hospital proportions. Think of a distribution as a set of values being listed along a line. We could have a list of values for hospitals ranging from, for example, 0.33% to 4.74%. Suppose we find that 10% of hospitals have a value less than 0.83%. Then the 10th percentile would be 0.83%. Then suppose half of the hospitals measure less than 1.76%. The median (also known as the 50th percentile) would be 1.76%.

Percentiles are computed for all Prospective Payment System hospitals in your state that had 100 or more discharges recorded for the fiscal year.

Prioritize — To arrange or sort items into an order according to some rule or characteristic to reflect importance or need. The Compare Worksheet was designed to assist hospitals with prioritizing data findings.

Quarter — In the Medicare Fiscal Year:

- Quarter 1 is from October 1 through December 31
- Quarter 2 is from January 1 through March 31
- Quarter 3 is from April 1 through June 30
- Quarter 4 is from July 1 through September 30

VI. Assistance with PEPPER

For assistance using PEPPER, please contact your state's QIO.

Appendix
DRG Pair Listing

DRG	Description
010	NERVOUS SYSTEM NEOPLASMS W CC
011	NERVOUS SYSTEM NEOPLASMS W/O CC
016	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC
017	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC
018	CRANIAL & PERIPHERAL NERVE DISORDERS W CC
019	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC
028	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC
029	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC
031	CONCUSSION AGE >17 W CC
032	CONCUSSION AGE >17 W/O CC
034	OTHER DISORDERS OF NERVOUS SYSTEM W CC
035	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC
046	OTHER DISORDERS OF THE EYE AGE >17 W CC
047	OTHER DISORDERS OF THE EYE AGE >17 W/O CC
068	OTITIS MEDIA & URI AGE >17 W CC
069	OTITIS MEDIA & URI AGE >17 W/O CC
083	MAJOR CHEST TRAUMA W CC
084	MAJOR CHEST TRAUMA W/O CC
085	PLEURAL EFFUSION W CC
086	PLEURAL EFFUSION W/O CC
092	INTERSTITIAL LUNG DISEASE W CC
093	INTERSTITIAL LUNG DISEASE W/O CC
094	PNEUMOTHORAX W CC
095	PNEUMOTHORAX W/O CC
096	BRONCHITIS & ASTHMA AGE >17 W CC
097	BRONCHITIS & ASTHMA AGE >17 W/O CC
099	RESPIRATORY SIGNS & SYMPTOMS W CC
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC
130	PERIPHERAL VASCULAR DISORDERS W CC
131	PERIPHERAL VASCULAR DISORDERS W/O CC
132	ATHEROSCLEROSIS W CC
133	ATHEROSCLEROSIS W/O CC
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC
141	SYNCOPE & COLLAPSE W CC
142	SYNCOPE & COLLAPSE W/O CC
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC
172	DIGESTIVE MALIGNANCY W CC
173	DIGESTIVE MALIGNANCY W/O CC
174	G.I. HEMORRHAGE W CC
175	G.I. HEMORRHAGE W/O CC

177 UNCOMPLICATED PEPTIC ULCER W CC
178 UNCOMPLICATED PEPTIC ULCER W/O CC
180 G.I. OBSTRUCTION W CC
181 G.I. OBSTRUCTION W/O CC
182 ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC
183 ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC
188 OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC
189 OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC
205 DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC
206 DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC
207 DISORDERS OF THE BILIARY TRACT W CC
208 DISORDERS OF THE BILIARY TRACT W/O CC
240 CONNECTIVE TISSUE DISORDERS W CC
241 CONNECTIVE TISSUE DISORDERS W/O CC
244 BONE DISEASES & SPECIFIC ARTHROPATHIES W CC
245 BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC
250 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC
251 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC
253 FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC
254 FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC
272 MAJOR SKIN DISORDERS W CC
273 MAJOR SKIN DISORDERS W/O CC
274 MALIGNANT BREAST DISORDERS W CC
275 MALIGNANT BREAST DISORDERS W/O CC
277 CELLULITIS AGE >17 W CC
278 CELLULITIS AGE >17 W/O CC
280 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC
281 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC
283 MINOR SKIN DISORDERS W CC
284 MINOR SKIN DISORDERS W/O CC
296 NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC
297 NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC
300 ENDOCRINE DISORDERS W CC
301 ENDOCRINE DISORDERS W/O CC
318 KIDNEY & URINARY TRACT NEOPLASMS W CC
319 KIDNEY & URINARY TRACT NEOPLASMS W/O CC
320 KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC
321 KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC
323 URINARY STONES W CC, &/OR ESW LITHOTRIPSY
324 URINARY STONES W/O CC
325 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC
326 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC
328 URETHRAL STRICTURE AGE >17 W CC
329 URETHRAL STRICTURE AGE >17 W/O CC
331 OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC
332 OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC
346 MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC
347 MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC
348 BENIGN PROSTATIC HYPERTROPHY W CC
349 BENIGN PROSTATIC HYPERTROPHY W/O CC
366 MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC

367 MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC

398 RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC

399 RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC

403 LYMPHOMA & NON-ACUTE LEUKEMIA W CC

404 LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC

413 OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC

414 OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC

419 FEVER OF UNKNOWN ORIGIN AGE >17 W CC

420 FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC

444 TRAUMATIC INJURY AGE >17 W CC

445 TRAUMATIC INJURY AGE >17 W/O CC

449 POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC

450 POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC

452 COMPLICATIONS OF TREATMENT W CC

453 COMPLICATIONS OF TREATMENT W/O CC

454 OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC

455 OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC

463 SIGNS & SYMPTOMS W CC

464 SIGNS & SYMPTOMS W/O CC

508 FULL THICKNESS BURN W/O SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA

509 FULL THICKNESS BURN W/O SKIN GRAFT OR INHAL INJ W/O CC OR SIG TRAUMA

510 NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA

511 NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA

521 ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC

522 ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHAB THERAPY W/O CC

523 ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHAB THERAPY W/O CC

529 VENTRICULAR SHUNT PROCEDURES W CC

530 VENTRICULAR SHUNT PROCEDURES W/O CC

531 SPINAL PROCEDURES W CC

532 SPINAL PROCEDURES W/O CC

533 EXTRACRANIAL PROCEDURES W CC

534 EXTRACRANIAL PROCEDURES W/O CC

537 LOCAL EXCISION & REMOVAL INT FIX DEVICES EXCEPT HIP & FEMUR W CC

538 LOCAL EXCISION & REMOVAL INT FIX DEVICES EXCEPT HIP & FEMUR W/O CC

539 LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC

540 LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC

562 SEIZURE AGE > 17 W CC

563 SEIZURE AGE > 17 W/O CC