Cost List for Manitoba Health Services

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Health Policy and Evaluation
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The Manitoba Centre for Health Policy and Evaluation

The Manitoba Centre for Health Policy and Evaluation (MCHPE) is a unit within the Department of Community Health Sciences, Faculty of Medicine, University of Manitoba. MCHPE is active in health services research, evaluation and policy analysis, concentrating on using the Manitoba health database to describe and explain patterns of care and profiles of health and illness.

Manitoba has one of the most complete, well-organized and useful health databases in North America. The database provides a comprehensive, longitudinal, population-based administrative record of health care use in the province.

Members of MCHPE consult extensively with government officials, health care administrators, and clinicians to develop a research agenda that is topical and relevant. This strength, along with its rigorous academic standards and its exceptional database, uniquely position MCHPE to contribute to improvements in the health policy process.

MCHPE undertakes several major research projects, such as this one, ever year under contract with Manitoba Health. In addition, MCHPE researchers secure major funding through the competitive grants process. Widely published and internationally recognized, they collaborate with a number of highly respected scientists from Canada, the United States and Europe.

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Executive Summary

The Manitoba Centre for Health Policy and Evaluation has developed a list of estimated costs for health care services in Manitoba. Included in this list are hospital inpatient services (by type of case and type of hospital), hospital outpatient procedures (by type), as well as home care, long term institutional care, and diagnostic procedures. When used with existing Manitoba drug formulary and physician tariff lists, the cost lists presented here can be linked to utilization data to measure the costs of a wide variety of episodes of health care, or of services used by the Manitoba population.

Although there are other such cost lists currently in use in Canada, this is the first designed to link directly to the type of data routinely generated by administrative records. These document the use of the health care system by patients and include hospital discharge abstracts, claims for physician contacts, purchased drugs, as well as home care and nursing home records (in Manitoba, nursing homes are called personal care homes; these terms are used interchangeably). When the cost list is used in conjunction with such utilization data, investigators can conduct studies for the general population and for particular groups (such as individuals with specific diseases). The cost list can also be used to allow investigators to compare the costs of specific interventions. Since the scope of this list is province-wide, the estimates that are made using this cost list will add to the generalizability of the studies, more so than if the costs were obtained for a single facility.

The use of this cost list is not appropriate in areas such as funding, budgeting, or comparing facilities. For some evaluations, a detailed 'micro-costing' technique may be more appropriate. However, where standard or average costs are needed, this cost list permits investigators to conduct studies that have realistic, generalizable results.

Introduction

The main purpose of this document is to provide an estimate of costs for a wide range of Manitoba health care services; these costs can be used to evaluate different ways that health care resources are used. This information will be useful to investigators who are examining issues relating to health care costs in Manitoba. This report provides province-wide cost estimates of inpatient hospital care, emergency department nursing, laboratory services, home care, proprietary personal care homes, chronic hospital care and long term hospital care; it also suggests sources of information that are useful for estimating costs associated with outpatient drugs, diagnostic procedures and physician services. In addition, examples of how the costs reported in this document might be used are provided. Until recently, investigators conducting economic analyses have had to develop their own cost estimates based on data from individual providers. While some indications for this approach remain, the time and expense associated with collecting costs for individual projects can be relatively high. Further, costs that are obtained from a single facility may not be representative of province-wide costs. The main advantage of the costs reported in this document is the availability and access to a wide range of province-wide cost estimates.

This report is an extension of a 1994 Manitoba Centre initiative aimed at reporting system-wide costs by estimating inpatient hospital costs for Manitoba (Shanahan, 1996). In this document efforts have been made to include as many services as practicable given the data available.

There are several possible applications of the costs reported in this document. First, in order to compare how residents of different areas use resources, costs may want to be obtained on a population basis. Indeed, an attempt may be made to determine the resource implications of higher hospitalisation rates in some regions. The cost list can be used in such “macro” measurements. Second, the cost list can be used to study issues at the “micro” level. The

economic impacts of a drug which shortens hospital stays, or an increase in home care combined with shorter hospital stays for hip replacement patients, may be measured.[1]

Concepts of Measuring Costs

The two most common ways that health care costs can be estimated are micro-costs and average costs. Generally, average costs are reported in this paper, and indications are given about when micro-costing is applicable. The following definitions are used:

- Micro-costs: using this approach, resources that are being used by a specific patient are identified, traced to the patient, and valued at a typical unit cost or price. For example, a report of the micro-costs for an emergency room visit requires the identification of the nursing hours, physician time, drugs and supplies consumed in treating this patient. The dollar values of each of these resources are then assigned; for example, wages paid for nursing hours used in the patient's care. The sum of these costs would be the micro-cost associated with caring for this particular (e.g., meningitis) patient treated at this hospital. It requires detailed knowledge of how individual patients are treated and cannot be necessarily generalized to other patients.

- Average cost: This is called average costing because the method starts at the top with total inpatient expenditures and then divides these by a measure of total patient services (average cost is equal to total cost divided by total output). The measure of output could be on a per case basis, a per service basis or a workload basis. For example, if a hospital spends $100,000 treating all meningitis patients and 10 patients are treated, then the top-down estimate on a per case basis is $10,000.

[1] This document is primarily oriented towards estimating the costs associated with health care providers. Costs facing patients such as payment of pharmaceuticals received out-of-hospital and co-payments associated with nursing home stays are also identified. If one wanted to include additional costs faced by patients such as time taken off work or the purchase of uninsured equipment, the costs included in this report would have to be supplemented.

• Mixed costing: Costing can occur in several stages. For example, a micro-costing technique may be employed to trace diagnostic tests to patients, but the costs of the tests themselves may be determined by an averaging process.

Micro-costing approaches have the advantage that each patient's actual use of nurses, physicians, lab tests, x-rays and any other relevant resources are identified and costed. A cost estimate is then produced for each patient treated in that program at that point in time. Such costs are not necessarily generalizable to other patients in different programs during other time periods.

Micro-costs are often informative, but difficult to estimate, particularly in our system since hospitals are funded by a global budget rather than for individual services. If the way in which a particular type of patient is treated has changed substantially, and recent estimates of average costs are not available, one should consider estimating micro-costs.

A cost list, such as that adopted here, has the distinct advantage of providing investigators with standard costs applicable to various studies across a wide variety of settings; this allows for comparisons to be made across studies.

This cost list builds on one of the most ambitious efforts in Canada to assess a very wide range of costs associated with inpatient hospital care and estimates how these costs vary by types of hospital and case. This deliverable builds on research tested with reference to several different years of data and developed with input from Manitoba hospitals; it has also been reviewed by outside experts (Wall et al. 1994, Shanahan et al. 1994, Loyd et al. 1995, Shanahan 1996, Finlayson et al. forthcoming). The findings arrived at by using various sources of cost data sets have been robust.

Related Documents

Several cost lists have been produced in other jurisdictions. A standard cost list was developed in Australia (Commonwealth Department of Health, Housing, and Community Services, 1992) in conjunction with the Australian Guidelines for economic analyses of pharmaceuticals. This list was updated in 1995 (Australia. Commonwealth Department of

Health, Housing, and Community Services, 1995). The Canadian Coordinating Office for Health Technology Assessment developed a set of guidelines for economic evaluations (Canadian Coordinating Office for Health Technology Assessment, 1996), and this was updated in 1997; they recommended the development of a standard cost list. This recommendation led to a report on the potential possibilities of a cost list for Canada (Jacobs, Bachynsky, Hall, 1995). A preliminary standard cost list was prepared for Alberta in 1996 (Jacobs, Hall, Bachynsky, 1996). The Manitoba and Alberta cost lists are similar in many respects. However, the Manitoba list contains more recent hospital data, and can more readily be applied to the extensive, well-developed Manitoba utilization data. The wide range of cost data reported in this document, along with the Manitoba data, offer a unique opportunity to investigate the costs associated with health care utiltization. The following sections describe the construction of the cost lists.

Hospital Care

This section deals with estimating the costs of hospital inpatient care, hospital day procedures and emergency departments.

The inpatient hospital cost list classifies cases into Refined Diagnostic Related Groups (RDRGs), rather than Case Mix Groups (CMGs); the latter was developed by the Canadian Institute for Health Information. While both approaches classify patients into clinically meaningful groups and use similar amounts of hospital resources, the RDRGs further divide patients in most diagnostic categories according to levels of severity defined by complications or co-morbidities which would be expected to affect the amount of hospital resources used.

In the future, when the work being done by the Canadian Institute for Health Information is finalized and resource intensity weights are available which categorize diagnostically grouped hospitalised patients also by age and complications, it may preferable to incorporate the CMGs into the cost list. The main contributions of this deliverable are the Manitoba inpatient hospital costs associated with each RDRG and the outpatient costs associated with each Day Procedure Group (DPG), an outpatient extension of the (inpatient) CMGs.

Inpatient Care - Hospital costing requires the classification of patients into clinically meaningful groups with similar hospital resource requirements. This is accomplished by classifying cases into Refined Diagnostically Related Groups (RDRGs) (version 7.0/11.0, 1993).[2] A detailed description of RDRGs (version 5) is available in Loyd et al. (1995, p.2); RDRGs have been used in other costing projects in Manitoba (Shanahan et al., 1996).

Simply put, the classification process begins by grouping patients into Adjacent Diagnostic Related Groups (ADRGs). Hospital cases within each ADRG are similar in terms of their diagnosis and hospital treatment. Within each ADRG the complications and co-morbidities (CC) associated with each case can have a significant impact on how hospital resources are used. For example, some patients classified into the ADRG called 'SPINAL PROCEDURES' will have no complications or co-morbidities, while others will have severe complications and co-morbidities that will have a significant impact on the cost of their treatment. For this reason each ADRG consisting of medical cases will be assigned one of three additional codes – one code for no CC and two codes for successively more complex CCs. Each ADRG consisting of surgical cases will be assigned one of four codes – one for no CC and three for successive levels of CCs. The higher the level of CC's the greater the amount of hospital resources which on average will be required to treat the case in question. For example, in Appendix 1 Refined Diagnostic Groups 0010-0013 are called 'CRANIOTOMY EXCEPT FOR TRAUMA.' The Craniotomy except for Trauma cases with the highest level of complications and co-morbidities are expected to stay in hospital an average of 16 days and to cost $11,197 per case on average. Within each diagnostic group, cases labelled 'No CC' are expected to have the lowest costs. (Craniotomy except for Trauma with no complications of co-morbidities is expected to stay 6.3 days and cost $5,366 per case on average.)

[2] RDRG software and documentation are available through Karen C. Schneider at Health Systems Consultants, Inc., 340 Whitney Avenue, New Haven, CT 06511 (203-785-0650).

The provincial cost associated with each inpatient RDRG was estimated by applying the five steps that are described in Table 1.[3]

[3] Shanahan (1996) applied steps 1 through 4 to each hospital. Shanahan et al. (1994, p.11-52) provides a non-technical introduction to case-mix costing.

Table 1: Estimating Inpatient RDRG costs

Step	Comments
1. Total provincial hospital costs from fiscal year 1993/94 are classified as either inpatient costs, outpatient costs or excluded costs.	For consistency all physician costs, even those that were in the hospital budgets, are excluded. Capital costs, depreciation and costs not directly related to patient care, such as education programs and research programs are excluded. Emergency room costs and clinic costs along with the associated supplies, wages, diagnostics and overheads are counted as outpatient costs. The inpatient costs therefore include all direct care costs for nursing, diagnostics and therapeutics, supplies and drugs as well as allocated overhead and administration costs.[4]
2. Each inpatient case is classified into an appropriate RDRG using a case mix grouping software package.	
3. A set of weights reflecting expected relative costs for each inpatient RDRG are constructed using inpatient cost data and length of stay data from Maryland (calendar years 1991 and 1992) and data from the province of Manitoba (fiscal years 1993/94 and 1994/95).	In Manitoba, as in most Canadian hospitals, patient specific costs are not available. Maryland data are used because of their availability statewide, and because the values approximate Maryland costs, rather than charges (as in most databases that allow one to identify case costs). The appropriate weight is applied to each case and weight adjustments are made to cases that report a long length of stay, a death or a transfer. Manitoba relative cost weights (RCW) are calculated for each RDRG using Maryland case weights adjusted for Manitoba LOS.
4. The sum of all inpatient RDRG weights[5] is divided into provincial inpatient hospital expenditure.	This gives the provincial inpatient cost per average weighted case.
5. The inpatient cost per average weighted case is multiplied by each RDRG typical case weight.	This produces an estimate of the cost of a 'typical' case in each RDRG. Each RDRG case cost is reported in Appendix 1. Typical patients are defined as those whose length of stay is not longer than the trim point, whose treatment was completed in a single acute care facility, did not end in death, and whose hospitalisation did not include days classified as non-acute.[6] The average cost per day and the marginal cost per day (excluding fixed costs) for each RDRG is also reported.[7]

Our estimate of the inpatient cost per case for each RDRG is reported in Appendix 1.

[4] For a detailed description of how hospital overhead costs are apportioned to hospital inpatient costs see Shanahan (1996) pages 6-7, Loyd et al. (1995) pages 68-80 and Shanahan et al. (1994) pages 18-24. A definition of overhead costs is in the Glossary.

[5] Here the provincial cost per weighted case is used. Shanahan et al., 1994 calculate a cost per weighted case for each hospital.

[6] Shanahan et al. (1994, p.28) use this same definition of typical cases.

Appendix 1 also provides investigators with the average length stay of Manitoba patients, the average cost per day, the trim point (which separates typical length of stay cases from long stay outliers according to a set of statistical rules), and the marginal cost per day for each RDRG. These were estimated from 1993/94 and 1994/95 data from all Manitoba hospitals (all of which are listed under the definition of "hospital type" in Appendix 3).

How the Inpatient Hospital Cost List May be Used

Whether and how an investigator should use the Manitoba cost list for inpatient services will depend on the circumstances of the investigator's study. In Table 2, four possible circumstances and a suggested cost method are described. The examples in Table 2 are applied to all patients in the RDRG called 'CRANIOTOMY EXCEPT FOR TRAUMA WITH NO CC'. The data reporting inpatient costs for this type of case is reported in the first row of Appendix 1 (RDRG 0010) which we have excerpted below.

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
0010 CRANIOTOMY EXCEPT FOR TRAUMA WITH NO CC	6.3	16.5	5366	852	595
0050 EXTRACRANIAL VASCULAR PROCEDURES WITH NO CC	3.9	8.0	3036	778	510
0100 NERVOUS SYSTEM NEOPLASMS WITH NO CC	6.4	24.5	3586	560	455

Table 2: The Application of Costs Reported in Appendix 1

Circumstances Related to Measure	Recommended Cost Measure
1. The number of hospitalisations changes but the pattern of care for each type of hospitalisation and the average length of stay (los) do not change.	Use an RDRG cost per case measure, and apply it to the number of cases within each RDRG.
2. Treatment will affect only the extra days or reduced days of care for a particular RDRG.	Use the marginal cost per day.
3. There are more (or fewer) cases and longer (or shorter) stays; or if one wants to cost a group of cases, e.g. all hospitalisations in 1998 for residents of Region X where los is known to be specific to the group.	Use average cost per case or average cost per case + (± marginal cost x number of days the stay is beyond or before the mean).
4. Treatment will affect how resources are used within an RDRG.	One should consider using micro-cost methods.

[7] An explanation of marginal costs is reported in Appendix 3.

The first circumstance listed in Table 2 occurs when the intervention under consideration affects the number of hospitalisations but not the treatment patterns (including LOS) within any RDRG. Under these circumstances, it is best to use the cost of a typical case (e.g. $5,366 for RDRG 0010) as the unit of measure.

The second circumstance in Table 2 demonstrates the appropriateness of the marginal costs reported in Appendix 1. If an intervention for craniotomy patients (DRG 0010) is expected to result in a longer stay, then the marginal cost would be used to estimate the cost of the extra days of stay. For example, if the expected increase is 3 days, the additional hospital costs of this intervention are calculable as $595 x 3 days or $1785. If a change in practice patterns was supposed to shorten the LOS for craniotomy patients from 6.3 days to 4.3 days, then 2 days times the marginal costs of this intervention would be saved (2x $595 = $1190). In other words, if one is only dealing with marginal days in a stay, one can ignore the costs of the unaffected days.

Under the third set of circumstances, the number of cases may change and the average stay of these cases is not expected to equal the typical average length of stay. For example, a new procedure might be applied for craniotomies whose stays are longer than average. Under these circumstances, each craniotomy (RDRG 0010) would be valued as follows: average cost per day x days of stay (up to the mean typical length of stay) + the marginal cost per day x the number of days beyond the mean. For example if the patients stayed for 10 days, then the cost for these cases would be $852 x 6.3 days + $595 x 3.7 days = $5,367 + $2,201 = $7,568.

The last circumstance in Table 2 emphasizes the limits of this cost list's applicability. For example, assume that a new type of anaesthetic has been introduced which reduces the time in the operating room, the amount of other drugs used, and the number of x-rays for a craniotomy. In order to determine the effects of this new drug, it would be wise to resort to a micro-cost analysis, comparing treatment costs before and after the new treatment, because resources within the RDRG would change as a result of the new treatment. Under these circumstances, the cost lists reported in this document would not be used.

It should be noted that abstractions have been made from another classification of patients categorizing them into five groups: typical cases, deaths, long stay, outliers, and transfer cases. Generally, it is thought that the costs of transfer cases behave differently from those of atypicals (deaths, transfers, outliers). If there is a significant portion of atypical cases, then circumstance 3 applies and per diem costing should be used.

Day Procedures – The measurement of day procedure costs is similar to that used to measure inpatient costs. Day procedure (i.e. outpatient surgery) cases were grouped together using a patient classification scheme called Day Procedure Groups (DPGs). The DPGs are designed to meet the same objective as RDRGs - cluster patients into clinically meaningful groups with similar resource implications.

Appendix 2 reports day procedure case costs. Each DPG cost is estimated by multiplying the inpatient cost per weighted case by an outpatient weight. The DPG weights were produced by the Canadian Institute for Health Information (CIHI). DPG weights were estimated with outpatient Maryland data and were linked to inpatient RDRG weights. While it might seem an obvious step to directly compare the costs associated with a procedure performed on a day surgery basis (Appendix 2) with the costs of that procedure performed on an inpatient basis (Appendix 1), the investigator must carefully think through such comparisons. The Day Procedure Groups sometimes contain only one procedure while the comparable RDRG group may contain several (or vice versa). It is also necessary to define the comparable episodes of care between inpatient and outpatient procedures. For example, within the outpatient care episode it would be necessary to include pre-operative blood work and any pre-anaesthetic assessments to ensure the fairness of comparisons.

Emergency Department - Nursing costs per emergency department visit are reported in Table 3. Data limitations preclude classifying emergency department cases into meaningful groups and from identifying overall (i.e. including ancillary services) emergency department costs. The calculation of the average nursing costs of an average emergency department visit is possible, however, on the basis of data from annual reports of 13 Manitoba hospitals detailing emergency department nursing hours, wages, benefits and visits.

Table 3: Emergency Department Nursing Costs

	Cost per Visit
Mean	$47.62
Standard Deviation[8]	$17.57
Number of Hospitals	13

(source - Manitoba Department of Health.)

Costs for Each Type of Hospital - Shanahan et al. (1994) point out that even after adjusting for the types of cases treated, the average cost per case for care delivered at different types of hospitals is relatively more or less costly. For this reason, the provincial cost for cases that are reported in Appendices 1 and 2 will likely be on average higher or lower, depending on the type of hospital in which care was received. Hospital type adjustment factors are reported in Table 4.

Table 4: Hospital Type Adjustment Factors

Type of Hospital	Relative Cost
Teaching	1.33
Urban Community	0.94
Major Rural	0.96
Intermediate Rural	0.87
Small Rural	0.88
Multi-Use Rural	1.02
Northern Isolated	2.11
Provincial Average	1.00

(source – Update Hospital Case Mix Costing 1993/94. Manitoba Centre for Health Policy and Evaluation, March 1996 p. 8. See Glossary for listing of Hospitals under Hospital Type.)

Multiplying the adjustment factor by a provincial average cost from Appendix 1 or 2 gives an estimate of the average cost per case for a particular type of hospital. The adjustment factors

[8] If the mean of $47.62 is an important measure in a particular study, the standard deviation could be used to determine how sensitive a cost measure is to relatively small changes in the mean. For example, one could use $47.62, $82.76 ($47.62+2x$17.57) and $12.48 ($47.62-2x$17.57) to examine the sensitivity of findings to these statistically small changes in the mean emergency department nursing costs.

equal the inpatient cost per weighted case for a given type of hospital divided by the provincial inpatient cost per weighted case. The adjustment factor can be applied to inpatient case costs or day procedure case costs.

Care should be taken when using these adjustment factors because they are averages across all types of care for groups of hospitals. These factors are neither accurate for an individual hospital in the group nor for specific types of cases within the group of hospitals; that is, we don't know that normal deliveries at teaching hospitals are 24% more expensive than the provincial average. We do know that across all types of care, and after adjusting for the types of cases treated at teaching hospitals, removing the direct costs of teaching, etc., the cost per case appears to be 24% more expensive than the provincial average.

Pharmaceuticals

Manitoba has implemented the Drug Program Information Network (DPIN).[9] DPIN is an administrative claims database of most prescriptions dispensed for out-of-hospital usage by Manitoba residents and is administered through real-time computer links with every community-based pharmacy in the province. It is maintained by the Ministry of Health. This is potentially a unique and valuable source of information for those undertaking cost studies. Researchers working with pharmaceutical costs should keep in mind that inpatient drug costs are already included in the RDRG costs reported in Appendix 1 and the DPG costs reported in Appendix 2.

Drug Costs – The key to costing out-of-hospital pharmaceutical use in Manitoba is contained at the web site www.gov.mb.ca\health\mdbif. Most drugs (including all those for which there is a generic equivalent) are included on the Manitoba Interchangeability Formulary available from Manitoba Health. This formulary identifies identical or very similar drugs produced by

[9] The DPIN system began July 18, 1994. Nursing homes were added in August 1995, although a few (e.g., Altona, Portage) get their drugs from hospital pharmacies. Hospitals with retail pharmacies dispensing drugs for patients treated in emergency departments joined the DPIN system as follows: HSC 3/95; Grace 7/95; St. Boniface 12/96; Concordia 3/98.

at least two manufacturers. The government reimburses drugs on this formulary at the lowest manufacturer's price among the group of interchangeable products. Manitoba Health updates this list every 2-4 months.

An economic analysis conducted from the perspective of the Manitoba Government Medicare program requires the use of the formulary price for each set of interchangeable drugs. There may be times when the retail price for drugs may be more appropriate. For example, if the person requiring them is not covered by Medicare, it may be more appropriate to use the retail price. If the drugs are not listed on the formulary, they will be identified in one of 3 sections: a list of those for which there is no generic equivalent and no specific criteria for use; a list of those for which there is no generic equivalent but with specific criteria for their use; and those identified as having exceptional drug status (there is no list of these). For those listed in the first 2 sections, the use of the manufacturer's wholesale drug price (to which should be added an average mark up price of 10%) is recommended. For those unlisted drugs in the exceptional category, Manitoba Health must grant permission for use. When applicable, these drugs should be priced using the wholesale list.

An example of the information reported in the Manitoba Interchangeability Formulary (Registered Feb. 5, 1998) on the cost per tablet for Penicillin is as follows "Penicillin V (Potassium) - 500,000 IU (300 mg) – Tablets."

Product Name	Manufacturer	Price in Cents
Apo-Pen VK	Apotex Inc	6.50
Novo-Pen-VK-500	Novopharm Ltd.	4.75
Nu-Pen-VK	Nu-Pharm Inc.	4.73
Nadopen	Nadeau Laboratory Ltd.	7.73

The Formulary also reports the costs associated with "Penicillin V (Potassium) - 125 mg/ 5 ml - Oral Liquid" and Penicillin V (Potassium) - 500,000 IU (300 mg)/5 ml - Oral Liquid". In an analysis conducted from the viewpoint of the government-payer, a price of $4.73 would be used for all of these listed drugs.

The use of data from the Drug Program Information Network (DPIN) claims includes actual expenditures (reflecting use of the formulary list price), at least for those individuals whose usage is co-insured as part of the Pharmacare system (representing approximately 73% of the prescriptions dispensed in Manitoba). For drug use by residents of nursing homes, as well as drug use covered in the DPIN system but paid for by agencies other than Manitoba Health, the formulary price can be used as an approximation.

Dispensing Fee - The average dispensing fee per prescription for Manitoba as of December 1996 was $6.21; as of December 1997, $6.05. There is no minimum or maximum fee; retail pharmacies set their own fees. The average fee is based on information gathered by the DPIN program based on actual charges of retail pharmacies. The dispensing fee applies to prescriptions issued to non-hospitalised patients, and should be added to prescription cost calculations.

Diagnostic Procedures

The following section identifies data sources that may be useful for estimating costs of radiology and laboratory procedures. Diagnostic procedures for patients who are hospitalised are included in the hospital costs that are reported in Appendices 1 and 2 and, therefore, should not be added a second time.

Radiological Procedures - Physician tariffs and associated payments for radiological procedures are listed in the Manitoba Health Insurance Plan Physician's Manual. There are two fees associated with the radiological tariff: technical and professional. A technical fee is the rate at which private and ambulatory facilities are funded for the production of radiographs and includes contrast media, equipment purchase and maintenance, rent and office maintenance, supplies, and salaries of technologists, support staff for reception, accounting, and report typing. A professional fee is the rate at which radiologists, nuclear medicine specialists, and physicians with special training to conduct some imaging examinations are paid for consultations and interpretations of films, fluoroscopes and other procedures, as well as staff supervision.

Procedures are insured only when provided in facilities approved by Manitoba Health. Radiography, fluoroscopy, and limited nuclear medicine examinations are insured in private ambulatory facilities. Higher imaging technologies such as ultrasound, angiography, interventional procedures, computed tomography, and magnetic resonance imaging are limited to hospitals. A professional fee for these procedures is paid in hospitals with the exception of ultrasound and magnetic resonance imaging for which other comparable payment arrangements prevail; there is no technical fee since it is included in the global budgets of hospitals. The technical component of the costs of these procedures should be obtained by micro-costing. Many of these payments are by contract to groups of imaging specialists. The payments provide a fee-for-service equivalent for services delivered and are adjusted to include teaching and complex administrative/professional costs.

MacEwan and colleagues (1994) assembled all of the imaging costs for the population of Manitoba for the fiscal year 1993. The average total technical and professional imaging costs were: radiography $77, ultrasound $140, computed tomography $281, nuclear medicine $184, and magnetic resonance $530.[10]

As an alternative source of data, Manitoba Health maintains a list of "Charges for Insured Out-Patient and In-Patient Services Provided to Insured Residents of other Provinces and Territories". This inter-provincial rate guide is issued every year and contains charges for high cost procedures including CT scan ($200) and MRI ($655).

Laboratory Procedures - Urban hospitals provide both inpatient and outpatient laboratory procedures. These procedures are funded through each hospital's global budget and will be covered in the RDRG and DPG case costs listed in Appendix 1 and 2. Laboratory services are also provided by three institutions operated by Manitoba Health (Westman Regional Laboratory Services in Brandon, Cadham Laboratory in Winnipeg and Rural Diagnostic Services located in most rural hospitals.) Registered private laboratories in rural and urban

[10] Lääperi (1996) presents the most thorough analysis of the subject and extensive data from Finland. Thus it is possible for investigators to estimate costs for individual imaging procedures using information from other jurisdictions if it is not known for their own region.

areas are reimbursed according to the test specific tariffs in the Manitoba Health Services Insurance Plan Physician's Manual (Manitoba Health, 1995).

Table 5: Operating Costs by Laboratory Section for 1995/96

Section	Cost/100 Workload Units
Nuclear Medicine	$207.14
Histopathology	$87.15
Haematology	$85.53
Total Laboratory	$81.10
Microbiology	$76.40
Chemistry	$70.75
Specimen Acquisition	$45.36

(source – Westman Region Laboratory Services Inc. 1995-96 Annual Report)

The Westman Laboratory provides most of the services performed in Brandon and a considerable amount of the services performed in rural Manitoba. Their annual report provides the most complete data on public laboratory costs.[11] Table 5 reports the costs per 100 workload units for several different types of tests. These costs include salaries, supplies and overhead.

Workload units are defined as the number of minutes of direct labour time required to perform a specific test or procedure. These labour time units are often used as an approximation of the total resources required to produce any type of test. Within each of the categories in Table 5, tests will have specific workload dollar values. To obtain the cost of a specific test, multiply the cost per 100 workload units, which is in Table 5, by a number of workload units. The workload units for each specific test within each section can be obtained from the Canadian Institute for Health Information.[12]

[11] Westman Regional Laboratory is located at 150 McTavish Avenue East, Brandon, Manitoba; 204-726-2028.
[12] MIS guidelines. Ottawa: Canadian Institute for Health Information, 1996. Section 6, Workload Measurement Systems. Write to 250 Ferrand Drive, Box 3900 Don Mills, Ontario, M3C2T9; 416-429-0464.

The Canadian Institute for Health Information [CIHI] workload units for a direct manual bilirubin test, which is a manual chemistry test, is 16 units. According to the Westman data, the unit cost per 100 chemistry tests is $70.75, which is $0.7075 for each test. The estimated cost for a bilirubin test is therefore $11.32 (=16 workload units x $0.7075). The CIHI also lists automated chemistry tests, which will have fewer workload units per test. Further examples are tests from the area of hematology (whose estimated cost is $0.8553 per test, according to the Westman data). An example of an automated hematology test is a profile complete blood count (CBC) (7 parameters). This test has 7 workload units. The estimated cost for such a profile is therefore $5.9871 (=$0.8553 x 7). Another hematology example is a manual test, red cell creatinine. It has 15 workload units; and so the unit cost is $12.829 (=$0.8553 x 15 units).

Home Care

Home care can be provided by registered nurses, licensed practical nurses, home care attendants and home helpers. Tables 6 to 8 report hourly costs for each type of provider according to where they work.

Table 6: Home Care Provided by Manitoba Health

Provider Category	Cost per Hour
Physiotherapy/Occupational Therapy (CTS)	$42.72
Registered Nurse	$24.30
Licensed Practical Nurse	$21.68
Home Care Attendant	$14.75
Home Support Worker	$12.01

(source – Manitoba Health Continuing Care)

Table 7: Home Care Provided by the Victorian Order of Nurses and Funded By Manitoba Health

Provider Category	Cost per Visit
Registered Nurse	$28.74
Home Support Worker	$11.76

(source – Manitoba Health Continuing Care)

Table 8: Home Care Provided by Olsten Health Services and Funded by Manitoba Health

Provider Category	Cost per Hour
Registered Nurse	$23.62
Licensed Practical Nurse	$19.47
Home Care Attendant	$13.23
Home Support Worker	$11.47

(source – Manitoba Health Continuing Care); the contract with Manitoba Health ended July 1998 and no government clients were continued past December, 1998.

These costs include the wages and benefits of the professionals who provide direct care and Manitoba Health overhead costs which have been allocated to home care. The delivery of direct in-home home care services is provided through Regional Health Authorities and contracted service agencies (such as the Victorian Order of Nurses, Olsten Health Services, Central Health Services and Community Therapy Services). The Victorian Order of Nurses is a private non-profit organization and Olsten Health Services is a private for-profit organization. Regional Health Authorities are responsible for determining client eligibility for Home Care services, assessing the functional ability and needs of eligible clients, and developing appropriate care and service plans for clients based on such assessments. The costs in Table 7 do not include case management (assessment and coordination). The costs cited above include travel expenses.

Long Term Institutional Care

This section explains how to estimate costs associated with Personal Care Homes and Rehabilitation and Chronic Care Hospitals.

Personal Care Homes (Nursing Homes) - There are two types of nursing homes in Manitoba – proprietary (for-profit) and non-proprietary. The latter include both those sponsored by ethnic and religious organizations as well as non-affiliated homes. Table 9 reports the daily rates at which Manitoba Health funded proprietary care homes in 1994/95, 1995/96, 1996/97, and 1997/98.

Table 9: Proprietary Care Homes

	Cost per Diem 1994/95	Cost per Diem 1995/96	Cost per Diem 1996/97	Cost per Diem 1997/98
Levels 1 & 2	$70.25	$70.95	$71.10	$71.45
Levels 3 & 4	$97.65	$98.60	$99.00	$99.35

(source – Manitoba Health, Long Term Care Division)

Manitoba Health funds proprietary personal care homes for each day of care that is provided to a resident. Residents are classified into levels of care depending on the hours of nursing care expected to be provided each day. The per diem payment is meant to cover the costs of administration/governance, hotel/hospitality and direct care such as nursing, activity programs and psycho-social services and supplies. The per diem payment is not meant to cover pharmaceuticals, rehabilitation services or physician payments; these would have to be added to personal home care costs by the investigator. In many Personal Care Homes[13]all pharmacy costs, except dispensing fees, are funded through the Pharmacare drug program. The estimated costs per day for pharmaceuticals in the nursing homes funded through the Pharmacare drug program were $2.88 in 1995/96 and $2.96 in 1996/97. This per diem cost should be added to the cost per diem contained in Table 9.

The rate of payment for proprietary homes is set at the median per diem cost in free-standing[14] non-proprietary homes. There are many non-proprietary (not-for-profit) personal care homes in Manitoba. They each have budgetary arrangements with Manitoba Health that vary according to the level of care and types of services provided. Unless the cost comparisons are focussing on care in different types of nursing homes, it would be appropriate to also use the daily rates reported in Table 9 for care provided in non-proprietary homes. To the daily rates should be added $4.36 per day representing the annual Manitoba

[13] In many rural personal care homes, as well as in the personal care units of Concordia Hospital, Riverview Hospital, and the Deer Lodge Centre in Winnipeg, drugs are obtained from either attached or separate hospital pharmacies; data covering drug costs for these nursing home residents will not be reported to the Pharmacare drug program (DPIN). Currently, 1603 beds are in this category.

[14] Free-standing refers to those nursing homes which are not attached to a hospital.

Health payments for capital costs to proprietary homes directly and on behalf of non-proprietary homes to lenders.[15]

If a research project requires the separation of public from private costs of nursing home care, it will be necessary to subtract the residential charges paid by nursing home patients from the daily rates reported in Table 9. Residents in all personal care homes are required to pay a residential charge.[16] As of August 1/97 residents paid between $24.80 and $57.90 per day depending on their net income less total tax payable.

For example,

Single/Widowed Separated/Divorced	Married	Daily Rate
Income Range		
$ 0.00 – 10,972.49	$ 0.00 – 30,137.49	$24.80
16,120.41 – 16,156.91	35,285.41 – 35,321.91	$39.00
23,020.80 and over	42,185.80 and over	$57.90

As a reflection of the public costs of nursing home care, an estimate of this charge (in 1997/98 the estimated average residential charge was $33.00[17]) should be subtracted from the amounts listed in Table 9.

Rehabilitation and Chronic Care Hospitals – Table 10 reports a per diem for Rehabilitation and Chronic Care hospitals for the fiscal year of 1997/98.[18] The per diem was provided by

[15] In estimating this figure a combination of 1996/97 and 1997/98 data were used to reflect typical annual amounts. Where extraordinary payments were made in one year, data from the alternate year were used. Note that the per diem payments to proprietary personal care homes also were designed to cover capital costs to varying degrees. Since the inception of the insured program in 1973, $2.40 per resident has been paid to all proprietary homes as a traditional capital cost allowance. Payment policies concerning capital costs have changed over the years and additional payments are being made to some homes; these amounts vary and depend upon when they were built or upgraded. The $4.36 represents our best estimate of these additional payments.

[16] In essence, Manitoba Health payments, which are based on approved budgets for non-proprietary homes and per diems for proprietary homes, are reduced by the amount of the estimated income they receive from residential charges. At year end adjustments occur (additional payments or withdrawals) based on audits of facility records. Residents who believe they should pay a reduced residential charge (i.e., less than the maximum of $57.90) must apply to the facility and provide income tax records. Residents who cannot pay the minimum rate can apply to Family Services for an income supplement.

[17] According to Manitoba Health.

Manitoba Health and reflects costs in four chronic care hospitals and chronic care units in urban hospitals.

Table 10: Chronic Care Hospital and Long Term Care Hospital

	Cost per Diem 1997/98
Hospital Long Stay per Diem	$280.00

(source - Manitoba Health)

Physician Costs

Physician tariffs are reported in the Manitoba Health Services Insurance Plan Physician's Manual (1995). This document is found in every physician's office. It is used to select the tariff appropriate for the service provided. The fees for common services such as Complete History and Physical Examination, Regional History and Examination, and Consultations vary according to the specialty of the physician as illustrated in Table 11.

Table 11: Examples of Physician Tariffs

Specialty Area	Code	Description	Tariff
Internal Medicine	8540	Complete History and Physical, New patient, or new illness, or complete exam of old patient	$50.15
Internal Medicine	8501	Regional History and Examination	$24.60
Internal Medicine	8550	Consultation[19]	$84.10
Emergency Medicine	8540	Complete History and Physical (hospital ER department only)	$35.10
General Practice	8540	Complete History and Physical	$35.15
General Practice	8509	Regional or Subsequent Visit (patient under 75 years)	$15.85
General Practice	8550	Consultation	$38.70
Immunisation	8601	DPT 1st dose	$3.75

(source – Manitoba Health Services Insurance Plan Physician's Manual 1995)

Table 12 shows the tariff differential paid to physicians practising outside of Winnipeg.

[18] These costs change; for instance, in 1995/96 the per diem was $263.

[19] Those who are interested in applying the Internal Medicine tariff (code 8550) should read rules 7 to 11 in the Manitoba Health Services Insurance Plan Physician's Manual.

Table 12: Physician Fee Differentials

Location	Differential
Northern Manitoba[20]	10.0%
Rural Manitoba	5.0%
City of Brandon	2.5%

(source – Manitoba Health Services Insurance Plan Physician's Manual 1995)

That is, those practising in Northern Manitoba are paid the fee associated with the tariff listed in Table 11, plus an additional 10%.

In the estimates of hospital case costs (Appendices 1 and 2) associated physician costs are excluded since methods of physician payment vary across hospitals and by type of physician. In any costing project, then, the investigator should include all physician costs associated with the hospital stay (including physician visits to patient, consultations taking place in hospital and, if surgery takes place, the surgical fee, the fee of the surgical assistant, and the anaesthesist's fee). All of these are usually billed separately. They are also recoverable from administrative data. Applicable fees will be found in the Manitoba Health Services Insurance Plan Physician's Manual.

Examples of How to Use the Manitoba Cost List

As an example of the use of the cost list, for a moment assume that an elderly male has hospitalised for simple pneumonia without complications (RDRG 0890). Two types of interventions may be provided, and the goal of this exercise is to determine the difference in costs between them.

Under intervention 1, he can be kept in hospital for 10 days under a drug regimen of penicillin and glycoside, both provided intravenously. A doctor visits the patient each day. Under

[20] The Northern Location is north of the 53rd parallel.

intervention 2, he can be released after three full days with a drug treatment of oral penicillin, with a daily dosage of 4 capsules for seven more days. Intervention 2 will require a daily, one hour, home care visit by a nurse for 7 days, and one visit to the general practitioner at the end of this 7 day period.

With regard to hospitalisation, the difference between the two interventions is 7 days under the same diagnosis. This case fits the example of the second circumstance listed in Table 2 (the treatment affects the length of stay for a particular RDRG). In this case it is appropriate to use the daily marginal cost of RDRG 0890, which is $361 per day. Hospitalisation alone adds $2,527 (7 x $361) to the differential between Interventions 1 and 2. Physician visits in hospital are $13.90 (per day for first and second week), according to the Manitoba Tariff Code (8519). For seven days this will amount to $97.30.

Additional costs for home care are 7 visits by a nurse (at $24.30 per hour, as in Table 6) or $170. According to the provincial formulary penicillin costs 4.73 cents for a tablet b.[21] Taken 4 times daily for 7 days, these capsules would cost $1.32 plus a dispensing fee of $6.21, for a total of $7.53. The visit to the G.P. at the end of 7 days would cost $15.85 (tariff code 8509 if the patient is under age75), or $19.80 (tariff code 8513) if the patient is aged 75 years and older.

In total, then, the additional hospital (including the intravenous drugs) and physician costs will be $2,624.30 for Intervention 1, and the additional home care, drug, and physician costs will be $197.33. The net difference between the two interventions is $2,426.97.

This is a didactic example, designed to demonstrate the use of the cost list. All elderly patients may not be eligible for early discharge. But if the resources in each case were as specified, then the cost list could be used in this way.

[21] The drug prices came from the Manitoba Drug Interchangeability Formulary (13th edition); this formulary is effective March 1, 1998. The formulary is available on the Internet at http://www.gov.mb.ca/health/mdbif/index.html.

Table 13: Cost List Example

Cost Categories	Intervention 1	Intervention 2	Difference	Savings Resulting from Intervention 2
Length of Stay in Hospital	10 days	3 days	+7 days	+7 days x $361 = +$2,527
Hospital Doctor Visits	10 visits	3 visits	+7 visits	+7 visits x $13.90 = +$97.30
Drugs	0 capsules	28 capsules	-28 capsules	-(28 x $0.0473) + $6.21 = -$7.53
Home Care Nurse Visits	0 hours	7 hours	-7 hours	-7 hours x $24.30 = -$170
Home Care Office Doctor Visits	0 visits	1 visit	-1 visit	-1 visit x $19.80 = -$19.80
Net Difference Between 1 and 2				+$2624.30 - $197.33 = $2426.97

Updating the Cost List

The sources of data and the years from which such data were derived are given in the text. Some data sources update their cost lists occasionally; some do so every year (for example, the drug formulary and the physician fee schedules). Effective use of this cost list requires it to be updated annually or biannually. Researchers must be prepared to acknowledge any limitations associated with using costs derived from non-concurrent years.

Summary

This document presents a set of province-wide costs to be used in health care studies with a cost component. The cost list is for use in conjunction with the wide variety of utilization data currently available in Manitoba, with a view to the provision of an economic component to health care studies. Most importantly, the costs reported are province-wide and this makes their application more readily generalizable than if they had been derived from only one provider or facility.

The primary purpose of this cost list is to facilitate cost effectiveness studies and to enrich the understanding of how health care dollars are spent. The data contained herein are not intended to be used for funding purposes, or for comparing inter-facility differences in care

delivered. Such studies would require much more detailed analyses. However, the data reported in this document are appropriate for estimating costs of care between different interventions, or for examining the economic implications of different utilization patterns in populations.

The Manitoba cost list is the first such list that has been developed so that it can readily be related to existing utilization databases. It can also be used in more detailed economic studies of changes in how healthcare is delivered. Those using this list will no doubt have suggestions for the Centre as to how improvements and extensions can be made. Such suggestions are welcome. It is hoped that this list, and future editions, will help researchers conduct economic studies in this area.

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Appendix 1: Refined Diagnostic Related Groups[22]

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
0010 CRANIOTOMY EXCEPT FOR TRAUMA WITH NO CC	6.3	16.5	5366	852	595
0011 CRANIOTOMY EXCEPT FOR TRAUMA WITH CLASS C CC	7.5	21.5	5028	670	471
0012 CRANIOTOMY EXCEPT FOR TRAUMA WITH CLASS B CC	8.6	31.5	7126	829	576
0013 CRANIOTOMY EXCEPT FOR TRAUMA WITH CLASS A CC	16.0	48.0	11197	700	530
0020 CRANIOTOMY FOR TRAUMA WITH NO CC *	6.1	15.0	5047	827	623
0021 CRANIOTOMY FOR TRAUMA WITH CLASS C CC *	15.0	45.0	5846	390	584
0022 CRANIOTOMY FOR TRAUMA WITH CLASS B CC *	20.0	74.0	9495	475	682
0023 CRANIOTOMY FOR TRAUMA WITH CLASS A CC *	44.0	75.0	15313	348	698
0040 SPINAL PROCEDURES WITH NO CC	5.1	15.5	3563	699	472
0041 SPINAL PROCEDURES WITH CLASS C CC *	16.0	48.0	4966	310	510
0042 SPINAL PROCEDURES WITH CLASS B CC *	10.0	32.5	6440	644	506
0043 SPINAL PROCEDURES WITH CLASS A CC *	6.5	22.5	10872	1673	545
0050 EXTRACRANIAL VASCULAR PROCEDURES WITH NO CC	3.9	8.0	3036	778	510
0051 EXTRACRANIAL VASCULAR PROCEDURES WITH CLASS C CC	3.8	8.0	2931	771	498
0052 EXTRACRANIAL VASCULAR PROCEDURES WITH CLASS B CC	4.5	9.0	3594	799	519
0053 EXTRACRANIAL VASCULAR PROCEDURES WITH CLASS A CC *	6.1	16.5	5279	865	500
0060 CARPAL TUNNEL RELEASE WITH NO CC	1.3	3.5	1219	938	418
0061 CARPAL TUNNEL RELEASE WITH CLASS C CC *	2.4	9.5	1351	563	410
0062 CARPAL TUNNEL RELEASE WITH CLASS B CC *	13.0	58.5	1878	144	421
0063 CARPAL TUNNEL RELEASE WITH CLASS A CC *	N.A.	N.A.	1182	N.A.	435
0070 PERIPH & CRANIAL NERVE & OTHER NERV PROC WITH NO CC	2.0	6.0	1799	900	507
0071 PERIPH & CRANIAL NERVE & OTHER NERV PROC WITH CLASS C CC *	5.8	23.3	3453	595	453
0072 PERIPH & CRANIAL NERVE & OTHER NERV PROC WITH CLASS B CC *	5.2	24.0	5148	990	504
0073 PERIPH & CRANIAL NERVE & OTHER NERV PROC WITH CLASS A CC *	29.0	75.0	6558	226	424
0090 SPINAL DISORDERS & INJURIES WITH NO CC	5.7	19.5	3204	562	465
0091 SPINAL DISORDERS & INJURIES WITH CLASS C CC *	21.0	62.5	4468	213	427
0092 SPINAL DISORDERS & INJURIES WITH CLASS B CC *	28.0	75.0	7624	272	459
0100 NERVOUS SYSTEM NEOPLASMS WITH NO CC	6.4	24.5	3586	560	455
0101 NERVOUS SYSTEM NEOPLASMS WITH CLASS C CC	6.9	23.0	3279	475	394
0102 NERVOUS SYSTEM NEOPLASMS WITH CLASS B CC *	17.0	49.5	5037	296	385
0120 DEGENERATIVE NERVOUS SYSTEM DISORDERS WITH NO CC	9.3	31.5	3784	407	355
0121 DEGENERATIVE NERVOUS SYSTEM DISORDERS WITH CLASS C CC	13.0	45.0	4973	383	343
0122 DEGENERATIVE NERVOUS SYSTEM DISORDERS WITH CLASS B CC	24.0	75.0	12535	522	480
0130 MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA WITH NO CC	7.5	21.5	2666	356	318
0131 MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA WITH CLASS C CC	10.0	33.5	3711	371	321
0132 MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA WITH CLASS B CC *	15.0	54.0	5728	382	314
0140 SPECIFIC CEREBROVASCULAR DIS EXCEPT TIA WITH NO CC	9.8	36.5	3828	391	346
0141 SPECIFIC CEREBROVASCULAR DIS EXCEPT TIA WITH CLASS C CC	15.0	51.0	5567	371	338

[22] Approximately 38% of the RDRGs (443 out of 1,158) were based on 15 or less cases in Manitoba during 1993/94 and 1994/95; these RDRGs are identified by a "*". In any RDRG with less than 15 cases in either the Manitoba or Maryland data bases we inputted the Average LOS, and in the Maryland data we inputted the Average daily cost and total case cost. This was done by using information from adjacent RDRGs which had 10 or more cases. See Loyd et al., 1995, p. 9. For 54 RDRGs there were no cases in Manitoba during 1993/94 and 1994/95. These RDRGs are identified by "N.A." (not available) under the average length of stay for typical cases, the trim point and the average cost per day columns. In this situation we do report the cost per case and the marginal cost per day; these are based on case weights from Maryland and the total hospital expenditure in Manitoba. For the RDRGs labelled 4800, 4801, 4802 and 4803 there was no information in Maryland or Manitoba. Cases in the RDRGs mentioned in this footnote are rare events; if an investigator is specifically interested in the cost of these cases they should calculate micro-costs. However, for broader studies of care these estimates may be used with caution.

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
0142 SPECIFIC CEREBROVASCULAR DIS EXCEPT TIA WITH CLASS B CC	22.0	70.5	9143	416	381
0150 TIA & PRECEREBRAL OCCLUSIONS WITH NO CC	3.5	12.0	1656	473	382
0151 TIA & PRECEREBRAL OCCLUSIONS WITH CLASS C CC	5.4	19.5	2268	420	358
0152 TIA & PRECEREBRAL OCCLUSIONS WITH CLASS B CC	14.0	50.3	5590	399	349
0160 NONSPECIFIC CEREBROVASCULAR DISORDERS WITH NO CC	5.9	19.5	2560	434	344
0161 NONSPECIFIC CEREBROVASCULAR DISORDERS WITH CLASS C CC	8.9	36.5	3660	411	353
0162 NONSPECIFIC CEREBROVASCULAR DISORDERS WITH CLASS B CC *	24.0	69.5	7186	299	446
0180 CRANIAL & PERIPHERAL NERVE DISORDERS WITH NO CC	4.2	14.5	1911	455	386
0181 CRANIAL & PERIPHERAL NERVE DISORDERS WITH CLASS C CC	7.7	30.5	3082	400	348
0182 CRANIAL & PERIPHERAL NERVE DISORDERS WITH CLASS B CC	14.0	45.5	5266	376	339
0200 NERVOUS SYS INFECT EXCEPT VIRAL MENINGITIS WITH NO CC	8.6	26.5	4174	485	426
0201 NERVOUS SYS INFECT EXCEPT VIRAL MENINGITIS WITH CLASS C CC	10.0	27.0	5370	537	438
0202 NERVOUS SYS INFECT EXCEPT VIRAL MENINGITIS WITH CLASS B CC	26.0	71.0	13562	522	495
0210 VIRAL MENINGITIS WITH NO CC	2.7	5.8	1312	486	398
0211 VIRAL MENINGITIS WITH CLASS C CC *	4.5	11.8	2257	501	408
0212 VIRAL MENINGITIS WITH CLASS B CC *	3.5	5.5	3789	1082	437
0220 HYPERTENSIVE ENCEPHALOPATHY WITH NO CC0	5.1	22.0	2148	421	372
0221 HYPERTENSIVE ENCEPHALOPATHY WITH CLASS C CC *	8.6	37.0	3671	427	403
0222 HYPERTENSIVE ENCEPHALOPATHY WITH CLASS B CC *	2.0	2.0	7109	3555	497
0230 NONTRAUMATIC STUPOR & COMA WITH NO CC	2.1	6.0	1123	535	452
0231 NONTRAUMATIC STUPOR & COMA WITH CLASS C CC	2.4	11.0	1121	467	386
0232 NONTRAUMATIC STUPOR & COMA WITH CLASS B CC *	5.0	5.0	1887	377	415
0240 SEIZURE & HEADACHE WITH NO CC	2.1	6.0	1086	517	427
0241 SEIZURE & HEADACHE WITH CLASS C CC	3.6	13.5	1732	481	400
0242 SEIZURE & HEADACHE WITH CLASS B CC	4.0	14.5	2261	565	461
0270 TRAUMATIC STUPOR & COMA, COMA >1 HR WITH NO CC	2.6	11.0	2389	919	695
0271 TRAUMATIC STUPOR & COMA, COMA >1 HR WITH CLASS C CC *	4.9	23.5	3266	667	628
0272 TRAUMATIC STUPOR & COMA, COMA >1 HR WITH CLASS B CC *	2.0	2.0	5809	2904	729
0280 TRAUMATIC STUPOR & COMA, COMA <1 HR WITH NO CC	1.2	3.5	958	799	596
0281 TRAUMATIC STUPOR & COMA, COMA <1 HR WITH CLASS C CC	2.8	13.5	1881	672	486
0282 TRAUMATIC STUPOR & COMA, COMA <1 HR WITH CLASS B CC *	9.5	29.5	2783	293	472
0310 CONCUSSION WITH NO CC	1.3	3.5	961	739	603
0311 CONCUSSION WITH CLASS C CC	2.6	11.0	1668	642	514
0312 CONCUSSION WITH CLASS B CC *	3.5	13.5	2346	670	468
0340 OTHER DISORDERS OF NERVOUS SYSTEM WITH NO CC	3.4	12.0	1818	535	424
0341 OTHER DISORDERS OF NERVOUS SYSTEM WITH CLASS C CC	9.0	37.0	3856	428	376
0342 OTHER DISORDERS OF NERVOUS SYSTEM WITH CLASS B CC	17.0	35.5	7985	470	421
0360 RETINAL PROCEDURES WITH NO CC	3.1	7.0	2279	735	462
0361 RETINAL PROCEDURES WITH CLASS C CC	3.2	7.0	2518	787	464
0362 RETINAL PROCEDURES WITH CLASS B CC	4.2	10.5	3026	720	424
0363 RETINAL PROCEDURES WITH CLASS A CC *	N.A.	N.A.	1734	N.A.	438
0370 ORBITAL PROCEDURES WITH NO CC	2.7	7.0	2280	844	502
0371 ORBITAL PROCEDURES WITH CLASS C CC *	5.8	12.5	2572	443	457
0372 ORBITAL PROCEDURES WITH CLASS B CC *	6.0	17.3	4171	695	546
0373 ORBITAL PROCEDURES WITH CLASS A CC *	5.0	5.0	6492	1298	564
0380 PRIMARY IRIS PROCEDURES WITH NO CC	2.3	6.0	1809	786	535
0381 PRIMARY IRIS PROCEDURES WITH CLASS C CC *	1.0	1.0	1884	1884	410
0382 PRIMARY IRIS PROCEDURES WITH CLASS B CC *	4.0	4.0	2617	654	421
0383 PRIMARY IRIS PROCEDURES WITH CLASS A CC *	N.A.	N.A.	1117	N.A.	435
0390 LENS PROCEDURES WITH OR WITHOUT VITRECTOMY WITH NO CC	1.6	3.5	1548	967	612
0391 LENS PROCEDURES WITH OR WITHOUT VITRECTOMY WITH CLASS C CC	2.3	4.5	1935	841	580
0392 LENS PROCEDURES WITH OR WITHOUT VITRECTOMY WITH CLASS B CC	2.0	4.5	1973	986	655
0393 LENS PROCEDURES WITH OR WITHOUT VITRECTOMY WITH CLASS A CC *	7.3	27.0	3083	422	676
0400 EXTRAOCULAR PROCEDURES EXCEPT ORBIT WITH NO CC	1.3	3.5	1230	946	492
0401 EXTRAOCULAR PROCEDURES EXCEPT ORBIT WITH CLASS C CC *	4.0	14.5	1471	368	553
0402 EXTRAOCULAR PROCEDURES EXCEPT ORBIT WITH CLASS B CC *	1.5	4.8	1847	1232	514
0403 EXTRAOCULAR PROCEDURES EXCEPT ORBIT WITH CLASS A CC *	N.A.	N.A.	762	N.A.	531

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
0420 INTRAOCULAR PROC EXC RETINA, IRIS & LENS WITH NO CC	2.6	8.5	2167	834	557
0421 INTRAOCULAR PROC EXC RETINA, IRIS & LENS WITH CLASS C CC	3.1	7.0	2382	768	525
0422 INTRAOCULAR PROC EXC RETINA, IRIS & LENS WITH CLASS B CC	3.8	12.0	2786	733	495
0423 INTRAOCULAR PROC EXC RETINA, IRIS & LENS WITH CLASS A CC *	9.0	29.0	4410	490	511
0430 HYPHEMA WITH NO CC	2.5	8.5	973	389	339
0431 HYPHEMA WITH CLASS C CC *	N.A.	N.A.	2051	N.A.	381
0440 ACUTE MAJOR EYE INFECTIONS WITH NO CC	4.4	12.0	1650	375	333
0441 ACUTE MAJOR EYE INFECTIONS WITH CLASS C CC	6.6	20.5	2504	379	328
0442 ACUTE MAJOR EYE INFECTIONS WITH CLASS B CC *	5.0	5.0	4275	855	352
0450 NEUROLOGICAL EYE DISORDERS WITH NO CC	3.1	9.5	1590	513	410
0451 NEUROLOGICAL EYE DISORDERS WITH CLASS C CC *	3.2	9.5	2103	657	353
0452 NEUROLOGICAL EYE DISORDERS WITH CLASS B CC *	6.5	12.5	3576	550	380
0460 OTHER DISORDERS OF THE EYE WITH NO CC	3.2	11.0	1475	461	382
0461 OTHER DISORDERS OF THE EYE WITH CLASS C CC	5.0	17.0	2261	452	391
0462 OTHER DISORDERS OF THE EYE WITH CLASS B CC *	5.0	15.5	3155	631	351
0490 MAJOR HEAD & NECK PROCEDURES WITH NO CC *	3.7	12.8	4965	1342	640
0491 MAJOR HEAD & NECK PROCEDURES WITH CLASS C CC	6.9	20.0	5796	840	556
0492 MAJOR HEAD & NECK PROCEDURES WITH CLASS B CC *	8.4	31.0	6531	777	452
0493 MAJOR HEAD & NECK PROCEDURES WITH CLASS A CC *	6.0	6.0	10167	1694	467
0500 SIALOADENECTOMY WITH NO CC	2.2	6.0	2069	940	433
0501 SIALOADENECTOMY WITH CLASS C CC *	3.6	6.5	2340	650	436
0502 SIALOADENECTOMY WITH CLASS B CC *	2.8	7.0	2939	1049	399
0503 SIALOADENECTOMY WITH CLASS A CC *	4.7	10.5	4655	990	412
0510 SALIVARY GLAND PROC EXCEPT SIALOADENECTOMY WITH NO CC	2.0	6.0	1673	836	436
0511 SALIVARY GLAND PROC EXCEPT SIALOADENECTOMY WITH C CC *	3.0	3.0	2170	723	442
0512 SALIVARY GLAND PROC EXCEPT SIALOADENECTOMY WITH B CC *	3.0	3.0	3034	1011	454
0513 SLAIVARY GLAND PROC EXCEPT SIALOADENECTOMY WITH A CC *	4.0	4.0	4754	1189	468
0520 CLEFT LIP & PALATE REPAIR WITH NO CC	3.1	5.5	2258	728	444
0521 CLEFT LIP & PALATE REPAIR WITH CLASS C CC *	N.A.	N.A.	1089	N.A.	450
0522 CLEFT LIP & PALATE REPAIR WITH CLASS B CC *	4.2	12.0	3494	832	462
0523 CLEFT LIP & PALATE REPAIR WITH CLASS A CC *	5.0	13.0	5499	1100	477
0530 SINUS & MASTOID PROCEDURES WITH NO CC	1.0	1.0	1327	1327	483
0531 SINUS & MASTOID PROCEDURES WITH CLASS C CC *	2.2	4.5	1458	663	446
0532 SINUS & MASTOID PROCEDURES WITH CLASS B CC *	5.0	18.5	2022	404	467
0533 SINUS & MASTOID PROCEDURES WITH CLASS A CC *	7.8	19.0	2564	329	436
0550 MISC EAR, NOSE, MOUTH & THROAT PROCEDURES WITH NO CC	1.4	3.5	1579	1128	532
0551 MISC EAR, NOSE, MOUTH & THROAT PROCEDURES WITH CLASS C CC *	3.0	11.0	1879	626	566
0552 MISC EAR, NOSE, MOUTH & THROAT PROCEDURES WITH CLASS B CC *	4.0	11.0	2588	647	561
0553 MISC EAR, NOSE, MOUTH & THROAT PROCEDURES WITH CLASS A CC *	6.5	28.5	3818	587	621
0560 RHINOPLASTY WITH NO CC	1.2	2.3	1265	1054	458
0561 RHINOPLASTY WITH CLASS C CC *	1.8	2.0	1596	887	481
0562 RHINOPLASTY WITH CLASS B CC *	2.0	6.0	2698	1349	520
0563 RHINOPLASTY WITH CLASS A CC *	N.A.	N.A.	2139	N.A.	537
0570 T&A PROC, EXC TONSILL &/OR ADENOID ONLY WITH NO CC	1.6	3.5	1154	721	464
0571 T&A PROC, EXC TONSILL &/OR ADENOID ONLY WITH CLASS C CC *	2.5	8.5	1486	594	464
0572 T&A PROC, EXC TONSILL &/OR ADENOID ONLY WITH CLASS B CC	1.5	3.5	1271	847	497
0573 T&A PROC, EXC TONSILL &/OR ADENOID ONLY WITH CLASS A CC *	2.0	2.0	1862	931	524
0590 TONSILLECTOMY &/OR ADENOIDECTOMY ONLY WITH NO CC	1.0	1.0	779	779	437
0591 TONSILLECTOMY &/OR ADENOIDECTOMY ONLY WITH CLASS C CC *	2.0	6.0	1340	670	473
0592 TONSILLECTOMY &/OR ADENOIDECTOMY ONLY WITH CLASS B CC	1.4	3.5	1042	744	451
0593 TONSILLECTOMY &/OR ADENOIDECTOMY ONLY WITH CLASS A CC *	2.0	2.0	1607	803	466
0610 MYRINGOTOMY W TUBE INSERTION WITH NO CC	1.0	1.0	1125	1125	465
0611 MYRINGOTOMY W TUBE INSERTION WITH CLASS C CC *	5.0	5.0	1376	275	471
0612 MYRINGOTOMY W TUBE INSERTION WITH CLASS B CC *	2.3	6.0	1846	803	484
0613 MYRINGOTOMY W TUBE INSERTION WITH CLASS A CC *	3.5	13.5	2679	765	499
0630 OTHER EAR, NOSE, MOUTH & THROAT O.R. PROC WITH NO CC	2.2	4.5	2535	1152	553
0631 OTHER EAR, NOSE, MOUTH & THROAT O.R. PROC WITH CLASS C CC	3.6	9.5	3195	887	522

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
0632 OTHER EAR, NOSE, MOUTH & THROAT O.R. PROC WITH CLASS B CC	3.2	8.3	3847	1202	580
0633 OTHER EAR, NOSE, MOUTH & THROAT O.R. PROC WITH CLASS A CC *	5.2	11.5	5055	972	589
0640 EAR, NOSE, MOUTH & THROAT MALIGNANCY WITH NO CC	3.1	12.3	1891	610	429
0641 EAR, NOSE, MOUTH & THROAT MALIGNANCY WITH CLASS C CC	6.9	29.5	3516	510	424
0642 EAR, NOSE, MOUTH & THROAT MALIGNANCY WITH CLASS B CC *	9.6	25.5	5332	555	405
0650 DYSEQUILIBRIUM WITH NO CC	2.6	8.5	1174	451	364
0651 DYSEQUILIBRIUM WITH CLASS C CC	3.7	12.0	1530	414	340
0652 DYSEQUILIBRIUM WITH CLASS B CC	7.6	26.5	2869	378	328
0660 EPISTAXIS WITH NO CC	2.7	8.5	964	357	300
0661 EPISTAXIS WITH CLASS C CC	3.3	9.5	1396	423	341
0662 EPISTAXIS WITH CLASS B CC *	3.9	10.5	2954	758	457
0670 EPIGLOTTITIS WITH NO CC	3.2	5.5	1807	565	484
0671 EPIGLOTTITIS WITH CLASS C CC *	5.0	5.0	2762	552	471
0672 EPIGLOTTITIS WITH CLASS B CC *	17.0	53.0	4700	276	507
0680 OTITIS MEDIA & URI WITH NO CC	2.7	8.5	1123	416	362
0681 OTITIS MEDIA & URI WITH CLASS C CC	3.3	9.5	1390	421	354
0682 OTITIS MEDIA & URI WITH CLASS B CC	4.7	14.5	2177	463	408
0710 LARYNGOTRACHEITIS WITH NO CC	1.5	3.5	695	463	427
0711 LARYNGOTRACHEITIS WITH CLASS C CC *	3.7	12.0	1115	301	431
0712 LARYNGOTRACHEITIS WITH CLASS B CC	2.7	8.5	1351	500	451
0720 NASAL TRAUMA & DEFORMITY WITH NO CC	1.8	6.0	1379	766	566
0721 NASAL TRAUMA & DEFORMITY WITH CLASS C CC *	2.0	6.0	2086	1043	580
0722 NASAL TRAUMA & DEFORMITY WITH CALSS B CC *	1.0	1.0	3557	3557	624
0730 OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES WITH NO CC	1.9	6.0	992	522	391
0731 OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES WITH CLASS C CC	3.1	11.0	1522	491	397
0732 OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES WITH CLASS B CC *	4.0	11.0	2624	656	438
0750 MAJOR CHEST PROCEDURES WITH NO CC	7.2	15.0	4779	664	490
0751 MAJOR CHEST PROCEDURES WITH CLASS C CC	8.6	18.5	5740	667	498
0752 MAJOR CHEST PROCEDURES WITH CLASS B CC	10.0	22.0	6999	700	515
0753 MAJOR CHEST PROCEDURES WITH CLASS A CC	17.0	50.0	10742	632	521
0760 OTHER RESP SYSTEM O.R. PROCEDURES WITH NO CC	2.2	8.5	1594	725	419
0761 OTHER RESP SYSTEM O.R. PROCEDURES WITH CLASS C CC	3.1	11.0	2043	659	424
0762 OTHER RESP SYSTEM O.R. PROCEDURES WITH CLASS B CC	5.1	19.5	3015	591	419
0763 OTHER RESP SYSTEM O.R. PROCEDURES WITH CLASS A CC	23.0	75.0	11251	489	448
0780 PULMONARY EMBOLISM WITH NO CC	7.9	16.0	3136	397	341
0781 PULMONARY EMBOLISM WITH CLASS C CC	10.0	22.0	4073	407	346
0782 PULMONARY EMBOLISM WITH CLASS B CC	13.0	37.0	6073	467	390
0790 RESPIRATORY INFECTIONS & INFLAMMATIONS WITH NO CC	11.0	37.8	3996	363	313
0791 RESPIRATORY INFECTIONS & INFLAMMATIONS WITH CLASS C CC	11.0	32.5	4387	399	357
0792 RESPIRATORY INFECTIONS & INFLAMMATIONS WITH CLASS B CC	15.0	47.5	6621	441	377
0820 RESPIRATORY NEOPLASMS WITH NO CC	5.8	19.5	2842	490	413
0821 RESPIRATORY NEOPLASMS WITH CLASS C CC	9.5	31.5	4195	442	379
0822 RESPIRATORY NEOPLASMS WITH CLASS B CC	11.0	34.3	5073	461	384
0830 MAJOR CHEST TRAUMA WITH NO CC	3.9	14.8	1813	465	389
0831 MAJOR CHEST TRAUMA WITH CLASS C CC	11.0	32.5	4518	411	381
0832 MAJOR CHEST TRAUMA WITH CLASS B CC	9.0	23.5	4042	449	383
0850 PLEURAL EFFUSION WITH NO CC	5.3	17.0	2241	423	351
0851 PLEURAL EFFUSION WITH CLASS C CC	8.9	31.5	3679	413	368
0852 PLEURAL EFFUSION WITH CLASS B CC	13.0	34.5	5584	430	397
0870 PULMONARY EDEMA & RESPIRATORY FAILURE WITH NO CC	5.5	15.5	2428	441	402
0871 PULMONARY EDEMA & RESPIRATORY FAILURE WITH CLASS C CC	8.0	24.0	3761	470	420
0872 PULMONARY EDEMA & RESPIRATORY FAILURE WITH CLASS B CC	7.3	19.0	3810	522	452
0880 CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH NO CC	6.1	18.0	2227	365	337
0881 CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH CLASS C CC	8.0	24.0	3016	377	345
0882 CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH CLASS B CC	11.0	33.5	4438	403	359
0890 SIMPLE PNEUMONIA & PLEURISY WITH NO CC	4.2	10.5	1692	403	361
0891 SIMPLE PNEUMONIA & PLEURISY WITH CLASS C CC	7.4	21.5	2898	392	350

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
0892 SIMPLE PNEUMONIA & PLEURISY WITH CLASS B CC	9.1	26.0	3928	432	376
0920 INTERSTITIAL LUNG DISEASE WITH NO CC	5.0	15.5	2159	432	358
0921 INTERSTITIAL LUNG DISEASE WITH CLASS C CC	8.4	25.0	3382	403	347
0922 INTERSTITIAL LUNG DISEASE WITH CLASS B CC	16.0	62.5	6696	419	370
0940 PNEUMOTHORAX WITH NO CC	3.9	12.0	1581	405	335
0941 PNEUMOTHORAX WITH CLASS C CC	6.0	18.0	2578	430	372
0942 PNEUMOTHORAX WITH CLASS B CC	9.7	34.0	4226	436	373
0960 BRONCHITIS & ASTHMA WITH NO CC	2.9	7.0	1256	433	394
0961 BRONCHITIS & ASTHMA WITH CLASS C CC	5.2	15.5	2009	386	343
0962 BRONCHITIS & ASTHMA WITH CLASS B CC	4.4	12.0	1987	452	406
0990 RESPIRATORY SIGNS & SYMPTOMS WITH NO CC	2.1	6.0	1089	519	428
0991 RESPIRATORY SIGNS & SYMPTOMS WITH CLASS C CC	3.7	12.0	1761	476	398
0992 RESPIRATORY SIGNS & SYMPTOMS WITH CLASS B CC	3.7	13.3	2078	562	449
1010 OTHER RESPIRATORY SYSTEM DIAGNOSES WITH NO CC	3.3	9.5	1655	501	432
1011 OTHER RESPIRATORY SYSTEM DIAGNOSES WITH CLASS C CC	5.8	18.0	2639	455	388
1012 OTHER RESPIRATORY SYSTEM DIAGNOSES WITH CLASS B CC	6.1	18.0	2916	478	405
1030 HEART TRANSPLANT WITH NO CC *	N.A.	N.A.	4493	N.A.	1176
1031 HEART TRANSPLANT WITH CLASS C CC *	N.A.	N.A.	4827	N.A.	1192
1032 HEART TRANSPLANT WITH CLASS B CC *	N.A.	N.A.	5768	N.A.	1224
1033 HEART TRANSPLANT WITH CLASS A CC *	N.A.	N.A.	47759	N.A.	1264
1040 CARDIAC VALVE PROC W CARD CATH WITH NO CC *	12.0	26.0	15491	1291	1448
1041 CARDIAC VALVE PROC W CARD CATH WITH CLASS C CC *	N.A.	N.A.	3097	N.A.	1467
1042 CARDIAC VALVE PROC W CARD CATH WITH CLASS B CC	15.0	30.0	19369	1291	1008
1043 CARDIAC VALVE PROC W CARD CATH WITH CLASS A CC	22.0	44.5	25728	1169	949
1050 CARDIAC VALVE PROC W/O CARD CATH WITH NO CC	9.6	18.0	14688	1530	1132
1051 CARDIAC VALVE PROC W/O CARD CATH WITH CLASS C CC *	8.7	13.0	14942	1717	893
1052 CARDIAC VALVE PROC W/O CARD CATH WITH CLASS B CC	13.0	26.5	15995	1230	950
1053 CARDIAC VALVE PROC W/O CARD CATH WITH CLASS A CC	14.0	28.0	16015	1144	846
1060 CORONARY BYPASS W CARDIAC CATH WITH NO CC *	11.0	16.5	11389	1035	675
1061 CORONARY BYPASS W CARDIAC CATH WITH CLASS C CC	15.0	28.0	15149	1010	767
1062 CORONARY BYPASS W CARDIAC CATH WITH CLASS B CC	17.0	35.3	15644	920	730
1063 CORONARY BYPASS W CARDIAC CATH WITH CLASS A CC	23.0	57.5	20562	894	703
1070 CORONARY BYPASS W/O CARDIAC CATH WITH NO CC	9.2	13.0	9802	1065	756
1071 CORONARY BYPASS W/O CARDIAC CATH WITH CLASS C CC	8.6	14.5	9159	1065	743
1072 CORONARY BYPASS W/O CARDIAC CATH WITH CLASS B CC	11.0	21.5	10898	991	709
1073 CORONARY BYPASS W/O CARDIAC CATH WITH CLASS A CC	16.0	42.5	14689	918	718
1080 OTHER CARDIOTHORACIC PROCEDURES WITH NO CC	6.5	8.5	7741	1191	846
1081 OTHER CARDIOTHORACIC PROCEDURES WITH CLASS C CC *	8.0	44.5	9580	1198	780
1082 OTHER CARDIOTHORACIC PROCEDURES WITH CLASS B CC	10.0	24.5	11725	1172	837
1083 OTHER CARDIOTHORACIC PROCEDURES WITH CLASS A CC *	30.0	75.0	27665	922	788
1100 MAJOR CARDIOVASCULAR PROCEDURES WITH NO CC	9.4	15.5	7024	747	573
1101 MAJOR CARDIOVASCULAR PROCEDURES WITH CLASS C CC	10.0	18.0	7049	705	530
1102 MAJOR CARDIOVASCULAR PROCEDURES WITH CLASS B CC	11.0	21.5	9044	822	628
1103 MAJOR CARDIOVASCULAR PROCEDURES WITH CLASS A CC	16.0	36.0	12811	801	656
1120 PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH NO CC	5.1	17.0	6211	1218	1120
1121 PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH CLASS C CC	6.1	22.0	7192	1179	1082
1122 PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH CLASS B CC	10.0	26.0	8892	889	765
1123 PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH CLASS A CC	22.0	51.8	15542	706	656
1130 AMPUT FOR CIRC SYSTEM EXC UPPER LIMB & TOE WITH NO CC *	29.0	75.0	11409	393	356
1131 AMPUT FOR CIRC SYSTEM EXC UPPER LIMB & TOE WITH CLASS C CC	36.0	75.0	14015	389	338
1132 AMPUT FOR CIRC SYSTEM EXC UPPER LIMB & TOE WITH CLASS B CC	33.0	75.0	14157	429	369
1133 AMPUT FOR CIRC SYSTEM EXC UPPER LIMB & TOE WITH CLASS A CC *	39.0	75.0	23132	593	375
1140 UPPER LIMB & TOE AMPUTATION FOR CIRC SYS WITH NO CC *	5.9	19.5	3646	618	310
1141 UPPER LIMB & TOE AMPUTATION FOR CIRC SYS WITH CLASS C CC	12.0	38.5	4635	386	321
1142 UPPER LIMB & TOE AMPUTATION FOR CIRC SYS WITH CLASS B CC	17.0	59.5	6582	387	329
1143 UPPER LIMB & TOE AMPUTATION FOR CIRC SYS WITH CLASS A CC *	36.0	75.0	11012	306	347
1150 PERM CARD PACE IMPL W/ AMI, HRT FAIL/SHK WITH NO CC *	12.0	12.0	7365	614	785

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1151 PERM CARD PACE IMPL W/ AMI, HRT FAIL/SHK WITH CLASS C CC *	7.4	11.0	9125	1233	801
1152 PERM CARD PACE IMPL W/ AMI, HRT FAIL/SHK WITH CLASS B CC *	20.0	53.0	11492	575	743
1153 PERM CARD PACE IMPL W/ AMI, HRT FAIL/SHK WITH CLASS A CC *	58.0	58.0	17004	293	683
1160 PERM CARD PACE IMPL W/O AMI, HRT FAIL/SHK WITH NO CC	2.8	8.5	5337	1906	1450
1161 PERM CARD PACE IMPL W/O AMI, HRT FAIL/SHK WITH CLASS C CC	4.4	14.5	6397	1454	1115
1162 PERM CARD PACE IMPL W/O AMI, HRT FAIL/SHK WITH CLASS B CC	7.2	23.0	8448	1173	937
1163 PERM CARD PACE IMPL W/O AMI, HRT FAIL/SHK WITH CLASS A CC	11.0	33.8	10789	981	769
1170 CARD PACE REV EXC DEVICE REPLACEMENT WITH NO CC	1.7	4.8	2089	1229	583
1171 CARD PACE REV EXC DEVICE REPLACEMENT WITH CLASS C CC	1.5	3.5	2324	1549	599
1172 CARD PACE REV EXC DEVICE REPLACEMENT WITH CLASS B CC *	2.5	4.5	2879	1151	555
1173 CARD PACE REV EXC DEVICE REPLACEMENT WITH CLASS A CC *	28.0	75.0	4269	152	573
1180 CARD PACE DEVICE REPLACEMENT WITH NO CC	2.3	8.5	5944	2584	2076
1181 CARD PACE DEVICE REPLACEMENT WITH CLASS C CC	1.4	3.5	2979	2128	1418
1182 CARD PACE DEVICE REPLACEMENT WITH CLASS B CC *	17.0	75.0	2881	169	970
1183 CARD PACE DEVICE REPLACEMENT WITH CLASS A CC *	N.A.	N.A.	18306	N.A.	788
1190 VEIN LIGATION & STRIPPING WITH NO CC	2.1	6.0	1595	760	375
1191 VEIN LIGATION & STRIPPING WITH CLASS C CC *	3.4	9.5	2019	594	420
1192 VEIN LIGATION & STRIPPING WITH CLASS B CC	3.1	9.5	2125	686	401
1193 VEIN LIGATION & STRIPPING WITH CLASS A CC *	8.5	18.5	3098	364	414
1200 OTHER CIRCULATORY SYSTEM O.R. PROCEDURES WITH NO CC *	11.0	35.0	2082	189	372
1201 OTHER CIRCULATORY SYSTEM O.R. PROCEDURES WITH CLASS C CC *	31.0	75.0	3257	105	447
1202 OTHER CIRCULATORY SYSTEM O.R. PROCEDURES WITH CLASS B CC	5.0	21.0	3127	625	445
1203 OTHER CIRCULATORY SYSTEM O.R. PROCEDURES WITH CLASS A CC *	12.0	50.0	4834	403	462
1210 CIRCULATORY DISORDERS W AMI WITH NO CC	7.4	13.5	3988	539	457
1211 CIRCULATORY DISORDERS W AMI WITH CLASS C CC	9.2	19.5	4753	517	444
1212 CIRCULATORY DISORDERS W AMI WITH CLASS B CC	15.0	37.8	7914	528	487
1240 CIRCULATORY DISORDERS EXCEPT AMI WITH NO CC	3.5	13.5	2738	782	688
1241 CIRCULATORY DISORDERS EXCEPT AMI WITH CLASS C CC	5.8	19.5	3626	625	540
1242 CIRCULATORY DISORDERS EXCEPT AMI WITH CLASS B CC	11.0	28.8	6514	592	504
1260 ACUTE & SUBACUTE ENDOCARDITIS WITH NO CC *	21.0	49.0	1707	81	331
1261 ACUTE & SUBACUTE ENDOCARDITIS WITH CLASS C CC *	17.0	39.0	2734	161	342
1262 ACUTE & SUBACUTE ENDOCARDITIS WITH CLASS B CC *	42.0	73.0	4689	112	364
1270 HEART FAILURE & SHOCK WITH NO CC	5.7	18.0	2215	389	337
1271 HEART FAILURE & SHOCK WITH CLASS C CC	6.9	21.5	2777	402	347
1272 HEART FAILURE & SHOCK WITH CLASS B CC	10.0	30.0	4579	458	396
1280 DEEP VEIN THROMBOPHLEBITIS WITH NO CC	7.2	21.5	2048	284	253
1281 DEEP VEIN THROMBOPHLEBITIS WITH CLASS C CC	9.5	30.0	3009	317	282
1282 DEEP VEIN THROMBOPHLEBITIS WITH CLASS B CC *	9.0	21.0	5287	587	304
1290 CARDIAC ARREST, UNEXPLAINED WITH NO CC *	6.8	15.8	2605	383	529
1291 CARDIAC ARREST, UNEXPLAINED WITH CLASS C CC *	3.0	11.0	4008	1336	511
1292 CARDIAC ARREST, UNEXPLAINED WITH CLASS B CC *	N.A.	N.A.	12565	N.A.	549
1300 PERIPHERAL VASCULAR DISORDERS WITH NO CC	7.1	19.0	2528	356	308
1301 PERIPHERAL VASCULAR DISORDERS WITH CLASS C CC	8.9	27.5	3361	378	321
1302 PERIPHERAL VASCULAR DISORDERS WITH CLASS B CC	10.0	27.0	4138	414	344
1320 ATHEROSCLEROSIS WITH NO CC	3.8	12.0	1749	460	379
1321 ATHEROSCLEROSIS WITH CLASS C CC	6.6	20.5	2992	453	382
1322 ATHEROSCLEROSIS WITH CLASS B CC	11.0	36.0	6381	580	471
1340 HYPERTENSION WITH NO CC	3.2	9.5	1335	417	354
1341 HYPERTENSION WITH CLASS C CC	4.2	12.0	1802	429	360
1342 HYPERTENSION WITH CLASS B CC	6.3	20.5	2868	455	389
1350 CARDIAC CONGENITAL & VALVULAR DISORDERS WITH NO CC	3.9	12.0	1840	472	417
1351 CARDIAC CONGENITAL & VALVULAR DISORDERS WITH CLASS C CC	6.0	20.5	2538	423	371
1352 CARDIAC CONGENITAL & VALVULAR DISORDERS WITH CLASS B CC *	12.0	34.0	5064	422	449
1380 CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS WITH NO CC	2.5	8.5	1174	470	387
1381 CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS WITH CLASS C CC	4.5	14.5	1979	440	369
1382 CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS WITH CLASS B CC	6.2	18.0	2971	479	393
1400 ANGINA PECTORIS WITH NO CC	3.2	9.5	1466	458	391

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
1401 ANGINA PECTORIS WITH CLASS C CC	4.6	14.5	2012	437	377
1402 ANGINA PECTORIS WITH CLASS B CC	5.6	18.0	2582	461	378
1410 SYNCOPE & COLLAPSE WITH NO CC	2.4	8.5	1177	491	400
1411 SYNCOPE & COLLAPSE WITH CLASS C CC	4.0	14.5	1765	441	374
1412 SYNCOPE & COLLAPSE WITH CLASS B CC *	4.4	18.5	2755	626	349
1430 CHEST PAIN WITH NO CC	2.1	6.0	1125	536	446
1431 CHEST PAIN WITH CLASS C CC	3.0	11.0	1587	529	435
1432 CHEST PAIN WITH CLASS B CC	4.6	16.0	2240	487	403
1440 OTHER CIRCULATORY SYSTEM DIAGNOSES WITH NO CC	5.2	17.0	2442	470	384
1441 OTHER CIRCULATORY SYSTEM DIAGNOSES WITH CLASS C CC	6.5	22.0	3288	506	412
1442 OTHER CIRCULATORY SYSTEM DIAGNOSES WITH CLASS B CC	10.0	34.0	5239	524	434
1460 RECTAL RESECTION WITH NO CC	10.0	16.5	5209	521	376
1461 RECTAL RESECTION WITH CLASS C CC	11.0	17.5	5584	508	379
1462 RECTAL RESECTION WITH CLASS B CC	13.0	25.0	7064	543	404
1463 RECTAL RESECTION WITH CLASS A CC	17.0	32.5	9226	543	428
1480 MAJOR SMALL & LARGE BOWEL PROCEDURES WITH NO CC	9.7	18.0	4616	476	350
1481 MAJOR SMALL & LARGE BOWEL PROCEDURES WITH CLASS C CC	11.0	19.0	5461	496	378
1482 MAJOR SMALL & LARGE BOWEL PROCEDURES WITH CLASS B CC	13.0	27.5	7037	541	411
1483 MAJOR SMALL & LARGE BOWEL PROCEDURES WITH CLASS A CC	18.0	44.5	10321	573	451
1500 PERITONEAL ADHESIOLYSIS WITH NO CC	7.6	21.5	3448	454	334
1501 PERITONEAL ADHESIOLYSIS WITH CLASS C CC	9.9	22.0	4477	452	343
1502 PERITONEAL ADHESIOLYSIS WITH CLASS B CC	12.0	26.5	5556	463	371
1503 PERITONEAL ADHESIOLYSIS WITH CLASS A CC	18.0	33.0	9508	528	429
1520 MINOR SMALL & LARGE BOWEL PROCEDURES WITH NO CC	7.3	13.5	3402	466	330
1521 MINOR SMALL & LARGE BOWEL PROCEDURES WITH CLASS C CC *	7.1	15.0	4260	600	334
1522 MINOR SMALL & LARGE BOWEL PROCEDURES WITH CLASS B CC	8.8	15.5	4776	543	387
1523 MINOR SMALL & LARGE BOWEL PROCEDURES WITH CLASS A CC *	11.0	20.8	6980	635	358
1540 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES WITH NO CC	7.3	17.5	3823	524	385
1541 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES WITH CLASS C CC	12.0	24.0	7150	596	461
1542 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES WITH CLASS B CC	13.0	33.0	8119	625	494
1543 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES WITH CLASS A CC	23.0	63.3	14841	645	532
1570 ANAL & STOMAL PROCEDURES WITH NO CC	2.9	7.0	1460	503	338
1571 ANAL & STOMAL PROCEDURES WITH CLASS C CC	4.2	10.5	1955	465	332
1572 ANAL & STOMAL PROCEDURES WITH CLASS B CC	5.4	13.0	2777	514	376
1573 ANAL & STOMAL PROCEDURES WITH CLASS A CC	11.0	45.0	5607	510	428
1590 HERNIA PROC EXCEPT INGUINAL & FEMORAL WITH NO CC	2.9	8.5	1729	596	365
1591 HERNIA PROC EXCEPT INGUINAL & FEMORAL WITH CLASS C CC	5.0	13.0	2645	529	374
1592 HERNIA PROC EXCEPT INGUINAL & FEMORAL WITH CLASS B CC	5.8	14.0	3186	549	383
1593 HERNIA PROC EXCEPT INGUINAL & FEMORAL WITH CLASS A CC	7.7	17.5	4395	571	429
1610 INGUINAL & FEMORAL HERNIA PROCEDURES WITH NO CC	2.1	6.0	1535	731	415
1611 INGUINAL & FEMORAL HERNIA PROCEDURES WITH CLASS C CC	3.1	7.0	1885	608	368
1612 INGUINAL & FEMORAL HERNIA PROCEDURES WITH CLASS B CC	4.8	14.5	2667	556	394
1613 INGUINAL & FEMORAL HERNIA PROCEDURES WITH CLASS A CC	6.7	20.0	3401	508	373
1640 APPENDECTOMY W COMPLICATED PRINCIPAL DIAG WITH NO CC	5.8	14.0	2752	475	357
1641 APPENDECTOMY W COMPLICATED PRINCIPAL DIAG WITH CLASS C CC *	6.0	15.0	3864	644	391
1642 APPENDECTOMY W COMPLICATED PRINCIPAL DIAG WITH CLASS B CC	8.8	18.5	4376	497	391
1643 APPENDECTOMY W COMPLICATED PRINCIPAL DIAG WITH CLASS A CC	11.0	20.3	5515	501	417
1660 APPENDECTOMY W/O COMPLIC PRINCIPAL DIAG WITH NO CC	3.2	7.0	1832	572	401
1661 APPENDECTOMY W/O COMPLIC PRINCIPAL DIAG WITH CLASS C CC	3.6	8.0	2078	577	394
1662 APPENDECTOMY W/O COMPLIC PRINCIPAL DIAG WITH CLASS B CC	5.0	10.3	2618	524	377
1663 APPENDECTOMY W/O COMPLIC PRINCIPAL DIAG WITH CLASS A CC	8.1	20.0	4101	506	411
1680 MOUTH PROCEDURES WITH NO CC	1.5	3.5	1512	1008	480
1681 MOUTH PROCEDURES WITH CLASS C CC *	2.9	10.3	2038	703	442
1682 MOUTH PROCEDURES WITH CLASS B CC	3.7	12.0	2698	729	488
1683 MOUTH PROCEDURES WITH CLASS A CC *	3.0	3.0	4128	1376	504
1700 OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH NO CC	5.1	17.0	4487	880	388
1701 OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CLASS C CC	9.5	31.5	4693	494	392

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
1702 OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CLASS B CC	12.0	33.0	6421	535	432
1703 OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CLASS A CC *	25.0	75.0	10728	429	443
1720 DIGESTIVE MALIGNANCY WITH NO CC	4.2	14.5	2175	518	409
1721 DIGESTIVE MALIGNANCY WITH CLASS C CC	6.4	23.0	3084	482	370
1722 DIGESTIVE MALIGNANCY WITH CLASS B CC	16.0	44.5	6879	430	383
1740 G.I. HEMORRHAGE WITH NO CC	3.5	9.5	1629	466	354
1741 G.I. HEMORRHAGE WITH CLASS C CC	5.2	15.5	2673	514	399
1742 G.I. HEMORRHAGE WITH CLASS B CC	10.0	27.5	5166	517	415
1760 COMPLICATED PEPTIC ULCER WITH NO CC	4.8	13.0	2162	451	344
1761 COMPLICATED PEPTIC ULCER WITH CLASS C CC	7.2	19.0	3109	432	347
1762 COMPLICATED PEPTIC ULCER WITH CLASS B CC *	24.0	75.0	6668	278	477
1770 UNCOMPLICATED PEPTIC ULCER WITH NO CC	3.2	9.5	1457	455	359
1771 UNCOMPLICATED PEPTIC ULCER WITH CLASS C CC	4.5	13.0	1915	426	325
1772 UNCOMPLICATED PEPTIC ULCER WITH CLASS B CC *	5.3	9.0	2978	562	330
1790 INFLAMMATORY BOWEL DISEASE WITH NO CC	5.8	18.0	2118	365	300
1791 INFLAMMATORY BOWEL DISEASE WITH CLASS C CC	6.7	19.0	2598	388	325
1792 INFLAMMATORY BOWEL DISEASE WITH CLASS B CC *	14.0	46.5	4488	321	350
1800 G.I. OBSTRUCTION WITH NO CC	4.2	12.0	1554	370	311
1801 G.I. OBSTRUCTION WITH CLASS C CC	6.2	18.0	2384	385	326
1802 G.I. OBSTRUCTION WITH CLASS B CC	9.0	28.0	3876	431	374
1820 ESOPHAGITIS, GASTROENT & MISC DIGEST WITH NO CC	2.7	8.5	1161	430	361
1821 ESOPHAGITIS, GASTROENT & MISC DIGEST WITH CLASS C CC	3.8	12.0	1586	417	340
1822 ESOPHAGITIS, GASTROENT & MISC DIGEST WITH CLASS B CC	6.8	23.0	3010	443	365
1850 DENTAL & ORAL DIS EXCEPT EXTRAC & RESTOR WITH NO CC	2.8	8.5	1592	568	403
1851 DENTAL & ORAL DIS EXCEPT EXTRAC & RESTOR WITH CLASS C CC	3.4	9.5	1863	548	439
1852 DENTAL & ORAL DIS EXCEPT EXTRAC & RESTOR WITH CLASS B CC *	3.3	8.3	3438	1042	499
1870 DENTAL EXTRACTIONS & RESTORATIONS WITH NO CC	1.3	3.5	1166	897	420
1871 DENTAL EXTRACTIONS & RESTORATIONS WITH CLASS C CC	1.6	3.5	1335	834	484
1872 DENTAL EXTRACTIONS & RESTORATIONS WITH CLASS B CC *	1.0	1.0	2249	2249	520
1880 OTHER DIGESTIVE SYSTEM DIAGNOSES WITH NO CC	2.5	8.5	1193	477	357
1881 OTHER DIGESTIVE SYSTEM DIAGNOSES WITH CLASS C CC	4.9	17.0	2350	480	377
1882 OTHER DIGESTIVE SYSTEM DIAGNOSES WITH CLASS B CC	7.7	25.5	3749	487	376
1910 PANCREAS, LIVER & SHUNT PROCEDURES WITH NO CC	10.0	22.0	6072	607	445
1911 PANCREAS, LIVER & SHUNT PROCEDURES WITH CLASS C CC *	18.0	52.8	7948	442	458
1912 PANCREAS, LIVER & SHUNT PROCEDURES WITH CLASS B CC	14.0	36.5	9034	645	497
1913 PANCREAS, LIVER & SHUNT PROCEDURES WITH CLASS A CC	23.0	60.5	15855	689	552
1930 BIL TR PROC EXC ONLY TOT CHOL W OR W/O CDE WITH NO CC	9.6	22.0	5169	538	400
1931 BIL TR PROC EXC ONLY TOT CHOL W OR W/O CDE WITH CLASS C CC	11.0	31.0	6375	580	418
1932 BIL TR PROC EXC ONLY TOT CHOL W OR W/O CDE WITH CLASS B CC	14.0	51.5	8514	608	449
1933 BIL TR PROC EXC ONLY TOT CHOL W OR W/O CDE WITH CLASS A CC	22.0	64.5	13265	603	487
1950 TOTAL CHOLECYSTECTOMY W C.D.E. WITH NO CC	8.8	18.5	4303	489	347
1951 TOTAL CHOLECYSTECTOMY W C.D.E. WITH CLASS C CC	8.0	24.5	4162	520	359
1952 TOTAL CHOLECYSTECTOMY W C.D.E. WITH CLASS B CC	11.0	28.0	5894	536	392
1953 TOTAL CHOLECYSTECTOMY W C.D.E. WITH CLASS A CC *	15.0	40.5	10096	673	445
1970 TOTAL CHOLECYSTECTOMY W/O C.D.E. WITH NO CC	5.5	11.5	3560	647	476
1971 TOTAL CHOLECYSTECTOMY W/O C.D.E. WITH CLASS C CC	7.9	20.0	4502	570	437
1972 TOTAL CHOLECYSTECTOMY W/O C.D.E. WITH CLASS B CC	8.0	18.5	4656	582	435
1973 TOTAL CHOLECYSTECTOMY W/O C.D.E. WITH CLASS A CC	10.0	18.0	6114	611	465
1990 HEPATOBILIARY DIAGNOSTIC PROC FOR MALIG WITH NO CC *	8.7	20.0	2217	255	484
1991 HEPATOBILIARY DIAGNOSTIC PROC FOR MALIG WITH CLASS C CC *	9.0	16.5	2275	253	387
1992 HEPATOBILIARY DIAGNOSTIC PROC FOR MALIG WITH CLASS B CC *	15.0	41.5	3011	201	426
1993 HEPATOBILIARY DIAGNOSTIC PROC FOR MALIG WITH CLASS A CC *	N.A.	N.A.	18202	N.A.	440
2000 HEPATOBILIARY DIAG PROC FOR NON MALIG WITH NO CC *	7.0	20.5	1768	253	427
2001 HEPATOBILIARY DIAG PROC FOR NON MALIG WITH CLASS C CC *	7.0	23.0	2294	328	455
2002 HEPATOBILIARY DIAG PROC FOR NON MALIG WITH CLASS B CC *	11.0	22.3	3342	304	503
2003 HEPATOBILIARY DIAG PROC FOR NON MALIG WITH CLASS A CC *	38.0	75.0	5295	139	512
2010 OTHER HEPATOBILIARY OR PANCREAS O.R. PROC WITH NO CC *	18.0	18.0	2025	112	470

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
2011 OTHER HEPATOBILIARY OR PANCREAS O.R. PROC WITH CLASS C CC *	10.0	18.0	2386	239	476
2012 OTHER HEPATOBILIARY OR PANCREAS O.R. PROC WITH CLASS B CC *	9.7	32.5	3117	321	490
2013 OTHER HEPATOBILIARY OR PANCREAS O.R. PROC WITH CLASS A CC *	26.0	75.0	4973	191	535
2020 CIRRHOSIS & ALCOHOLIC HEPATITIS WITH NO CC	5.7	15.5	2305	404	327
2021 CIRRHOSIS & ALCOHOLIC HEPATITIS WITH CLASS C CC	8.2	29.0	3249	396	334
2022 CIRRHOSIS & ALCOHOLIC HEPATITIS WITH CLASS B CC	8.3	28.8	4339	523	397
2030 MALIG OF HEPATOBILIARY SYS OR PANCREAS WITH NO CC	7.0	25.5	3562	509	416
2031 MALIG OF HEPATOBILIARY SYS OR PANCREAS WITH CLASS C CC	7.2	21.5	3242	450	367
2032 MALIG OF HEPATOBILIARY SYS OR PANCREAS WITH CLASS B CC *	12.0	34.3	5735	478	409
2040 DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITH NO CC	4.9	13.0	1955	399	333
2041 DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITH CLASS C CC	6.6	19.0	2636	399	337
2042 DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITH CLASS B CC	13.0	35.8	5693	438	386
2050 DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA WITH NO CC	3.5	9.5	1471	420	334
2051 DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA WITH CLASS C CC	5.5	18.0	2502	455	364
2052 DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA WITH CLASS B CC	9.6	31.0	4721	492	380
2070 DISORDERS OF THE BILIARY TRACT WITH NO CC	3.4	11.0	1696	499	402
2071 DISORDERS OF THE BILIARY TRACT WITH CLASS C CC	5.9	18.0	2702	458	373
2072 DISORDERS OF THE BILIARY TRACT WITH CLASS B CC	9.4	23.5	4544	483	397
2090 MAJ JT & LIMB REATTACH PROC OF LOWER EXT WITH NO CC	11.0	23.0	8618	783	600
2091 MAJ JT & LIMB REATTACH PROC OF LOWER EXT WITH CLASS C CC	13.0	25.0	9848	758	589
2092 MAJ JT & LIMB REATTACH PROC OF LOWER EXT WITH CLASS B CC	15.0	36.0	10837	722	556
2093 MAJ JT & LIMB REATTACH PROC OF LOWER EXT WITH CLASS A CC	18.0	40.5	11144	619	471
2100 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH NO CC	11.0	38.5	5638	513	383
2101 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH CLASS C CC	20.0	58.5	9264	463	387
2102 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH CLASS B CC	28.0	75.0	12150	434	374
2103 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH CLASS A CC	29.0	75.0	13770	475	405
2130 AMPUTATION FOR MUSC SYS & CONN TISSUE WITH NO CC	5.3	22.0	2806	529	349
2131 AMPUTATION FOR MUSC SYS & CONN TISSUE WITH CLASS C CC *	21.0	75.0	3264	155	335
2132 AMPUTATION FOR MUSC SYS & CONN TISSUE WITH CLASS B CC *	17.0	48.0	4427	260	328
2133 AMPUTATION FOR MUSC SYS & CONN TISSUE WITH CLASS A CC *	29.0	75.0	7544	260	365
2140 BACK & NECK PROCEDURES WITH NO CC	5.1	13.0	2915	572	385
2141 BACK & NECK PROCEDURES WITH CLASS C CC	7.3	23.5	4562	625	428
2142 BACK & NECK PROCEDURES WITH CLASS B CC	9.2	24.8	5884	640	455
2143 BACK & NECK PROCEDURES WITH CLASS A CC *	17.0	50.5	9596	564	478
2160 BIOPSIES OF MUSC SYS & CONNECTIVE TISSUE WITH NO CC	4.9	19.5	2758	563	372
2161 BIOPSIES OF MUSC SYS & CONNECTIVE TISSUE WITH CLASS C CC *	13.0	31.0	3326	256	368
2162 BIOPSIES OF MUSC SYS & CONNECTIVE TISSUE WITH CLASS B CC *	21.0	75.0	9297	443	381
2163 BIOPSIES OF MUSC SYS & CONNECTIVE TISSUE WITH CLASS A CC *	32.0	73.5	14191	443	363
2170 WND DEBRID & SKN GRFT EXC HAND, FOR MUSC WITH NO CC	5.1	18.8	3181	624	388
2171 WND DEBRID & SKN GRFT EXC HAND, FOR MUSC WITH CLASS C CC *	9.2	26.5	5146	559	456
2172 WND DEBRID & SKN GRFT EXC HAND, FOR MUSC WITH CLASS B CC	24.0	75.0	12595	525	428
2173 WND DEBRID & SKN GRFT EXC HAND, FOR MUSC WITH CLASS A CC	22.0	64.0	11439	520	406
2180 LOWER EXTREM & HUM PROC EXC HIP,FOOT,FEMUR W NO CC	3.5	9.5	2449	700	431
2181 LOWER EXTREM & HUM PROC EXC HIP,FOOT,FEMUR W CLASS C CC	5.5	14.0	3700	673	438
2182 LOWER EXTREM & HUM PROC EXC HIP,FOOT,FEMUR W CLASS B CC	11.0	36.0	6339	576	431
2183 LOWER EXTREM & HUM PROC EXC HIP,FOOT,FEMUR W CLASS A CC *	14.0	37.5	8860	633	462
2210 KNEE PROCEDURES WITH NO CC	2.3	6.0	2162	940	520
2211 KNEE PROCEDURES WITH CLASS C CC	6.5	22.0	4017	618	445
2212 KNEE PROCEDURES WITH CLASS B CC *	7.7	39.5	5184	673	429
2213 KNEE PROCEDURES WITH CLASS A CC *	4.0	9.0	7459	1865	390
2230 MAJOR SHOULDER/ELBOW PROC WITH NO CC	2.1	6.0	1633	778	425
2231 MAJOR SHOULDER/ELBOW PROC WITH CLASS C CC *	5.0	5.0	2002	400	438
2232 MAJOR SHOULDER/ELBOW PROC WITH CLASS B CC *	4.7	15.5	2280	485	388
2233 MAJOR SHOULDER/ELBOW PROC WITH CLASS A CC *	5.0	5.0	3592	718	400
2240 OTHER SHOULD,ELB OR LOWARM PROC,EXC MAJ JT WITH NO CC	2.3	6.0	1874	815	462
2241 OTHER SHOULD,ELB OR LOWARM PROC,EXC MAJ JT WITH CLASS C CC	3.3	7.0	2426	735	445
2242 OTHER SHOULD,ELB OR LOWARM PROC,EXC MAJ JT WITH CLASS B CC *	5.9	18.0	3231	548	451

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
2243 OTHER SHOULD,ELB OR LOWARM PROC,EXC MAJ JT WITH CLASS A CC *	9.4	30.0	5969	635	574
2250 FOOT PROCEDURES WITH NO CC	2.4	6.0	1860	775	426
2251 FOOT PROCEDURES WITH CLASS C CC	3.1	8.3	2150	694	426
2252 FOOT PROCEDURES WITH CLASS B CC *	6.5	23.0	2402	370	353
2253 FOOT PROCEDURES WITH CLASS A CC *	18.0	58.5	3229	179	332
2260 SOFT TISSUE PROCEDURES WITH NO CC	2.2	6.0	1652	751	424
2261 SOFT TISSUE PROCEDURES WITH CLASS C CC	3.0	10.3	1892	631	397
2262 SOFT TISSUE PROCEDURES WITH CLASS B CC *	6.1	24.5	2567	421	405
2263 SOFT TISSUE PROCEDURES WITH CLASS A CC *	2.7	7.0	2062	764	395
2280 MAJOR THUMB OR JOINT PROC WITH NO CC	2.1	6.0	1881	896	488
2281 MAJOR THUMB OR JOINT PROC WITH CLASS C CC *	3.8	6.8	2635	693	583
2282 MAJOR THUMB OR JOINT PROC WITH CLASS B CC *	7.0	24.0	2457	351	406
2283 MAJOR THUMB OR JOINT PROC WITH CLASS A CC *	17.0	74.5	3811	224	419
2290 OTHER HAND OR WRIST PROC, EX MAJ JT PROC WITH NO CC	1.6	3.5	1501	938	464
2291 OTHER HAND OR WRIST PROC, EX MAJ JT PROC WITH CLASS C CC	2.8	7.0	2084	744	463
2292 OTHER HAND OR WRIST PROC, EX MAJ JT PROC WITH CLASS B CC *	2.9	8.5	2378	820	384
2293 OTHER HAND OR WRIST PROC, EX MAJ JT PROC WITH CLASS A CC *	5.8	19.5	4481	773	491
2300 LOC EXCIS & REMOV OF DEVICE OF HIP & FEMUR WITH NO CC	1.9	6.0	1462	769	419
2301 LOC EXCIS & REMOV OF DEVICE OF HIP & FEMUR WITH CLASS C CC *	6.0	26.0	1728	288	394
2302 LOC EXCIS & REMOV OF DEVICE OF HIP & FEMUR WITH CLASS B CC *	7.3	24.5	2293	314	391
2303 LOC EXCIS & REMOV OF DEVICE OF HIP & FEMUR WITH CLASS A CC *	6.0	6.0	3428	571	402
2310 LOC EXCIS & REMOV OF DEVICE EX HIP & FEMUR WITH NO CC	2.0	6.0	1719	859	451
2311 LOC EXCIS & REMOV OF DEVICE EX HIP & FEMUR WITH CLASS C CC *	3.1	12.0	2262	730	474
2312 LOC EXCIS & REMOV OF DEVICE EX HIP & FEMUR WITH CLASS B CC	7.2	34.5	4111	571	419
2313 LOC EXCIS & REMOV OF DEVICE EX HIP & FEMUR WITH CLASS A CC *	13.0	58.5	6208	478	413
2320 ARTHROSCOPY WITH NO CC	1.6	3.5	1603	1002	501
2321 ARTHROSCOPY WITH CLASS C CC *	2.0	2.0	2043	1022	507
2322 ARTHROSCOPY WITH CLASS B CC *	N.A.	N.A.	1320	N.A.	521
2323 ARTHROSCOPY WITH CLASS A CC *	11.0	44.5	3639	331	538
2330 OTHER MUSC SYS & CONN TISS O.R. PROC WITH NO CC	3.7	13.5	2795	755	497
2331 OTHER MUSC SYS & CONN TISS O.R. PROC WITH CLASS C CC	6.9	15.0	5343	774	549
2332 OTHER MUSC SYS & CONN TISS O.R. PROC WITH CLASS B CC	17.0	54.3	8881	522	427
2333 OTHER MUSC SYS & CONN TISS O.R. PROC WITH CLASS A CC *	9.5	14.0	16188	1704	489
2350 FRACTURES OF FEMUR WITH NO CC	17.0	53.5	5838	343	292
2351 FRACTURES OF FEMUR WITH CLASS C CC *	19.0	67.8	8105	427	276
2352 FRACTURES OF FEMUR WITH CLASS B CC *	49.0	49.0	13869	283	296
2360 FRACTURES OF HIP & PELVIS WITH NO CC	14.0	46.0	4422	316	278
2361 FRACTURES OF HIP & PELVIS WITH CLASS C CC	21.0	66.8	6713	320	292
2362 FRACTURES OF HIP & PELVIS WITH CLASS B CC	26.0	71.0	7846	302	279
2370 SPRAINS & DISLOC OF HIP, PELVIS & THIGH WITH NO CC	4.8	21.0	1983	413	340
2371 SPRAINS & DISLOC OF HIP, PELVIS & THIGH WITH CLASS C CC *	12.0	41.0	3077	256	338
2372 SPRAINS & DISLOC OF HIP, PELVIS & THIGH WITH CLASS B CC *	N.A.	N.A.	828	N.A.	363
2380 OSTEOMYELITIS WITH NO CC	8.8	29.0	3341	380	316
2381 OSTEOMYELITIS WITH CLASS C CC	12.0	33.0	4428	369	291
2382 OSTEOMYELITIS WITH CLASS B CC	18.0	47.0	6198	344	287
2390 PATH FRACTURES & MUSC & CONN TISS MALIG WITH NO CC	12.0	38.5	3882	323	294
2391 PATH FRACTURES & MUSC & CONN TISS MALIG WITH CLASS C CC	11.0	39.0	4490	408	331
2392 PATH FRACTURES & MUSC & CONN TISS MALIG WITH CLASS B CC	19.0	55.0	7394	389	340
2400 CONNECTIVE TISSUE DISORDERS WITH NO CC	7.0	23.0	2690	384	318
2401 CONNECTIVE TISSUE DISORDERS WITH CLASS C CC	10.0	36.5	4297	430	344
2402 CONNECTIVE TISSUE DISORDERS WITH CLASS B CC	13.0	39.5	6686	514	413
2420 SEPTIC ARTHRITIS WITH NO CC	7.4	25.5	2714	367	311
2421 SEPTIC ARTHRITIS WITH CLASS C CC	12.0	49.0	4404	367	315
2422 SEPTIC ARTHRITIS WITH CLASS B CC *	25.0	75.0	7304	292	336
2430 MEDICAL BACK PROBLEMS WITH NO CC	4.7	17.0	1706	363	312
2431 MEDICAL BACK PROBLEMS WITH CLASS C CC	9.2	33.0	3260	354	309
2432 MEDICAL BACK PROBLEMS WITH CLASS B CC	13.0	47.5	4741	365	325

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
2440 BONE DISEASES & SPECIFIC ARTHROPATHIES WITH NO CC	6.4	20.5	2288	357	313
2441 BONE DISEASES & SPECIFIC ARTHROPATHIES WITH CLASS C CC	11.0	39.0	3915	356	319
2442 BONE DISEASES & SPECIFIC ARTHROPATHIES WITH CLASS B CC	21.0	69.0	7251	345	316
2460 NON SPECIFIC ARTHROPATHIES WITH NO CC	4.7	14.5	1789	381	321
2461 NON SPECIFIC ARTHROPATHIES WITH CLASS C CC	8.7	29.0	3129	360	319
2462 NON SPECIFIC ARTHROPATHIES WITH CLASS B CC *	8.8	26.0	5349	608	343
2470 SIGNS & SYMPTOMS OF MUSC SYS & CONN TISSUE WITH NO CC	3.2	11.0	1437	449	377
2471 SIGNS & SYMPTOMS OF MUSC SYS & CONN TISSUE WITH CLASS C CC	5.9	22.0	2377	403	349
2472 SIGNS & SYMPTOMS OF MUSC SYS & CONN TISSUE WITH CLASS B CC *	13.0	47.5	4052	312	376
2480 TENDONITIS, MYOSITIS & BURSITIS WITH NO CC	3.9	14.5	1581	405	338
2481 TENDONITIS, MYOSITIS & BURSITIS WITH CLASS C CC	6.1	20.5	2404	394	339
2482 TENDONITIS, MYOSITIS & BURSITIS WITH CLASS B CC *	26.0	61.5	4202	162	373
2490 AFTERCARE, MUSC SYSTEM & CONNECTIVE TISSUE WITH NO CC	11.0	43.0	4091	372	335
2491 AFTERCARE, MUSC SYSTEM & CONNECTIVE TISSUE WITH CLASS C CC	20.0	63.8	6178	309	283
2492 AFTERCARE, MUSC SYSTEM & CONNECTIVE TISSUE WITH CLASS B CC *	23.0	55.8	9148	398	262
2500 FX, SPRN, STRN & DISL OF UPARM, HAND, FOOT WITH NO CC	1.3	3.5	941	724	487
2501 FX, SPRN, STRN & DISL OF UPARM, HAND, FOOT WITH CLASS C CC	5.3	22.0	2707	511	421
2502 FX, SPRN, STRN & DISL OF UPARM, HAND, FOOT WITH CLASS B CC *	12.0	44.0	4465	372	449
2530 FX, SPRN, & DISL OF UPARM,LOWLEG EX FOOT WITH NO CC	3.3	13.5	1524	462	381
2531 FX, SPRN, & DISL OF UPARM,LOWLEG EX FOOT WITH CLASS C CC	8.2	37.0	3296	402	349
2532 FX, SPRN, & DISL OF UPARM,LOWLEG EX FOOT WITH CLASS B CC	24.0	75.0	8739	364	335
2560 OTHER MUSC SYSTEM & CONNECTIVE TISSUE DIAG WITH NO CC	3.6	16.0	1734	482	407
2561 OTHER MUSC SYSTEM & CONNECTIVE TISSUE DIAG WITH CLASS C CC	5.1	24.5	2212	434	344
2562 OTHER MUSC SYSTEM & CONNECTIVE TISSUE DIAG WITH CLASS B CC *	8.7	20.0	3312	381	325
2570 TOTAL MASTECTOMY FOR MALIGNANCY WITH NO CC	5.4	11.5	2828	524	346
2571 TOTAL MASTECTOMY FOR MALIGNANCY WITH CLASS C CC	5.7	11.5	2974	522	345
2572 TOTAL MASTECTOMY FOR MALIGNANCY WITH CLASS B CC	9.6	23.5	4610	480	352
2573 TOTAL MASTECTOMY FOR MALIGNANCY WITH CLASS A CC *	12.0	26.8	7722	643	387
2590 SUBTOTAL MASTECTOMY FOR MALIGNANCY WITH NO CC	3.5	9.5	2082	595	376
2591 SUBTOTAL MASTECTOMY FOR MALIGNANCY WITH CLASS C CC	4.2	10.5	2376	566	370
2592 SUBTOTAL MASTECTOMY FOR MALIGNANCY WITH CLASS B CC	7.0	25.5	3944	563	413
2593 SUBTOTAL MASTECTOMY FOR MALIGNANCY WITH CLASS A CC *	6.0	6.0	6277	1046	426
2610 BREAST PROC, NON MALIG EX BIOP & LOC EXCIS WITH NO CC	1.8	3.5	2001	1111	490
2611 BREAST PROC, NON MALIG EX BIOP & LOC EXCIS WITH CLASS C CC *	2.5	7.0	2132	853	457
2612 BREAST PROC, NON MALIG EX BIOP & LOC EXCIS WITH CLASS B CC *	3.1	7.0	2705	873	432
2613 BREAST PROC, NON MALIG EX BIOP 7 LOC EXCIS WITH CLASS A CC *	N.A.	N.A.	1934	N.A.	446
2620 BREAST BIOPSY & LOCAL EXCIS FOR NON MALIG WITH NO CC	1.5	3.5	1134	756	401
2621 BREAST BIOPSY & LOCAL EXCIS FOR NON MALIG WITH CLASS C CC *	2.7	9.5	1303	483	404
2622 BREAST BIOPSY & LOCAL EXCIS FOR NON MALIG WITH CLASS B CC *	2.8	7.8	1840	657	404
2623 BREAST BIOPSY & LOCAL EXCIS FOR NON MALIG WITH CLASS A CC *	4.0	4.0	2764	691	418
2630 SKIN GRAFT &/OR DBRID, SKN ULCR OR CELLU WITH NO CC	15.0	57.5	5207	347	294
2631 SKIN GRAFT &/OR DBRID, SKN ULCR OR CELLU WITH CLASS C CC	11.0	34.5	4368	397	316
2632 SKIN GRAFT &/OR DBRID, SKN ULCR OR CELLU WITH CLASS B CC	24.0	72.5	9177	382	325
2633 SKIN GRAFT &/OR DBRID, SKN ULCR OR CELLU WITH CLASS A CC	35.0	75.0	13446	384	334
2650 SKIN GRAFT &/OR DBRID EX SKN ULCR OR CELLU WITH NO CC	4.3	14.5	2689	625	395
2651 SKIN GRAFT &/OR DBRID EX SKN ULCR OR CELLU WITH CLASS C CC	4.6	14.5	2993	651	395
2652 SKIN GRAFT &/OR DBRID EX SKN ULCR OR CELLU WITH CLASS B CC	10.0	31.0	5754	575	394
2653 SKIN GRAFT &/OR DBRID EX SKN ULCR OR CELLU WITH CLASS A CC *	5.6	18.5	8293	1481	382
2670 PERIANAL & PILONIDAL PROCEDURES WITH NO CC	2.2	6.0	1304	593	348
2671 PERIANAL & PILONIDAL PROCEDURES WITH CLASS C CC *	4.5	14.5	1665	370	352
2672 PERIANAL & PILONIDAL PROCEDURES WITH CLASS B CC *	5.2	13.0	1784	343	298
2673 PERIANAL & PILONIDAL PROCEDURES WITH CALSS A CC *	1.5	3.5	2787	1858	308
2680 SKIN, SUBCUT TISSUE & BREAST PLASTIC PROC WITH NO CC	2.0	6.0	1614	807	399
2681 SKIN, SUBCUT TISSUE & BREAST PLASTIC PROC WITH CLASS C CC *	4.0	12.0	2186	546	538
2682 SKIN, SUBCUT TISSUE & BREAST PLASTIC PROC WITH CLASS B CC *	2.0	6.0	2564	1282	424
2683 SKIN, SUBCUT TISSUE & BREAST PLASTIC PROC WITH CLASS A CC *	2.0	2.0	4049	2024	438
2690 OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC WITH NO CC	2.6	8.5	1594	613	395

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
2691 OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC WITH CLASS C CC	4.1	12.0	2186	533	389
2692 OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC WITH CLASS B CC	6.9	25.5	3520	510	373
2693 OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC WITH CLASS A CC *	24.0	75.0	5165	215	358
2710 SKIN ULCERS WITH NO CC	11.0	37.5	3462	315	286
2711 SKIN ULCERS WITH CLASS C CC	12.0	39.5	4157	346	308
2712 SKIN ULCERS WITH CLASS B CC *	22.0	75.0	6591	300	295
2720 MAJOR SKIN DISORDERS WITH NO CC	5.6	18.0	2106	376	331
2721 MAJOR SKIN DISORDERS WITH CLASS C CC	8.0	24.0	3774	472	387
2722 MAJOR SKIN DISORDERS WITH CLASS B CC *	6.6	14.0	6540	991	418
2740 MALIGNANT BREAST DISORDERS WITH NO CC	4.9	17.0	2392	488	369
2741 MALIGNANT BREAST DISORDERS WITH CLASS C CC	6.4	23.0	3464	541	440
2742 MALIGNANT BREAST DISORDERS WITH CLASS B CC *	13.0	43.5	4338	334	340
2760 NON MALIGANT BREAST DISORDERS WITH NO CC	2.8	7.0	1222	436	324
2761 NON MALIGANT BREAST DISORDERS WITH CLASS C CC	4.7	15.3	1824	388	342
2762 NON MALIGANT BREAST DISORDERS WITH CLASS B CC *	17.0	18.5	3104	183	367
2770 CELLULITIS WITH NO CC	4.1	12.0	1484	362	307
2771 CELLULITIS WITH CLASS C CC	6.7	19.0	2426	362	312
2772 CELLULITIS WITH CLASS B CC	11.0	38.3	4405	400	351
2800 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST WITH NO CC	2.2	8.5	1442	655	517
2801 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST WITH CLASS C CC	3.6	13.5	1966	546	446
2802 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST WITH CLASS B CC	11.0	45.5	4519	411	374
2830 MINOR SKIN DISORDERS WITH NO CC	3.2	11.0	1267	396	328
2831 MINOR SKIN DISORDERS WITH CLASS C CC	6.9	23.0	2623	380	335
2832 MINOR SKIN DISORDERS WITH CLASS B CC *	10.0	27.0	4205	421	341
2850 AMPUT OF LOWER LIMB FOR ENDO,NUTR,& METAB WITH NO CC *	N.A.	N.A.	1112	N.A.	283
2851 AMPUT OF LOWER LIMB FOR ENDO,NUTR,& METAB WITH CLASS C CC *	N.A.	N.A.	22326	N.A.	287
2852 AMPUT OF LOWER LIMB FOR ENDO,NUTR,& METAB WITH CLASS B CC *	17.0	41.5	6498	382	314
2853 AMPUT OF LOWER LIMB FOR ENDO,NUTR,& METAB WITH CLASS A CC *	41.0	75.0	9662	236	304
2860 ADRENAL & PITUITARY PROCEDURES WITH NO CC	4.5	10.5	3985	886	552
2861 ADRENAL & PITUITARY PROCEDURES WITH CLASS C CC *	4.6	13.0	5078	1104	593
2862 ADRENAL & PITUITARY PROCEDURES WITH CLASS B CC *	9.3	23.5	6242	671	543
2863 ADRENAL & PITUITARY PROCEDURES WITH CLASS A CC *	18.0	75.0	9208	512	539
2870 SKN GFT & WND DBRID FOR ENDO, NUTR & METAB WITH NO CC *	9.0	9.0	3937	437	315
2871 SKN GFT & WND DBRID FOR ENDO, NUTR & METAB WITH CLASS C CC *	N.A.	N.A.	531	N.A.	319
2872 SKN GFT & WND DBRID FOR ENDO, NUTR & METAB WITH CLASS B CC	18.0	60.5	6716	373	322
2873 SKN GFT & WND DBRID FOR ENDO, NUTR & METAB WITH CLASS A CC *	N.A.	N.A.	25807	N.A.	330
2880 O.R. PROCEDURES FOR OBESITY WITH NO CC	2.9	7.0	2096	723	398
2881 O.R. PROCEDURES FOR OBESITY WITH CLASS C CC *	N.A.	N.A.	1138	N.A.	449
2882 O.R. PROCEDURES FOR OBESITY WITH CLASS B CC *	4.0	10.5	3133	783	444
2883 O.R. PROCEDURES FOR OBESITY WITH CLASS A CC *	N.A.	N.A.	35585	N.A.	458
2890 PARATHYROID PROCEDURES WITH NO CC	2.5	4.5	2068	827	405
2891 PARATHYROID PROCEDURES WITH CLASS C CC *	2.6	4.5	2577	991	412
2892 PARATHYROID PROCEDURES WITH CLASS B CC *	3.8	8.0	3445	907	463
2893 PARATHYROID PROCEDURES WITH CLASS A CC *	8.0	24.0	5320	665	478
2900 THYROID PROCEDURES WITH NO CC	2.5	4.5	1910	764	406
2901 THYROID PROCEDURES WITH CLASS C CC	2.7	5.8	2298	851	448
2902 THYROID PROCEDURES WITH CLASS B CC	4.7	11.8	3531	751	488
2903 THYROID PROCEDURES WITH CLASS A CC *	5.0	9.0	5538	1108	504
2910 THYROGLOSSAL PROCEDURES WITH NO CC	1.3	3.5	1291	993	422
2911 THYROGLOSSAL PROCEDURES WITH CLASS C CC *	4.0	4.0	1667	417	428
2912 THYROGLOSSAL PROCEDURES WITH CLASS B CC *	N.A.	N.A.	1259	N.A.	440
2913 THYROGLOSSAL PROCEDURES WITH CLASS A CC *	N.A.	N.A.	1775	N.A.	454
2920 OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH NO CC *	4.0	13.5	3871	968	421
2921 OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH CLASS C CC *	12.0	38.5	5551	463	459
2922 OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH CLASS B CC *	9.5	23.5	8252	869	493
2923 OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH CLASS A CC *	22.0	35.5	10643	484	402
2940 DIABETES AGE > 35 WITH NO CC	4.8	14.5	1584	330	281

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
2941 DIABETES AGE > 35 WITH CLASS C CC	7.1	21.5	2625	370	317
2942 DIABETES AGE > 35 WITH CLASS B CC	9.0	23.5	4342	482	403
2950 DIABETES AGE 0 35 WITH NO CC	3.3	9.5	1416	429	379
2951 DIABETES AGE 0 35 WITH CLASS C CC	4.9	13.0	2344	478	412
2952 DIABETES AGE 0 35 WITH CLASS B CC	6.7	15.0	3652	545	464
2960 NUTRITIONAL & MISC METABOLIC DISORDERS WITH NO CC	4.5	14.5	1647	366	316
2961 NUTRITIONAL & MISC METABOLIC DISORDERS WITH CLASS C CC	6.1	22.0	2367	388	330
2962 NUTRITIONAL & MISC METABOLIC DISORDERS WITH CLASS B CC	11.0	37.0	4290	390	353
2990 INBORN ERRORS OF METABOLISM WITH NO CC	3.8	12.0	1714	451	385
2991 INBORN ERRORS OF METABOLISM WITH CLASS C CC *	5.7	19.5	3266	573	471
2992 INBORN ERRORS OF METABOLISM WITH CLASS B CC *	10.0	28.5	4780	478	434
3000 ENDOCRINE DISORDERS WITH NO CC	5.1	17.0	2222	436	380
3001 ENDOCRINE DISORDERS WITH CLASS C CC	7.2	25.5	2877	400	356
3002 ENDOCRINE DISORDERS WITH CLASS B CC *	10.0	31.8	4723	472	405
3020 KIDNEY TRANSPLANT WITH NO CC	9.5	19.5	23420	2465	1977
3021 KIDNEY TRANSPLANT WITH CLASS C CC	8.8	15.5	21151	2404	1818
3022 KIDNEY TRANSPLANT WITH CLASS B CC	12.0	28.0	31830	2653	1943
3023 KIDNEY TRANSPLANT WITH CLASS A CC *	19.0	39.0	40006	2106	1541
3030 KIDNEY,URETER & MAJ BLADDER PROC FOR NEOPL WITH NO CC	7.8	14.5	4690	601	397
3031 KIDNEY,URETER & MAJ BLADDER PROC FOR NEOPL WITH CLASS C CC	11.0	27.0	6108	555	394
3032 KIDNEY,URETER & MAJ BLADDER PROC FOR NEOPL WITH CLASS B CC	11.0	25.5	7282	662	472
3033 KIDNEY,URETER & MAJ BLADDER PROC FOR NEOPL WITH CLASS A CC	15.0	41.0	10230	682	496
3040 KIDNEY,URETER & MAJ BLAD PROC, NON NEOPL WITH NO CC	6.3	12.5	3597	571	404
3041 KIDNEY,URETER & MAJ BLAD PROC, NON NEOPL WITH CLASS C CC	7.9	20.0	4445	563	405
3042 KIDNEY,URETER & MAJ BLAD PROC, NON NEOPL WITH CLASS B CC	11.0	27.0	6439	585	450
3043 KIDNEY,URETER & MAJ BLAD PROC, NON NEOPL WITH CLASS A CC	16.0	45.0	9482	593	461
3060 PROSTATECTOMY WITH NO CC	4.0	10.5	1984	496	319
3061 PROSTATECTOMY WITH CLASS C CC	8.6	26.5	3565	415	316
3062 PROSTATECTOMY WITH CLASS B CC *	14.0	46.3	5310	379	341
3063 PROSTATECTOMY WITH CLASS A CC *	33.0	75.0	8380	254	344
3080 MINOR BLADDER PROCEDURES WITH NO CC	3.9	12.0	2416	619	389
3081 MINOR BLADDER PROCEDURES WITH CLASS C CC	5.8	18.0	2995	516	352
3082 MINOR BLADDER PROCEDURES WITH CLASS B CC	11.0	25.5	6200	564	401
3083 MINOR BLADDER PROCEDURES WITH CLASS A CC	7.9	29.0	4618	585	395
3100 TRANSURETHRAL PROCEDURES WITH NO CC	2.8	8.5	1680	600	398
3101 TRANSURETHRAL PROCEDURES WITH CLASS C CC	3.8	12.0	2000	526	353
3102 TRANSURETHRAL PROCEDURES WITH CLASS B CC	4.8	14.5	2551	531	365
3103 TRANSURETHRAL PROCEDURES WITH CLASS A CC *	11.0	27.0	3951	359	368
3120 URETHRAL PROCEDURES WITH NO CC	2.2	6.0	1519	690	382
3121 URETHRAL PROCEDURES WITH CLASS C CC *	2.8	12.0	1620	579	333
3122 URETHRAL PROCEDURES WITH CLASS B CC *	5.0	14.5	2310	462	361
3123 URETHRAL PROCEDURES WITH CLASS A CC *	5.0	9.0	3503	701	373
3150 OTHER KIDNEY & URINARY TRACT O.R. PROC WITH NO CC	2.1	4.5	2190	1043	596
3151 OTHER KIDNEY & URINARY TRACT O.R. PROC WITH CLASS C CC	3.7	15.8	2832	765	460
3152 OTHER KIDNEY & URINARY TRACT O.R. PROC WITH CLASS B CC	4.4	17.0	3432	780	469
3153 OTHER KIDNEY & URINARY TRACT O.R. PROC WITH CLASS A CC	19.0	56.8	9880	520	433
3160 RENAL FAILURE WITH NO CC	5.0	17.0	2308	462	370
3161 RENAL FAILURE WITH CLASS C CC	7.4	25.5	3497	473	383
3162 RENAL FAILURE WITH CLASS B CC	14.0	43.5	6829	488	400
3170 ADMIT FOR RENAL DIALYSIS WITH NO CC *	4.0	13.5	2019	505	545
3171 ADMIT FOR RENAL DIALYSIS WITH CLASS C CC *	6.0	13.5	3097	516	527
3172 ADMIT FOR RENAL DIALYSIS WITH CLASS B CC *	15.0	55.0	5297	353	567
3180 KIDNEY & URINARY TRACT NEOPLASMS WITH NO CC	5.7	22.0	3118	547	444
3181 KIDNEY & URINARY TRACT NEOPLASMS WITH CLASS C CC	6.7	24.5	2943	439	364
3182 KIDNEY & URINARY TRACT NEOPLASMS WITH CLASS B CC *	17.0	54.5	5109	301	393
3200 KIDNEY & URINARY TRACT INFECTIONS WITH NO CC	3.6	9.5	1423	395	332
3201 KIDNEY & URINARY TRACT INFECTIONS WITH CLASS C CC	5.5	15.5	2166	394	328

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
3202 KIDNEY & URINARY TRACT INFECTIONS WITH CLASS B CC	7.0	19.0	2749	393	335
3230 URINARY STONES W LITHOTRIPSY WITH NO CC	3.3	9.5	2407	729	406
3231 URINARY STONES W LITHOTRIPSY WITH CLASS C CC *	4.3	10.5	2783	647	340
3232 URINARY STONES W LITHOTRIPSY WITH CLASS B CC *	14.0	14.0	4751	339	366
3240 URINARY STONES WITH NO CC	2.0	6.0	1000	500	371
3241 URINARY STONES WITH CLASS C CC	3.3	9.5	1571	476	362
3242 URINARY STONES WITH CLASS B CC *	6.2	16.5	2620	423	355
3250 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS WITH NO CC	3.1	9.5	1445	466	356
3251 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS WITH CLASS C CC	4.6	14.5	1894	412	324
3252 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS WITH CLASS B CC *	6.2	23.0	3636	586	392
3280 URETHRAL STRICTURE WITH NO CC	1.7	3.5	953	561	326
3281 URETHRAL STRICTURE WITH CLASS C CC *	4.6	13.0	1371	298	344
3282 URETHRAL STRICTURE WITH CLASS B CC *	5.5	11.5	2320	422	370
3310 OTHER KIDNEY & URINARY TRACT DIAGNOSES WITH NO CC	3.4	9.5	1654	486	375
3311 OTHER KIDNEY & URINARY TRACT DIAGNOSES WITH CLASS C CC	5.1	17.0	2402	471	381
3312 OTHER KIDNEY & URINARY TRACT DIAGNOSES WITH CLASS B CC	14.0	43.5	6193	442	390
3340 MAJOR MALE PELVIC PROCEDURES WITH NO CC	6.6	11.0	4002	606	380
3341 MAJOR MALE PELVIC PROCEDURES WITH CLASS C CC	6.7	15.0	4060	606	381
3342 MAJOR MALE PELVIC PROCEDURES WITH CLASS B CC	8.5	14.5	5213	613	407
3343 MAJOR MALE PELVIC PROCEDURES WITH CLASS A CC *	10.0	19.3	6398	640	424
3360 TRANSURETHRAL PROSTATECTOMY WITH NO CC	3.8	8.0	1803	474	309
3361 TRANSURETHRAL PROSTATECTOMY WITH CLASS C CC	5.9	15.5	2558	434	310
3362 TRANSURETHRAL PROSTATECTOMY WITH CLASS B CC	5.9	14.0	2929	496	336
3363 TRANSURETHRAL PROSTATECTOMY WITH CLASS A CC *	11.0	30.0	4575	416	346
3380 TESTES PROCEDURES, FOR MALIGNANCY WITH NO CC	2.5	8.5	1766	706	453
3381 TESTES PROCEDURES, FOR MALIGNANCY WITH CLASS C CC	4.9	17.0	2649	541	372
3382 TESTES PROCEDURES, FOR MALIGNANCY WITH CLASS B CC *	5.6	23.8	4023	718	423
3383 TESTES PROCEDURES, FOR MALIGNANCY WITH CLASS A CC *	48.0	75.0	6314	132	437
3390 TESTES PROCEDURES, NON MALIGNANCY WITH NO CC	1.5	3.5	1259	840	449
3391 TESTES PROCEDURES, NON MALIGNANCY WITH CLASS C CC	2.6	11.0	1491	573	353
3392 TESTES PROCEDURES, NON MALIGNANCY WITH CLASS B CC *	3.0	11.0	2149	716	369
3393 TESTES PROCEDURES, NON MALIGNANCY WITH CLASS A CC *	9.7	30.0	3288	339	381
3410 PENIS PROCEDURES WITH NO CC	3.3	5.5	3135	950	637
3411 PENIS PROCEDURES WITH CLASS C CC *	4.6	10.5	3897	847	612
3412 PENIS PROCEDURES WITH CLASS B CC *	8.1	24.0	4580	565	534
3413 PENIS PROCEDURES WITH CLASS A CC *	22.0	75.0	5790	263	417
3420 CIRCUMCISION WITH NO CC	1.4	3.5	1323	945	371
3421 CIRCUMCISION WITH CLASS C CC *	3.2	13.5	1607	502	375
3422 CIRCUMCISION WITH CLASS B CC *	N.A.	N.A.	1202	N.A.	386
3423 CIRCUMCISION WITH CLASS A CC *	N.A.	N.A.	1472	N.A.	398
3440 OTHER MALE REPROD SYS O.R. PROC FOR MALIG WITH NO CC	2.8	8.5	3566	1274	650
3441 OTHER MALE REPROD SYS O.R. PROC FOR MALIG WITH CLASS C CC	4.1	10.5	2636	643	400
3442 OTHER MALE REPROD SYS O.R. PROC FOR MALIG WITH CLASS B CC *	5.5	15.5	4037	734	461
3443 OTHER MALE REPROD SYS O.R. PROC FOR MALIG WITH CLASS A CC *	17.0	38.5	6225	366	476
3450 OTHER MALE REPROD SYS O.R. PROC EX MALIG WITH NO CC *	2.9	7.0	2919	1006	349
3451 OTHER MALE REPROD SYS O.R. PROC EX MALIG WITH CLASS C CC *	4.0	16.0	3626	906	353
3452 OTHER MALE REPROD SYS O.R. PROC EX MALIG WITH CLASS B CC *	N.A.	N.A.	740	N.A.	362
3453 OTHER MALE REPROD SYS O.R. PROC EX MALIG WITH CLASS A CC *	N.A.	N.A.	13591	N.A.	374
3460 MALIGNANCY, MALE REPRODUCTIVE SYSTEM WITH NO CC	5.7	15.5	2790	490	404
3461 MALIGNANCY, MALE REPRODUCTIVE SYSTEM WITH CLASS C CC	8.7	30.5	3597	413	347
3462 MALIGNANCY, MALE REPRODUCTIVE SYSTEM WITH CLASS B CC *	12.0	35.5	5766	480	347
3480 BENIGN PROSTATIC HYPERTROPHY WITH NO CC	3.3	11.0	1399	424	336
3481 BENIGN PROSTATIC HYPERTROPHY WITH CLASS C CC	6.5	22.0	2479	381	325
3482 BENIGN PROSTATIC HYPERTROPHY WITH CLASS B CC *	6.8	21.8	3382	497	284
3500 INFLAMMATION OF THE MALE REPRODUCTIVE SYS WITH NO CC	4.1	12.0	1499	366	306
3501 INFLAMMATION OF THE MALE REPRODUCTIVE SYS WITH CLASS C CC	5.7	15.5	2098	368	312
3502 INFLAMMATION OF THE MALE REPRODUCTIVE SYS WITH CLASS B CC *	6.4	14.0	3062	478	290

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
3510 STERILIZATION, MALE WITH NO CC *	1.0	1.0	3280	3280	371
3511 STERILIZATION, MALE WITH CLASS C CC *	N.A.	N.A.	946	N.A.	375
3512 STERILIZATION, MALE WITH CLASS B CC *	N.A.	N.A.	1202	N.A.	386
3520 OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES WITH NO CC	2.0	6.0	1029	514	367
3521 OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES WITH CLASS C CC *	6.4	27.0	1613	252	403
3522 OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES WITH CLASS B CC *	7.0	7.0	2733	390	433
3530 PELVIC EVIS, RAD HYSTER & RAD VULVECTOMY WITH NO CC	6.2	12.5	3953	638	426
3531 PELVIC EVIS, RAD HYSTER & RAD VULVECTOMY WITH CLASS C CC *	8.6	21.0	5015	583	415
3532 PELVIC EVIS, RAD HYSTER & RAD VULVECTOMY WITH CLASS B CC *	13.0	33.0	7880	606	498
3533 PELVIC EVIS, RAD HYSTER & RAD VULVECTOMY WITH CLASS A CC *	N.A.	N.A.	2898	N.A.	514
3540 UTER,ADNEXA PROC FOR NON OVAR/ADNEXA MALIG WITH NO CC	5.3	11.5	2752	519	352
3541 UTER,ADNEXA PROC FOR NON OVAR/ADNEXA MALIG WITH CLASS C CC	6.2	10.0	3560	574	389
3542 UTER,ADNEXA PROC FOR NON OVAR/ADNEXA MALIG WITH CLASS B CC	9.0	21.0	5228	581	431
3543 UTER,ADNEXA PROC FOR NON OVAR/ADNEXA MALIG WITH CLASS A CC *	29.0	75.0	9131	315	496
3560 FEMALE REPROD SYS RECONSTRUCTIVE PROC WITH NO CC	5.1	9.0	2185	428	291
3561 FEMALE REPROD SYS RECONSTRUCTIVE PROC WITH CLASS C CC	7.8	16.0	3010	386	286
3562 FEMALE REPROD SYS RECONSTRUCTIVE PROC WITH CLASS B CC	7.6	17.5	3501	461	336
3563 FEMALE REPROD SYS RECONSTRUCTIVE PROC WITH CLASS A CC *	35.0	75.0	5603	160	347
3570 UTER & ADNEXA PROC FOR OVAR/ADNEXAL MALIG WITH NO CC	6.0	14.0	3502	584	411
3571 UTER & ADNEXA PROC FOR OVAR/ADNEXAL MALIG WITH CLASS C CC	9.0	18.5	5603	623	440
3572 UTER & ADNEXA PROC FOR OVAR/ADNEXAL MALIG WITH CLASS B CC	11.0	25.5	6817	620	469
3573 UTER & ADNEXA PROC FOR OVAR/ADNEXAL MALIG WITH CLASS A CC *	18.0	50.5	10759	598	484
3580 UTERINE & ADNEXA PROC FOR NON MALIGNANCY WITH NO CC	4.4	8.0	2352	535	341
3581 UTERINE & ADNEXA PROC FOR NON MALIGNANCY WITH CLASS C CC	5.8	10.0	3035	523	352
3582 UTERINE & ADNEXA PROC FOR NON MALIGNANCY WITH CLASS B CC	6.4	12.5	3485	545	367
3583 UTERINE & ADNEXA PROC FOR NON MALIGNANCY WITH CLASS A CC	8.5	20.0	5530	651	498
3600 VAGINA, CERVIX & VULVA PROCEDURES WITH NO CC	3.3	11.0	1853	562	364
3601 VAGINA, CERVIX & VULVA PROCEDURES WITH CLASS C CC	5.2	13.0	2589	498	341
3602 VAGINA, CERVIX & VULVA PROCEDURES WITH CLASS B CC	5.2	11.5	3320	638	424
3603 VAGINA, CERVIX & VULVA PROCEDURES WITH CLASS A CC *	12.0	55.3	5120	427	438
3610 LAPAROSCOPY & INCIS TUBAL INTERRUPTION WITH NO CC	2.0	6.0	1478	739	445
3611 LAPAROSCOPY & INCIS TUBAL INTERRUPTION WITH CLASS C CC	2.2	4.5	1756	798	511
3612 LAPAROSCOPY & INCIS TUBAL INTERRUPTION WITH CLASS B CC *	5.1	13.0	2210	433	457
3613 LAPAROSCOPY & INCIS TUBAL INTERRUPTION WITH CLASS A CC *	N.A.	N.A.	3875	N.A.	472
3620 ENDOSCOPIC TUBAL INTERRUPTION WITH NO CC	1.4	3.5	1133	809	432
3621 ENDOSCOPIC TUBAL INTERRUPTION WITH CLASS C CC *	1.6	3.5	1435	897	437
3622 ENDOSCOPIC TUBAL INTERRUPTION WITH CLASS B CC *	1.5	3.5	1982	1321	449
3623 ENDOSCOPIC TUBAL INTERRUPTION WITH CLASS A CC *	N.A.	N.A.	1174	N.A.	464
3630 D&C, CONIZATION & RADIO IMPLANT, FOR MALIG WITH NO CC	1.7	3.5	1339	787	545
3631 D&C, CONIZATION & RADIO IMPLANT, FOR MALIG WITH CLASS C CC	2.3	7.8	1489	647	471
3632 D&C, CONIZATION & RADIO IMPLANT, FOR MALIG WITH CLASS B CC *	3.4	14.5	1848	544	431
3633 D&C, CONIZATION & RADIO IMPLANT, FOR MALIG WITH CLASS A CC *	3.0	3.0	2780	927	445
3640 D&C, CONIZATION EXCEPT FOR MALIGNANCY WITH NO CC	1.4	3.5	950	679	435
3641 D&C, CONIZATION EXCEPT FOR MALIGNANCY WITH CLASS C CC	1.7	3.5	1161	683	501
3642 D&C, CONIZATION EXCEPT FOR MALIGNANCY WITH CLASS B CC *	1.8	3.5	1521	845	443
3643 D&C, CONIZATION EXCEPT FOR MALIGNANCY WITH CLASS A CC *	2.5	4.5	2298	919	457
3650 OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROC WITH NO CC	4.9	13.0	2440	498	347
3651 OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROC WITH CLASS C CC *	5.8	12.5	3519	607	398
3652 OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROC WITH CLASS B CC *	12.0	40.5	5080	423	434
3653 OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROC WITH CLASS A CC *	50.0	50.0	7929	159	448
3660 MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH NO CC	4.5	18.5	2232	496	432
3661 MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CLASS C CC	7.5	25.5	3687	492	433
3662 MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CLASS B CC *	11.0	33.5	6238	567	463
3680 INFECTIONS, FEMALE REPRODUCTIVE SYSTEM WITH NO CC	3.2	7.0	1353	423	358
3681 INFECTIONS, FEMALE REPRODUCTIVE SYSTEM WITH CLASS C CC	4.2	8.0	1874	446	385
3682 INFECTIONS, FEMALE REPRODUCTIVE SYSTEM WITH CLASS B CC *	4.6	9.0	2953	642	380
3690 MENSTRUAL & OTHER FEMALE REPROD SYS DIAG WITH NO CC	1.5	3.5	748	498	396

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
3691 MENSTRUAL & OTHER FEMALE REPROD SYS DIAG WITH CLASS C CC	2.8	11.0	1318	471	383
3692 MENSTRUAL & OTHER FEMALE REPROD SYS DIAG WITH CLASS B CC *	7.8	30.8	2050	263	378
3700 CESAREAN SECTION WITH NO CC	4.9	9.0	2453	501	459
3701 CESAREAN SECTION WITH CLASS C CC	5.7	10.0	2983	523	481
3702 CESAREAN SECTION WITH CLASS B CC	7.0	15.0	3813	545	502
3703 CESAREAN SECTION WITH CLASS A CC *	8.2	18.0	6199	756	711
3720 VAGINAL DELIVERY W COMPLICATING DIAG WITH NO CC	3.1	7.0	1829	590	432
3721 VAGINAL DELIVERY W COMPLICATING DIAG WITH CLASS C CC	3.6	8.0	2141	595	435
3722 VAGINAL DELIVERY W COMPLICATING DIAG WITH CLASS B CC *	4.2	14.5	3022	720	555
3730 VAGINAL DELIVERY W/O COMPLICATING DIAG WITH NO CC	2.5	4.5	1454	582	432
3731 VAGINAL DELIVERY W/O COMPLICATING DIAG WITH CLASS C CC	3.0	7.0	1745	582	441
3732 VAGINAL DELIVERY W/O COMPLICATING DIAG WITH CLASS B CC *	4.4	14.5	1928	438	448
3740 VAGINAL DELIVERY W STERILIZATION &/OR D&C WITH NO CC	3.2	5.5	2261	707	609
3741 VAGINAL DELIVERY W STERILIZATION &/OR D&C WITH CLASS C CC	3.8	8.0	2623	690	615
3742 VAGINAL DELIVERY W STERILIZATION &/OR D&C WITH CLASS B CC	4.2	8.0	2541	605	530
3743 VAGINAL DELIVERY W STERILIZATION &/OR D&C WITH CLASS A CC *	4.0	4.0	3366	842	649
3750 VAGINAL DEL W OR PROC EXC STERIL &/OR D&C WITH NO CC *	6.1	18.0	2340	384	572
3751 VAGINAL DEL W OR PROC EXC STERIL &/OR D&C WITH CLASS C CC *	8.7	42.0	3738	430	793
3752 VAGINAL DEL W OR PROC EXC STERIL &/OR D&C WITH CLASS B CC *	N.A.	N.A.	2190	N.A.	477
3753 VAGINAL DEL W OR PROC EXC STERIL &/OR D&C WITH CLASS A CC *	N.A.	N.A.	3767	N.A.	584
3760 POSTPART & POST ABORTION DIAG W/O OR PROC WITH NO CC	2.6	8.5	1095	421	348
3761 POSTPART & POST ABORTION DIAG W/O OR PROC WITH CLASS C CC	3.1	7.0	1395	450	372
3762 POSTPART & POST ABORTION DIAG W/O OR PROC WITH CLASS B CC *	4.4	10.5	1719	391	427
3770 POSTPART & POST ABORTION DIAG W OR PROC WITH NO CC	1.3	3.5	928	714	510
3771 POSTPART & POST ABORTION DIAG W OR PROC WITH CLASS C CC	1.6	3.5	1077	673	503
3772 POSTPART & POST ABORTION DIAG W OR PROC WITH CLASS B CC *	2.7	11.0	2183	808	628
3773 POSTPART & POST ABORTION DIAG W OR PROC WITH CLASS A CC *	64.0	64.0	2939	46	768
3780 ECTOPIC PREGNANCY WITH NO CC	2.9	7.0	1935	667	398
3781 ECTOPIC PREGNANCY WITH CLASS C CC	4.1	8.0	2533	618	392
3782 ECTOPIC PREGNANCY WITH CLASS B CC *	5.0	9.0	2885	577	420
3790 THREATENED ABORTION WITH NO CC	1.0	1.0	668	668	467
3791 THREATENED ABORTION WITH CLASS C CC	1.5	3.5	975	650	456
3792 THREATENED ABORTION WITH CLASS B CC *	1.8	4.8	1029	571	440
3800 ABORTION W/O D&C WITH NO CC	1.3	3.5	1007	775	574
3801 ABORTION W/O D&C WITH CLASS C CC *	1.9	6.0	1520	800	533
3810 ABORTION W D&C, ASPIR CURET OR HYSTEROTOMY WITH NO CC	1.0	1.0	844	844	660
3811 ABORTION W D&C, ASPIR CURET OR HYSTEROTOMY WITH CLASS C CC	1.8	6.0	1350	750	623
3812 ABORTION W D&C, ASPIR CURET OR HYSTEROTOMY WITH CLASS B CC *	1.6	3.5	1579	987	547
3820 FALSE LABOR WITH NO CC	1.0	1.0	533	533	419
3821 FALSE LABOR WITH CLASS C CC	1.0	1.0	599	599	463
3822 FALSE LABOR WITH CLASS B CC *	1.5	3.5	617	411	493
3830 OTHER ANTEPARTUM DIAG W MEDICAL COMPLIC WITH NO CC	1.5	3.5	587	392	321
3831 OTHER ANTEPARTUM DIAG W MEDICAL COMPLIC WITH CLASS C CC	2.5	8.5	1032	413	336
3832 OTHER ANTEPARTUM DIAG W MEDICAL COMPLIC WITH CLASS B CC	2.7	7.0	1269	470	379
3840 OTHER ANTEPARTUM DIAG W/O MEDICAL COMPLIC WITH NO CC	1.3	3.5	675	519	384
3841 OTHER ANTEPARTUM DIAG W/O MEDICAL COMPLIC WITH CLASS C CC	2.0	6.0	1016	508	394
3842 OTHER ANTEPARTUM DIAG W/O MEDICAL COMPLIC WITH CLASS B CC *	2.0	2.0	973	486	337
3860 BIRTH WEIGHT < 1000G WITH NO NEONATE CC *	2.3	8.5	766	333	485
3861 BIRTH WEIGHT < 1000G WITH CLASS C NEONATE CC *	4.0	4.0	1777	444	490
3862 BIRTH WEIGHT < 1000G WITH CLASS B NEONATE CC *	27.0	75.0	12569	466	492
3863 BIRTH WEIGHT < 1000G WITH CLASS A NEONATE CC *	60.0	75.0	30944	516	541
3880 BIRTH WEIGHT 1500-2499G WITH NO NEONATE CC	5.2	17.0	1443	277	286
3881 BIRTH WEIGHT 1500- 2499G WITH CLASS C NEONATE CC	5.2	11.5	1394	268	275
3882 BIRTH WEIGHT 1500- 2499G WITH CLASS B NEONATE CC	16.0	40.0	5719	357	367
3883 BIRTH WEIGHT 1500- 2499G WITH CLASS A NEONATE CC	27.0	75.0	8230	305	415
3893 BIRTH WEIGHT 1000-1499G (ALL CLASSES 0F CC) *	N.A.	N.A.	23761	N.A.	433
3910 BIRTH WEIGHT >= 2500G WITH NO NEONATE CC	2.3	4.5	445	193	197

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
3911 BIRTH WEIGHT >= 2500G WITH CLASS C NEONATE CC	3.6	9.5	732	203	209
3912 BIRTH WEIGHT >= 2500G WITH CLASS B NEONATE CC	3.4	9.5	992	292	301
3913 BIRTH WEIGHT >= 2500G WITH CLASS A NEONATE CC	4.6	13.0	1595	347	352
3920 SPLENECTOMY WITH NO CC	6.5	15.0	3852	593	434
3921 SPLENECTOMY WITH CLASS C CC *	7.5	9.5	6885	918	631
3922 SPLENECTOMY WITH CLASS B CC *	9.7	29.3	6846	706	515
3923 SPLENECTOMY WITH CLASS A CC *	11.0	31.0	11112	1010	550
3940 OTHER O.R. PROCEDURES OF THE BLOOD WITH NO CC	2.9	11.0	1938	668	425
3941 OTHER O.R. PROCEDURES OF THE BLOOD WITH CLASS C CC *	2.3	7.0	2549	1108	454
3942 OTHER O.R. PROCEDURES OF THE BLOOD WITH CLASS B CC *	16.0	47.0	3579	224	477
3943 OTHER O.R. PROCEDURES OF THE BLOOD WITH CLASS A CC *	30.0	75.0	7491	250	665
3950 RED BLOOD CELL DISORDERS WITH NO CC	3.7	12.0	1552	419	351
3951 RED BLOOD CELL DISORDERS WITH CLASS C CC	5.3	17.0	2548	481	385
3952 RED BLOOD CELL DISORDERS WITH CLASS B CC	7.9	30.5	4212	533	410
3970 COAGULATION DISORDERS WITH NO CC	3.6	11.0	2600	722	577
3971 COAGULATION DISORDERS WITH CLASS C CC	4.0	14.5	2720	680	511
3972 COAGULATION DISORDERS WITH CLASS B CC	5.5	18.0	4552	828	631
3980 RETICULOENDOTHELIAL & IMMUNITY DISORDERS WITH NO CC	3.7	12.0	1837	496	413
3981 RETICULOENDOTHELIAL & IMMUNITY DISORDERS WITH CLASS C CC	7.2	21.5	4376	608	530
3982 RETICULOENDOTHELIAL & IMMUNITY DISORDERS WITH CLASS B CC	8.4	24.5	5945	708	564
4000 LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE WITH NO CC	6.1	18.0	3709	608	403
4001 LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE WITH CLASS C CC *	4.5	13.0	4229	940	384
4002 LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE WITH CLASS B CC	13.0	33.0	7713	593	452
4003 LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE WITH CLASS A CC	25.0	75.0	19726	789	649
4010 LYMPHOMA & NON ACUTE LEUKE W OTH OR PROC WITH NO CC	4.3	14.5	2725	634	427
4011 LYMPHOMA & NON ACUTE LEUKE W OTH OR PROC WITH CLASS C CC *	9.0	25.0	4447	494	383
4012 LYMPHOMA & NON ACUTE LEUKE W OTH OR PROC WITH CLASS B CC *	9.6	36.5	7456	777	463
4013 LYMPHOMA & NON ACUTE LEUKE W OTH OR PROC WITH CLASS A CC *	26.0	64.0	9514	366	380
4030 LYMPHOMA & NON-ACUTE LEUKEMIA WITH NO CC	5.1	19.5	2649	519	426
4031 LYMPHOMA & NON ACUTE LEUKEMIA WITH CLASS C CC	8.6	29.0	3908	454	381
4032 LYMPHOMA & NON ACUTE LEUKEMIA WITH CLASS B CC	11.0	40.0	7259	660	541
4050 ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE WITH NO CC	3.9	17.0	3220	826	752
4051 ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE WITH CLASS C CC *	21.0	75.0	5271	251	754
4052 ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE WITH CLASS B CC	26.0	75.0	29992	1154	1126
4060 MYEL DIS OR POOR DIFF NEOPL W MAJ OR PROC WITH NO CC	5.7	14.0	3829	672	457
4061 MYEL DIS OR POOR DIFF NEOPL W MAJ OR PROC WITH CLASS C CC *	8.9	24.3	7570	851	715
4062 MYEL DIS OR POOR DIFF NEOPL W MAJ OR PROC WITH CLASS B CC *	20.0	61.8	6573	329	459
4063 MYEL DIS OR POOR DIFF NEOPL W MAJ OR PROC WITH CLASS A CC *	14.0	48.0	10848	775	509
4080 MYEL DIS OR POOR DIFF NEOPL W OTH O.R.PROC WITH NO CC	2.2	5.3	1925	875	541
4081 MYEL DIS OR POOR DIFF NEOPL W OTH O.R.PROC WITH CLASS C CC *	6.5	23.0	2038	314	491
4082 MYEL DIS OR POOR DIFF NEOPL W OTH O.R.PROC WITH CLASS B CC *	18.0	66.3	2815	156	509
4083 MYEL DIS OR POOR DIFF NEOPL W OTH O.R.PROC WITH CLASS A CC *	11.0	11.0	5534	503	643
4090 RADIOTHERAPY WITH NO CC *	1.7	6.0	1442	848	671
4091 RADIOTHERAPY WITH CLASS C CC	4.2	13.0	2270	541	415
4092 RADIOTHERAPY WITH CLASS B CC *	18.0	68.0	3854	214	446
4100 CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SEC DX WITH NO CC	1.4	3.5	1042	744	601
4101 CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SEC DX WITH CLASS C CC	2.7	8.5	1682	623	520
4102 CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SEC DX WITH CLASS B CC	5.0	17.0	3268	654	474
4110 HISTORY OF MALIGNANCY W/O ENDOSCOPY WITH NO CC	3.0	9.5	1957	652	582
4111 HISTORY OF MALIGNANCY W/O ENDOSCOPY WITH CLASS C CC	8.7	24.0	5293	608	580
4112 HISTORY OF MALIGNANCY W/O ENDOSCOPY WITH CLASS B CC *	8.4	29.0	9052	1078	623
4120 HISTORY OF MALIGNANCY W ENDOSCOPY WITH NO CC *	2.9	11.0	1596	550	582
4121 HISTORY OF MALIGNANCY W ENDOSCOPY WITH CLASS C CC *	9.5	43.5	2435	256	580
4122 HISTORY OF MALIGNANCY W ENDOSCOPY WITH CLASS B CC *	6.0	22.0	4134	689	623
4130 OTHER MYEL DIS OR POORLY DIFF NEOPL DIAG WITH NO CC	7.1	26.8	3389	477	413
4131 OTHER MYEL DIS OR POORLY DIFF NEOPL DIAG WITH CLASS C CC	9.9	31.5	4241	428	366
4132 OTHER MYEL DIS OR POORLY DIFF NEOPL DIAG WITH CLASS B CC	13.0	42.5	6557	504	437

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
4150 O.R. PROC FOR INFECTIOUS & PARASITIC DIS WITH NO CC	7.8	24.0	3379	433	337
4151 O.R. PROC FOR INFECTIOUS & PARASITIC DIS WITH CLASS C CC *	11.0	28.5	4629	421	366
4152 O.R. PROC FOR INFECTIOUS & PARASITIC DIS WITH CLASS B CC	16.0	44.3	7750	484	385
4153 O.R. PROC FOR INFECTIOUS & PARASITIC DIS WITH CLASS A CC	20.0	57.0	10235	512	416
4160 SEPTICEMIA WITH NO CC	4.2	12.0	1750	417	352
4161 SEPTICEMIA WITH CLASS C CC	7.3	21.5	3158	433	358
4162 SEPTICEMIA WITH CLASS B CC	14.0	39.0	6739	481	406
4180 POSTOPERATIVE & POST TRAUMATIC INFECTIONS WITH NO CC	5.2	15.5	1861	358	307
4181 POSTOP & POST TRAUMATIC INFECTIONS WITH CLASS C CC	5.9	18.0	2164	367	309
4182 POSTOP & POST TRAUMATIC INFECTIONS WITH CLASS B CC	9.8	35.0	4109	419	351
4190 FEVER OF UNKNOWN ORIGIN WITH NO CC	2.5	8.5	1200	480	399
4191 FEVER OF UNKNOWN ORIGIN WITH CLASS C CC	4.6	14.5	2237	486	403
4192 FEVER OF UNKNOWN ORIGIN WITH CLASS B CC	5.6	20.5	2922	522	451
4210 VIRAL ILLNESS WITH NO CC	2.6	8.5	1194	459	391
4211 VIRAL ILLNESS WITH CLASS C CC	3.8	12.0	1702	448	391
4212 VIRAL ILLNESS WITH CLASS B CC	4.8	13.0	2958	616	556
4230 OTHER INFECTIOUS & PARASITIC DISEASES DIAG WITH NO CC	5.7	19.5	2297	403	356
4231 OTHER INFECTIOUS & PARASITIC DISEASES DIAG WITH CLASS C CC	10.0	34.0	4301	430	381
4232 OTHER INFECTIOUS & PARASITIC DISEASES DIAG WITH CLASS B CC *	12.0	27.0	8834	736	488
4240 O.R. PROC W PRINCIPAL DIAG OF MENTAL ILL WITH NO CC	18.0	65.0	6129	340	300
4241 O.R. PROC W PRINCIPAL DIAG OF MENTAL ILL WITH CLASS C CC *	25.0	46.5	7631	305	294
4242 O.R. PROC W PRINCIPAL DIAG OF MENTAL ILL WITH CLASS B CC *	38.0	75.0	11208	295	306
4243 O.R. PROC W PRINCIPAL DIAG OF MENTAL ILL WITH CLASS A CC *	40.0	75.0	19529	488	328
4250 ACUTE ADJ REA & DISTURB OF PSYCHOSOC DYSF WITH NO CC	3.0	11.0	1040	347	351
4251 ACUTE ADJ REA & DISTURB OF PSYCHOSOC DYSF WITH CLASS C CC	4.5	19.5	1710	380	383
4252 ACUTE ADJ REA & DISTURB OF PSYCHOSOC DYSF WITH CLASS B CC *	3.5	14.5	3266	933	434
4260 DEPRESSIVE NEUROSES WITH NO CC	6.4	23.0	1973	308	323
4261 DEPRESSIVE NEUROSES WITH CLASS C CC	7.6	28.0	2441	321	342
4262 DEPRESSIVE NEUROSES WITH CLASS B CC	19.0	71.0	7778	409	419
4270 NEUROSES EXCEPT DEPRESSIVE WITH NO CC	9.1	33.0	2797	307	319
4271 NEUROSES EXCEPT DEPRESSIVE WITH CLASS C CC	8.1	33.0	2588	319	329
4272 NEUROSES EXCEPT DEPRESSIVE WITH CLASS B CC *	8.0	8.0	4907	613	362
4280 DISORDERS OF PERSONALITY & IMPULSE CONTROL WITH NO CC	8.9	35.5	2685	302	318
4281 DISORDERS OF PERSONALITY & IMPULSE CONTROL WITH CLASS C CC	13.0	54.0	4067	313	333
4282 DISORDERS OF PERSONALITY & IMPULSE CONTROL WITH CLASS B CC *	14.0	48.0	7753	554	367
4290 ORGANIC DISTURBANCES & MENTAL RETARDATION WITH NO CC	14.0	52.5	4625	330	338
4291 ORGANIC DISTURBANCES & MENTAL RETARDATION WITH CLASS C CC	22.0	70.0	7705	350	360
4292 ORGANIC DISTURBANCES & MENTAL RETARDATION WITH CLASS B CC	26.0	75.0	9416	362	365
4300 PSYCHOSES WITH NO CC	19.0	63.5	5483	289	306
4301 PSYCHOSES WITH CLASS C CC	21.0	69.5	6436	306	320
4302 PSYCHOSES WITH CLASS B CC	27.0	75.0	9206	341	349
4310 CHILDHOOD MENTAL DISORDERS WITH NO CC	9.5	39.5	3118	328	346
4311 CHILDHOOD MENTAL DISORDERS WITH CLASS C CC *	15.0	54.8	3750	250	322
4312 CHILDHOOD MENTAL DISORDERS WITH CLASS B CC *	17.0	54.0	7168	422	354
4320 OTHER MENTAL DISORDER DIAGNOSES WITH NO CC	8.5	30.5	2690	316	355
4321 OTHER MENTAL DISORDER DIAGNOSES WITH CLASS C CC *	3.1	11.5	3768	1216	365
4322 OTHER MENTAL DISORDER DIAGNOSES WITH CLASS B CC *	5.7	33.5	7264	1274	401
4330 ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA WITH NO CC	1.9	6.0	699	368	368
4331 ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA WITH CLASS C CC	2.8	8.5	1106	395	396
4332 ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA WITH CLASS B CC *	2.5	8.5	1708	683	427
4340 ALC/DRUG ABUSE OR DEPEND OR OTH SYMPTOMS WITH NO CC	3.5	9.5	1075	307	313
4341 ALC/DRUG ABUSE OR DEPEND OR OTH SYMPTOMS WITH CLASS C CC	4.9	15.5	1681	343	346
4342 ALC/DRUG ABUSE OR DEPEND OR OTH SYMPTOMS WITH CLASS B CC	7.1	23.0	3017	425	430
4390 SKIN GRAFTS FOR INJURIES WITH NO CC	5.8	21.5	2970	512	321
4391 SKIN GRAFTS FOR INJURIES WITH CLASS C CC *	N.A.	N.A.	1771	N.A.	439
4392 SKIN GRAFTS FOR INJURIES WITH CLASS B CC *	14.0	50.5	5641	403	370
4393 SKIN GRAFTS FOR INJURIES WITH CLASS A CC *	22.0	75.0	5483	249	290

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
4400 WOUND DEBRIDEMENTS FOR INJURIES WITH NO CC	6.3	25.5	3211	510	377
4401 WOUND DEBRIDEMENTS FOR INJURIES WITH CLASS C CC *	8.7	36.5	3964	456	385
4402 WOUND DEBRIDEMENTS FOR INJURIES WITH CLASS B CC *	19.0	50.0	6486	341	438
4403 WOUND DEBRIDEMENTS FOR INJURIES WITH CLASS A CC *	25.0	75.0	10138	406	445
4410 HAND PROCEDURES FOR INJURIES WITH NO CC	3.0	8.5	2108	703	397
4411 HAND PROCEDURES FOR INJURIES WITH CLASS C CC *	9.0	32.5	2522	280	414
4412 HAND PROCEDURES FOR INJURIES WITH CLASS B CC *	9.3	22.5	3621	389	402
4413 HAND PROCEDURES FOR INJURIES WITH CLASS A CC *	8.2	18.5	5661	690	415
4420 OTHER O.R. PROCEDURES FOR INJURIES WITH NO CC	3.4	13.5	2228	655	431
4421 OTHER O.R. PROCEDURES FOR INJURIES WITH CLASS C CC	6.3	23.0	3809	605	455
4422 OTHER O.R. PROCEDURES FOR INJURIES WITH CLASS B CC	11.0	36.0	6533	594	443
4423 OTHER O.R. PROCEDURES FOR INJURIES WITH CLASS A CC	17.0	55.5	9677	569	466
4440 MULTIPLE TRAUMA WITH NO CC	2.4	8.5	1248	520	406
4441 MULTIPLE TRAUMA WITH CLASS C CC	5.1	17.0	2208	433	375
4442 MULTIPLE TRAUMA WITH CLASS B CC	11.0	33.5	4716	429	373
4470 ALLERGIC REACTIONS WITH NO CC	1.3	3.5	604	465	392
4471 ALLERGIC REACTIONS WITH CLASS C CC *	3.4	13.5	1069	315	399
4472 ALLERGIC REACTIONS WITH CLASS B CC *	2.3	8.5	2051	892	480
4490 POISONING & TOXIC EFFECTS OF DRUGS WITH NO CC	1.4	3.5	713	509	544
4491 POISONING & TOXIC EFFECTS OF DRUGS WITH CLASS C CC	2.7	8.5	1342	497	412
4492 POISONING & TOXIC EFFECTS OF DRUGS WITH CLASS B CC	6.2	20.5	3589	579	517
4520 COMPLICATIONS OF TREATMENT WITH NO CC	2.1	6.0	930	443	342
4521 COMPLICATIONS OF TREATMENT WITH CLASS C CC	4.8	14.5	2117	441	361
4522 COMPLICATIONS OF TREATMENT WITH CLASS B CC	8.8	33.0	4163	473	402
4540 OTHER INJURY, POISONING & TOXIC EFF DIAG WITH NO CC	2.8	11.0	2311	825	695
4541 OTHER INJURY, POISONING & TOXIC EFF DIAG WITH CLASS C CC	2.8	11.0	1837	656	459
4542 OTHER INJURY, POISONING & TOXIC EFF DIAG WITH CLASS B CC *	6.3	23.0	3184	505	528
4560 BURNS, TRANSFERRED TO ANOTHER FACILITY WITH NO CC *	4.7	13.0	2208	470	501
4561 BURNS, TRANSFERRED TO ANOTHER FACILITY WITH CLASS C CC *	N.A.	N.A.	14336	N.A.	883
4562 BURNS, TRANSFERRED TO ANOTHER FACILITY WITH CLASS B CC *	N.A.	N.A.	22769	N.A.	298
4572 EXTENSIVE BURNS W/O O.R. PROCEDURE WITH CLASS B CC *	N.A.	N.A.	8604	N.A.	436
4580 NON EXTENSIVE BURNS W SKIN GRAFT WITH NO CC	12.0	37.5	5423	452	384
4581 NON EXTENSIVE BURNS W SKIN GRAFT WITH CLASS C CC *	12.0	24.0	6054	504	405
4582 NON EXTENSIVE BURNS W SKIN GRAFT WITH CLASS B CC *	25.0	75.0	15248	610	516
4583 NON EXTENSIVE BURNS W SKIN GRAFT WITH CLASS A CC *	21.0	57.5	18898	900	740
4590 NON EXTENS BURNS W WOUND DBRID/OTH OR PROC WITH NO CC *	8.5	18.5	3035	357	329
4591 NON EXTENS BURNS W WOUND DBRID/OTH OR PROC WITH CLASS C CC *	8.5	32.5	2493	293	333
4600 NON EXTENSIVE BURNS W/O O.R. PROCEDURE WITH NO CC	4.5	16.0	2018	448	407
4601 NON EXTENSIVE BURNS W/O O.R. PROCEDURE WITH CLASS C CC	6.7	21.5	2597	388	345
4602 NON EXTENSIVE BURNS W/O O.R. PROCEDURE WITH CLASS B CC *	17.0	58.0	10845	638	581
4610 OR PROC W DIAG OF OTH CONTAC W HEALTH SERV WITH NO CC	3.6	9.5	2269	630	434
4611 OR PROC W DIAG OF OTH CONTAC W HEALTH SERV WITH CLASS C CC *	4.5	29.5	2644	588	416
4612 OR PROC W DIAG OF OTH CONTAC W HEALTH SERV WITH CLASS B CC	23.0	75.0	11044	480	447
4613 OR PROC W DIAG OF OTH CONTAC W HEALTH SERV WITH CLASS A CC	47.0	75.0	21846	465	451
4620 REHABILITATION WITH NO CC	21.0	65.0	7093	338	339
4621 REHABILITATION WITH CLASS C CC	34.0	75.0	14237	419	436
4622 REHABILITATION WITH CLASS B CC *	43.0	75.0	22157	515	420
4630 SIGNS & SYMPTOMS WITH NO CC	4.7	17.0	2059	438	373
4631 SIGNS & SYMPTOMS WITH CLASS C CC	6.4	24.5	2702	422	351
4632 SIGNS & SYMPTOMS WITH CLASS B CC	11.0	41.5	4179	380	332
4650 AFTERCARE WITH NO CC	1.9	6.0	1137	599	462
4651 AFTERCARE WITH CLASS C CC	7.0	23.0	4578	654	603
4652 AFTERCARE WITH CLASS B CC *	4.9	20.5	4758	971	392
4670 OTHER FACTORS INFLUENCING HEALTH STATUS WITH NO CC	2.8	13.5	1040	371	318
4671 OTHER FACTORS INFLUENCING HEALTH STATUS WITH CLASS C CC	4.7	18.5	2630	560	431
4672 OTHER FACTORS INFLUENCING HEALTH STATUS WITH CLASS B CC	7.7	32.0	3338	433	349
4680 EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	7.9	30.5	4669	591	452

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
4690 PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGOSIS *	7.0	27.0	4050	579	559
4700 UNGROUPABLE *	4.1	9.5	1541	376	363
4710 BILAT OR MULT MAJ JT PROCS OF LOWER EXTREM WITH NO CC *	24.0	46.5	9374	391	791
4711 BILAT OR MULT MAJ JT PROCS OF LOWER EXTREM WITH CLASS C CC *	17.0	17.0	12234	720	829
4712 BILAT OR MULT MAJ JT PROCS OF LOWER EXTREM WITH CLASS B CC *	21.0	48.0	13451	641	639
4713 BILAT OR MULT MAJ JT PROCS OR LOWER EXTREM WITH CLASS A CC *	48.0	61.5	21088	439	660
4720 EXTENSIVE BURNS W O.R. PROCEDURE WITH NO CC *	N.A.	N.A.	18406	N.A.	384
4722 EXTENSIVE BURNS W O.R. PROCEDURE WITH CLASS B CC *	9.0	9.0	3353	373	389
4723 EXTENSIVE BURNS W O.R. PROCEDURE WITH CLASS A CC *	64.0	75.0	26416	413	413
4750 RESP SYS DIAG WITH VENT SUPP W NO CC *	6.2	23.8	4385	707	700
4751 RESP SYS DIAG WITH VENT SUPP W CLASS C CC *	12.0	28.5	8260	688	702
4752 RESP SYS DIAG WITH VENT SUPP W CLASS B CC	17.0	48.5	12472	734	730
4760 PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	28.0	73.0	10515	376	331
4770 NON EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAG	7.8	34.5	3800	487	392
4780 OTHER VASCULAR PROCEDURES WITH NO CC	7.5	17.5	5089	678	503
4781 OTHER VASCULAR PROCEDURES WITH CLASS C CC	5.7	19.5	4259	747	535
4782 OTHER VASCULAR PROCEDURES WITH CLASS B CC	10.0	25.8	6693	669	491
4783 OTHER VASCULAR PROCEDURES WITH CLASS A CC	17.0	42.5	9700	571	456
4800 LIVER TRANSPLANT WITH NO CC *	N.A.	N.A.	N.A.	N.A.	N.A.
4801 LIVER TRANSPLANT WITH CLASS C CC *	N.A.	N.A.	N.A.	N.A.	N.A.
4802 LIVER TRANSPLANT WITH CLASS B CC *	N.A.	N.A.	N.A.	N.A.	N.A.
4803 LIVER TRANSPLANT WITH CLASS A CC *	N.A.	N.A.	N.A.	N.A.	N.A.
4810 BONE MARROW TRANSPLANT WITH NO CC *	27.0	73.0	26226	971	891
4811 BONE MARROW TRANSPLANT WITH CLASS C *	30.0	75.0	33809	1127	903
4812 BONE MARROW TRANSPLANT WITH CLASS B CC *	41.0	75.0	41549	1013	1149
4813 BONE MARROW TRANSPLANT WITH CLASS A CC	46.0	75.0	67059	1458	1152
4820 TRACH W MOUTH, LARYNX, OR PHARYNX DISORDER WITH NO CC	14.0	30.8	7930	566	439
4821 TRACH W MOUTH, LARYNX, OR PHARYNX DISORDER WITH CLASS C CC	15.0	32.0	10094	673	490
4822 TRACH W MOUTH, LARYNX, OR PHARYNX DISORDER WITH CLASS B CC	17.0	38.3	12191	717	507
4823 TRACH W MOUTH, LARYNX, OR PHARYNX DISORDER WITH CLASS A CC	25.0	64.5	15342	614	475
4830 TRACH EXCEPT MOUTH, LARYNX, OR PHARYNX	38.0	75.0	36325	956	846
4840 CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA WITH NO CC *	N.A.	N.A.	22987	N.A.	624
4841 CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA WITH CLASS C CC *	6.0	6.0	6298	1050	633
4842 CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA WITH CLASS B CC *	N.A.	N.A.	27367	N.A.	650
4843 CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA WITH CLASS A CC *	N.A.	N.A.	51570	N.A.	671
4850 LIMB REATTACH, HIP & FEMUR PROC, MULT TRMA WITH NO CC *	20.0	58.5	14966	748	550
4851 LIMB REATTACH, HIP & FEMUR PROC, MULT TRMA WITH CLASS C CC *	9.0	17.0	9528	1059	551
4852 LIMB REATTACH, HIP & FEMUR PROC, MULT TRMA WITH CLASS B CC *	27.0	67.0	22074	818	602
4853 LIMB REATTACH, HIP & FEMUR PROC, MULT TRMA WITH CLASS A CC *	N.A.	N.A.	35915	N.A.	627
4860 OTHER O.R. PROCS FOR MULT SIGNIF TRAUMA WITH NO CC *	9.9	31.0	8692	878	647
4861 OTHER O.R. PROCS FOR MULT SIGNIF TRAUMA WITH CLASS C CC *	20.0	22.5	14674	734	608
4862 OTHER O.R. PROCS FOR MULT SIGNIF TRAUMA WITH CLASS B CC *	16.0	47.5	15264	954	691
4863 OTHER O.R. PROCS FOR MULT SIGNIF TRAUMA WITH CLASS A CC *	23.0	64.5	21446	932	720
4870 OTHER MULTIPLE SIGNIFICANT TRAUMA WITH NO CC	7.4	28.0	4025	544	438
4871 OTHER MULTIPLE SIGNIFICANT TRAUMA WITH CLASS C CC *	18.0	64.8	9628	535	478
4872 OTHER MULTIPLE SIGNIFICANT TRAUMA WITH CLASS B CC *	11.0	32.5	7434	676	542
4880 HIV W EXTENSIVE O.R. PROCEDURE WITH NO CC *	9.5	11.5	4491	473	441
4882 HIV W EXTENSIVE O.R. PROCEDURE WITH CLASS B CC *	6.0	6.0	3588	598	511
4883 HIV W EXTENSIVE O.R. PROCEDURE WITH CLASS A CC *	26.0	26.0	13598	523	507
4890 HIV W MAJOR RELATED CONDITION WITH NO CC	8.0	27.5	3527	441	434
4891 HIV W MAJOR RELATED CONDITION WITH CLASS C CC *	9.5	27.5	4471	471	462
4892 HIV W MAJOR RELATED CONDITION WITH CLASS B CC	8.8	27.5	4305	489	481
4900 HIV W OR W/O OTHER RELATED CONDITION WITH NO CC *	4.9	17.0	2367	483	469
4901 HIV W OR W/O OTHER RELATED CONDITION WITH CLASS C CC *	5.2	10.5	2531	487	473
4902 HIV W OR W/O OTHER RELATED CONDITION WITH CLASS B CC *	6.6	21.5	3446	522	511
4910 MAJ JT & LIMB REATTACH PROC OF UPPER EXT WITH NO CC	5.0	11.5	4537	907	578
4911 MAJ JT & LIMB REATTACH PROC OF UPPER EXT WITH CLASS C CC *	3.5	8.0	5557	1588	561

Refined Diagnostic Related Group	Average Length of Stay for Typical Cases (days)	Trim (days)	Cost per Case ($)	Average Cost per Day ($)	Marginal Cost per Day ($)
4912 MAJ JT & LIMB REATTACH PROC OF UPPER EXT WITH CLASS B CC *	24.0	75.0	6397	267	481
4913 MAJ JT & LIMB REATTACH PROC OF UPPER EXT WITH CLASS A CC *	N.A.	N.A.	2788	N.A.	497
4920 CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SEC DX WITH NO CC	1.2	3.5	1115	929	728
4921 CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SEC DX WITH CLASS C CC *	12.0	61.0	2260	188	857
4922 CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SEC DX WITH CLASS B CC *	27.0	46.5	4670	173	1084
4930 LAPARSCOPIC CHOLECYSTECTOMY WITH NO CC	1.6	3.5	1992	1245	1446
4931 LAPARSCOPIC CHOLECYSTECTOMY WITH CLASS C CC	2.0	6.0	1414	707	1284
4932 LAPARSCOPIC CHOLECYSTECTOMY WITH CLASS B CC	3.8	12.0	2358	620	984
4933 LAPARSCOPIC CHOLECYSTECTOMY WITH CLASS A CC	6.3	21.5	3552	564	789
8010 EARLY DEATH MDC 01	1.3	3.5	1733	1333	714
8010 EARLY DEATH MDC 02 *	N.A.	N.A.	871	N.A.	769
8030 EARLY DEATH MDC 03 *	1.4	3.5	1307	934	1086
8040 EARLY DEATH MDC 04	1.4	3.5	1296	926	717
8050 EARLY DEATH MDC 05	1.3	3.5	1575	1211	812
8060 EARLY DEATH MDC 06	1.3	3.5	1435	1104	1092
8070 EARLY DEATH MDC 07	1.3	3.5	1371	1054	874
8080 EARLY DEATH MDC 08 *	1.7	3.5	1465	861	822
8090 EARLY DEATH MDC 09 *	1.3	3.5	1080	831	718
8100 EARLY DEATH MDC 10	1.3	3.5	1128	868	659
8110 EARLY DEATH MDC 11	1.3	3.5	1255	965	737
8120 EARLY DEATH MDC 12 *	1.3	3.5	734	564	764
8130 EARLY DEATH MDC 13 *	1.0	1.0	413	413	450
8150 NEONATE EARLY DEATH	1.0	1.0	645	645	263
8151 NEONATE EARLY TRANSFER	1.5	3.5	785	523	571
8160 EARLY DEATH MDC 16 *	1.4	3.5	2566	1833	933
8170 EARLY DEATH MDC 17	1.3	3.5	1414	1088	1555
8180 EARLY DEATH MDC 18	1.3	3.5	1685	1296	2749
8190 EARLY DEATH MDC 19 *	1.4	3.5	952	680	827
8200 EARLY DEATH MDC 20 *	1.4	3.5	2635	1882	1223
8210 EARLY DEATH MDC 21 *	N.A.	N.A.	2195	N.A.	1223
8220 EARLY DEATH MDC 22	1.3	3.5	1235	950	583
8230 EARLY DEATH MDC 23 *	1.3	3.5	3988	3068	1969
8240 EARLY DEATH MDC 24 *	1.4	3.5	922	659	753
9150 BIRTH WEIGHT 1000-2488 WITH RESP ASSIS	35.0	75.0	6635	190	266
9150 BIRTH WEIGHT 1000-2488 W PROLONG RESP ASSIS	41.0	75.0	7937	194	304
9152 BIRTH WT <1000GM WITH RESP ASSIST *	51.0	75.0	8491	166	309
9153 BIRTH WT < 1000 W PROLONG ASSIST *	71.0	75.0	14249	201	344

Appendix 2: Day Procedure Groups

Day Procedure Group	Cost per Case ($)
01 Nerve and Other Procedure	552.67
02 Spinal Procedure	244.69
03 Nerve Injections	181.18
04 Orbital and Other Eye Procedure	762.99
05 Lens Procedure	1015.07
06 Iris and Other Eye Procedure	384.32
07 Strabismus Surgery	704.05
08 External Eye Procedure	281.88
09 Respiratory Procedure	691.43
10 Tympanoplasty	799.53
11 Sinus Procedure	736.02
12 Other Sinus Procedure	505.91
13 Tonsil/Adenoid Procedure	480.46
14 Nasal Procedure	375.19
15 Other Respiratory Procedure	354.96
16 External Ear Procedure	322.34
17 Endoscopy - ENT	560.28
18 Pacemakers	3843.66
19 Cardiac Catheterization	1018.77
20 Angiography	792.79
21 Vascular Procedure	922.20
22 Other Vascular Procedure	676.64
23 Lymphatic Procedure	472.41
24 Minor Vascular Procedure	245.78
25 Cholecystectomy	1149.92
26 Hernia Repair	657.50
27 Hepatobiliary Procedure	630.97
28 Endoscopy - Gl	330.38
29 Ano-Rectal Procedure	449.36
30 Minor Anal Procedure	315.59
31 Mechanical Implants	2188.49
32 Lithotripsy	1115.99
33 Upper Urinary Procedure	741.68
34 Lower Urinary and Genital Procedure	580.51
35 Bladder and Urethral Procedure	343.87
36 Vasectomy	371.06
37 Circumcision	426.52
38 Urological Diagnostic Procedure	265.79
39 Uterus and Adnexal Procedure	969.40
40 Endoscopy and Gyn Procedure	718.40
41 Minor Gyn Procedure	441.31
42 Evacuations	446.31
43 Maxillo-Facial Procedure	700.13
44 Chest Wall Procedure	648.15
45 Upper Extremity Procedure	879.14
46 Open reductions	804.53
47 Tendon and Muscle Procedure	714.27
48 Closed Reductions	590.08

Day Procedure Group	Cost per Case ($)
49 Lower Extremity Procedure	767.12
50 Knee Procedure	824.54
51 Ankle and Foot Procedure	724.49
52 Removal Internal Fixation	521.35
53 Soft Tissue Procedure	502.21
54 Manipulations	392.81
55 Mastectomy	595.95
56 Augmentation/Mammoplasty	819.98
57 Breast Plastic Procedure	488.29
58 Plastic Reconstruction	642.06
59 Skin Procedure	334.30
60 Dental Surgery	620.09
61 Biopsy	373.45
62 Hemodialysis	437.18
63 Transfusions	504.82
64 Cardioversion	187.27
65 Chemotherapy	253.17
66 Myelogram	414.56
99 Ungroupable	192.92

Appendix 3: **Glossary**

bottom-up costing - See definition of micro-costing.

marginal cost - "The added cost of producing one additional unit of output" (Gold et. al. 1996, p.401). In this deliverable we report daily marginal costs, which is the cost of providing one additional hospital day to a patient.

micro-costing - "A valuation technique which starts with a detailed identification and measurement of all the inputs consumed in a health care intervention and all of its sequelae. Once the resources consumed have been identified and quantified, they are then converted into value terms to produce a cost estimate" (Gold et. al. 1996, p.401).

overhead cost - "An accounting term for those resources that serve many different departments and programmes, e.g. general hospital administration, central laundry, medical records, cleaning, porters, power, etc." (Drummond et. al. 1997, p.62).

Refined Diagnostically Related Group (RDRG) - Each Diagnostically Related Group (DRG) consists of hospital patients who are similar in terms of diagnosis and treatment. Each group is collapsed into Adjacent DRGs (ADRGs) and then subdivided into different levels of severity based on co-morbidities and complications that are expected to influence hospital resource use. A more detailed description of RDRGs is in Shanahan et al. (1994, p. 7-10).

top-down cost - To calculate a top-down cost one must start at the top with total cost and then allocate it down to a measure of output. In this deliverable we start at the top with hospital inpatient expenditures and then we allocate it down to each RDRG by using RDRG weights.

trim point - "The point after which any additional days are classified as outlier days" (Loyd et. al. 1995, p.118).

hospital type: Teaching – St. Boniface General Hospital, Health Sciences Centre;

Urban Community – Brandon General Hospital, Grace General Hospital, Misericordia Health Centre, Victoria General Hospital, Concordia General Hospital, Seven Oaks General Hospital;

Major Rural – Bethel Hospital, Winkler, Bethesda Helath & Social Services, Steinbach, Dauphin Regional Health Centre, Flin Flon General Hospital Inc., Morden District General Hospital, Portage District General Hospital, The Pas Health Complex Inc., Selkirk and District General Hospital, Swan River Valley Hospital, Thompson General Hospital;

Intermediate Rural – Altona Community Memorial Health Centre, Beausejour District Hospital, Carman Memorial Hospital, Churchill Health Centre, Johnson Memorial Hospital, Gimli, Minnedosa District Hospital, Neepawa District Memorial Hospital, Ste. Rose General Hospital, Souris Health District, Health District No. 10, Virden;

Small Rural – Arborg & District Health Centre, Baldur Health District, Boissevain Health District, Winnipegosis General Hospital, Rock Lake Health District, Crystal City, Southwest Health District, Deloraine, De Salaberry District Health Centre, St. Pierre, E.M. Crowe Memorial Hospital, Eriksdale, Erickson District Health Centre, Emerson Hospital, Carberry Plains District Health Centre, Seven Regions Health Centre, Gladstone, Glenboro Health District, Grandview District Hospital, Hamiota District Health Centre, Teulon-Hunter Memorial Health

District, Lorne Memorial Hospital, Swan Lake, Tri-Lake Health Centre, Killarney, McCreary Alonsa Health Centre, Morris General Hospital, Notre Dame Medical Nursing Unit, Pine Falls Health Complex, Pinawa Hospital, Roblin District Health Centre, Riverdale Health Services District, Rivers, Russell District Hospital, Birtle Health Services District, Shoal Lake-Strathclair Health Centre, Stonewall and District Health Centre, Lakeshore General Hospital, Ashern, Ste. Anne Hospital, Vita and District Health Centre Inc., St. Claude Hospital, Tiger Hills Health District, Treherne, Melita Health Centre, Wawanesa District Memorial Health Centre, Percy E. Moore Hospital, Hodgson;

Multi-Use Rural – Benito Health Centre, Pembina-Manitou Health Centre, MacGregor and District Health Centre, Health District No. 10, Reston, Rossburn District Health Centre, Whitemouth District Health Centre;

Northern Isolated – Snow Lake Medical Nursing Unit, Gillam Hospital Inc., Lynn Lake Hospital, Leaf Rapids Health Centre, Norway House Hospital