In our over 50 years’ worth of cumulative experience in healthcare practice and management, we have become intimately familiar with the difficulties hospitals face in achieving optimal financial health. And there is one challenge that has reared its head more frequently than any other at the hundreds of hospitals we’ve worked with: how to accurately capture the severity and complexity of illnesses in hospitalized patients.

All too often, physicians are unaware of the precise terminology required to allow proper coding, and coders’ lack of clinical training keeps them from recognizing diagnoses that should be clarified before billing. Successfully bridging this cultural divide by equipping physicians, documentation specialists, and coders with the knowledge they need has become a specialty of our consultancy practice. One of our chief goals is to help hospitals achieve complete and accurate concurrent documentation in the medical record in a way that can be translated into precise ICD-9-CM coding and more accurate DRG assignment.

Why is this so important?

The obvious answer is that hospitals deserve to be reimbursed for the care they provide. The reality of today’s electronically based healthcare data systems is: If it isn’t coded, it didn’t happen. But the importance of clinical documentation extends well beyond the immediate impact of reimbursement. Accurate DRG assignment is crucial for evaluating quality indicators, resource consumption, and publicly reported outcome measures.

For example, consider the physician who fails to document sepsis in patients with UTI, or whose cases of serious life-threatening pneumonia are coded simply as DRG 193–195 (Simple Pneumonia). His or her complication rates, mortality figures, length of stay, and other indicators of quality of patient care and resource utilization will suffer. Or consider a surgery department whose records regularly omit major comorbidities. Their outcome measures for seriously ill patients will be unwittingly compared with those of patients with no
comorbid conditions—and the hospital’s performance measures will be unaccountably poor. Indeed, the only way for hospitals to truly understand where improvements in care need to be made is to be able to rely on accurate records. Clinical documentation is ultimately a matter of patient care.

We created this handbook to provide coding professionals and documentation specialists with the clinical information and guidance they need to help physicians accomplish thorough documentation. This manual grew out of our desire to create a simple, easy-to-use handbook that would stay with our clients long after we’d completed our consultancy at their hospital. But we believe the material will prove useful for anyone seeking to increase his or her mastery of the profession.

We have chosen to focus on the high-volume, high-yield opportunities that connect documentation not just to coding, but to quality and utilization management as well. The material is organized into five major sections, each of which contains a wealth of material for hands-on application at the desk or at the bedside.

HOW TO USE THIS MANUAL

Each section of the manual has a different purpose:

The Guidelines section provides the most important guidelines and coding rules for DRG assignment. Review all the guidelines carefully and refer to them frequently. Use the specific principal diagnosis coding rules to look for an alternate principal diagnosis based on the definition of the principal diagnosis or sequencing of coequal or interrelated diagnoses according to official coding guidelines.

The Key References section provides detailed clinical definitions and criteria, and specific coding guidelines for important diagnoses and procedure codes.
The MCC-CC section includes a list of common MCC and CC opportunities, severity levels, and the clinical indicators to help you identify them in the record.

The DRG Tips section includes tips for alternate DRG selection and includes select DRGs which, in our experience, have a high likelihood of another principal diagnosis, MCC-CC, or procedure. Look here to identify possible alternatives for optimal DRG assignment.

The 2014 MS-DRG Table is a complete list of the current 751 DRGs, their relative weights, and GMLOS for quick reference.

Also included in this edition are sections regarding the impact of ICD-10, including what’s new for ICD-10 revisions and other tips.

We trust you will find this handbook a useful tool in addressing the daily complexities of clinical documentation. The ultimate goal is not just more accurate coding and better reimbursement, but improved quality and outcomes reports for both physician and hospital.

Note: The views expressed in this handbook are the opinions of the authors, based upon their combined education and experience and supported by the professional references cited. Correct and compliant coding depends entirely upon the specific circumstances of each individual case as documented in the medical record pursuant to ICD-9-CM, current Official Guidelines for Coding and Reporting, and advice from Coding Clinic. Nothing in this handbook is intended to modify or replace those authoritative sources, nor does this manual in any way establish or recommend any standard of care or particular medical practices.
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PRINCIPAL DIAGNOSIS CODING RULES

On the following pages, the key principal diagnosis coding rules from the most recent ICD-9-CM Official Coding Guidelines for Coding and Reporting (OCG) for the selection of the principal diagnosis (PDX) have been summarized to assist coding and CDI professionals in selecting and assigning the principal diagnosis.

The authoritative sources for coding guidance should be reviewed and referenced routinely for specific situations and circumstances to ensure accurate coding. These include:

- ICD-9-CM Classification
- Official Coding Guidelines for Coding & Reporting (OCG)
- AHA Coding Clinic

Note that the instructions and coding conventions in ICD-9-CM Volumes I and II (soon to be ICD-10-CM) take precedence over the Official Coding Guidelines, which in turn takes precedence over Coding Clinic.

Definition of Principal Diagnosis:

“That condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” OCG Section II.

Also, consider *WHY* the patient was admitted to the hospital and could not go home.

The condition (or at least some signs or symptoms referable to the condition) must be present on admission. In some cases it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission.

Per OCG page 1, “The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.”
1. Two or More Diagnoses That Equally Meet the Criteria for Principal Diagnosis

“In the unusual instance when two or more diagnososes equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup, and/or therapy provided and the Alphabetic Index, Tabular List, or another coding guideline does not provide sequencing direction, any one of the diagnoses may be sequenced first.” OCG Section II.C.

Examples:

**Patient admitted with CHF and pneumonia. Patient given IV Lasix and IV antibiotics. Either may be sequenced as the PDX.**

**Patient is admitted to the ICU with respiratory failure due to severe exacerbation of COPD. A pulmonary consult is called. Treatment includes IV antibiotics, steroids, oxygen, pulse oximetry, and aggressive respiratory therapy modalities. Either may be sequenced as PDX.**

**Patient is admitted with sepsis and meningitis. Treated with IV antibiotics for both conditions. Either may be sequenced as PDX.**
2. Uncertain Diagnosis

“If the diagnosis documented at the time of discharge* is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” “still to be ruled out,” or other similar terms indicating uncertainty, code the condition as if it existed or was established.

The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.” OCG Section II.H.

Exception: Code only confirmed cases of HIV infection/illness and influenza due to certain viruses – H1N1, avian, novel influenza A.

Other terms qualified as uncertain diagnosis are “consistent with”, “compatible with”, “indicative of”, “suggestive of”, “comparable with”, “appears to be”. “Evidence of” does not qualify as uncertain diagnosis.

This guideline is applicable only to inpatient admissions (not outpatient visits).

Example: “RLL pneumonia possibly due to aspiration.” Code aspiration pneumonia.

*Many coding experts interpret “at the time of discharge” to imply documentation in the discharge summary or final progress note. However, the second sentence of this rule suggests that the entire record should be considered when interpreting and applying this rule. The Official Coding Guidelines also state, “The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.”

The key issue is to ensure that the uncertain nature of a diagnosis or condition remains uncertain and is not further clarified at the time of discharge. For example, “possible gram-negative pneumonia” would not be assigned when later determined to be pneumococcal.
**PRINCIPAL DIAGNOSIS CODING RULES**

3. **Codes for Symptoms, Signs, and Ill-Defined Conditions**

“Codes for symptoms, signs, and ill-defined conditions from Chapter 16 are not to be used as principal diagnosis when a related definitive diagnosis has been established.” OCG Section II.A.

**Example:** *Syncope due to cardiac arrhythmia. Cardiac arrhythmia is the PDX, syncope is secondary diagnosis.*

Do not assign a separate code at all for signs and symptoms that are routinely associated with a disease process.

**Example:** *Viral gastroenteritis with fever, abdominal pain, nausea, vomiting, diarrhea. Code only viral gastroenteritis.*

When applying this rule, remember that Rule #3 treats uncertain diagnoses as “established.”

**Example:** *Fever possibly due to UTI. Code UTI only.*

See further details regarding coding of Signs & Symptoms in the section that follows.
PRINCIPAL DIAGNOSIS CODING RULES

4. Original Treatment Plan Not Carried Out

“Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.” OCG Section II.F.

**Example:** A patient with cholecystitis was admitted to the hospital for a cholecystectomy. Prior to surgery, the patient fell and sustained a left femur fracture. The surgery was canceled and a hip pinning was carried out on the second hospital day.

The PDX remains cholecystitis, since it necessitated the admission to the hospital. The fractured femur is sequenced as a secondary diagnosis since it occurred during the hospital stay.

5. Complications of Surgery and Other Medical Care

“When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis.” OCG Section II.G.

The physician must indicate the condition is a “complication” or “due to” previous medical care/surgery in his or her documentation. A cause-and-effect relationship must be documented. The term “postop” by itself does not necessarily establish a cause-and-effect relationship.

**Examples:**

* A patient was discharged two days following a hysterectomy. On the second day at home, she strained lifting a small child. She was readmitted with wound dehiscence. Sequence the wound dehiscence as the PDX.

* A patient is admitted with respiratory failure and large iatrogenic pneumothorax 3 days following outpatient thoracentesis for malignant pleural effusion. Iatrogenic pneumothorax is the PDX.
6. Admission From Observation Units

Medical Observation: “When a patient is admitted to an observation unit for a medical condition, which either worsens or does not improve, and is subsequently admitted as an inpatient of the same hospital for this same medical condition, the principal diagnosis would be the medical condition which led to the hospital admission.” OCG Section II.I.1.

Postoperative Observation: “When a patient is admitted to an observation unit to monitor a condition (or complication) that developed following outpatient surgery, hospitals should apply the Uniform Hospital Discharge Data Set (UHHDS) definition of principal diagnosis as ‘that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” OCG Section II.I.2.

Example: A patient is treated in an observation unit for 16 hours with an exacerbation of COPD, then admitted as an inpatient for treatment of a pulmonary embolism discovered on chest CT. Pulmonary embolism is PDX.

7. Admission From Outpatient Surgery

If admitted following an outpatient surgery due to a complication of the surgery, assign the complication as principal diagnosis. OCG Section II.J.

Example: Patient admitted for postoperative bleeding following outpatient TURP; postoperative bleeding would be the PDX.

If no complication or other condition is documented as the reason for admission, assign the reason for the surgery as PDX.

If admitted due to an unrelated condition, assign the unrelated condition as PDX.
8. Two or More Comparative/Contrasting Diagnoses

“In those rare instances when two or more contrasting or comparative diagnoses are documented as “either/or” (or similar terminology), they are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.” OCG Section II.D.

Example: “Acute pancreatitis vs. acute cholecystitis”: Either may be sequenced as PDX.

9. Symptom Followed by Contrasting/Comparative Diagnoses

“When a symptom(s) is followed by contrasting/comparative [“or”] diagnoses, the symptom is sequenced first. However, if the symptom code is integral to the conditions listed, no code for the symptom is reported (ICD-10 change). All the contrasting/comparative diagnoses should be coded as additional diagnoses.” OCG Section II.E.

Example: Chest pain due to either angina or esophageal spasm. Chest pain is the PDX, with angina and esophageal spasm as additional diagnoses. (ICD-10: Chest pain would not be coded since chest pain is integral to these conditions).

Example: Syncope: Dehydration vs. cardiac arrhythmia. Syncope is the PDX, with dehydration and cardiac arrhythmia as secondary diagnoses.

However, if a symptom is followed by two definitive (“and”) diagnoses, then either condition can be sequenced as the principal diagnosis based on Rule #1.

Continued —
Example: “Chest pain due to angina and esophageal spasm”: Either angina or esophageal spasm may be PDX.

Note: This rule does not apply to secondary diagnoses—assign the symptom only (see Coding Clinic, First Quarter 1998, p. 9)

Other important (chapter-specific) coding rules for assigning the principal diagnosis are included below. Specific coding rules are also included in Key References for the specific conditions listed in that section.

**Diabetes**

When a patient is admitted for a condition that is due to diabetes mellitus, the diabetes code 250.xx is assigned as the principal diagnosis, followed by the associated condition. OCG Section I.C.3.

Example: A patient is admitted with a diabetic autonomic neuropathy. Sequence the diabetes code 250.6x as PDX, followed by autonomic neuropathy 337.1 as a secondary diagnosis.

**ICD-10:** Combination codes for diabetes will include the type of diabetes, body system affected, and the complications affecting that body system (category E08–E13). Sequencing is based on the reason for a particular encounter. Unspecified type defaults to Type 2. Diabetes documented as inadequately controlled, out of control, or poorly controlled are coded to diabetes, by type, with hyperglycemia.

- E10.40: Type 1 diabetes mellitus with diabetic neuropathy, unspecified
- E11.65: Type 2 diabetes mellitus with hyperglycemia
Neoplasms

If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis. When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the metastasis only, the metastasis is designated as the principal diagnosis even though the primary malignancy is still present. OCG Section I.C.2.

When a primary neoplasm has been excised but still being treated, (chemotherapy, etc.), the malignancy should be coded. If previously excised or eradicated and no further treatment and no evidence of any remaining malignancy at the primary site, do not code the malignancy.

**Signs and symptoms** associated with an existing primary or secondary malignancy cannot be used to replace the malignancy as principal diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

**Admit Solely for Chemotherapy/Radiation Therapy.** If the patient is admitted solely for the purpose of receiving chemotherapy or radiotherapy, V58.11 or V58.0 are sequenced as PDX.

**Complications.** When the reason for admission is treatment of complications associated with the malignancy or adverse effects of chemotherapy, and the complication is the focus of treatment (not the malignancy) sequence the complication as the PDX.

**Dehydration.** When the admission is for management of dehydration due to the malignancy or the therapy, or a combination of both, and **ONLY** the dehydration is being treated (IV rehydration), the dehydration is the PDX, followed by the malignancy code(s).

**Anemia.** When the admission is for management of an anemia associated with the malignancy or due to chemo-/immuno-/radiotherapy, and the treatment is **ONLY** for anemia, the anemia is
Neoplasms, Continued

designated as the PDX, followed by the malignancy code(s). If treatment of the malignancy or other conditions is provided and a transfusion given, the anemia is coded as a SDX.

**ICD-10:** When the admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis.

**Pain**

Pain should not be used as PDX when the underlying definitive diagnosis has been established by the physician. OCG I.C.6.a.

When the reason for the admission/encounter is *pain control or pain management only*, a code from category 338 is used as the PDX.

If the encounter is for any other reason except pain control or pain management, and a definitive diagnosis has not been established, assign the code for the specific site of pain first, followed by the appropriate code from category 338.

Pain due to a device is coded as a complication.

**Neoplasm-Related Pain** (338.3): Code 338.3 is assigned to pain (whether acute or chronic) documented as being related to or associated with a malignancy.

This code would be assigned as PDX when the stated reason for the admission/encounter is documented as pain control or pain management only.

**Example:** “Patient admitted for insertion of porta-cath for administration of narcotics to control refractory pain due to malignancy.” Code first 338.3, followed by malignancy.
PRINCIPAL DIAGNOSIS CODING RULES

Poisoning

When a patient is admitted due to poisoning (defined as a reaction to the improper use of a medication), the poisoning is sequenced first, followed by the manifestation. OCG Section I.C.17.e.

Poisoning includes wrong person, wrong dose, wrong substance, wrong route of administration, combination with alcohol, combination with OTC (without MD approval), overdose, and toxicity due to a non-medicinal chemical substance.

Example: A patient is admitted with a cocaine overdose producing seizures with cocaine dependence. Sequence cocaine overdose (968.5) as PDX, with seizures and cocaine dependence as secondary diagnoses.

An adverse effect, in contrast to poisoning, is a reaction to a therapeutic substance correctly prescribed and properly administered. In these cases the manifestation is coded first, followed by the appropriate E code for the drug causing it (E930–E949). Adverse effects include allergic reaction, toxicity, synergistic reaction, side effect, or idiosyncratic reaction. Documentation of a drug toxicity, such as Digoxin toxicity, is coded as an adverse effect unless it is specifically documented that the drug was incorrectly prescribed or taken.

ICD-10: Poisonings and adverse effects of medication (categories T36–T50) are expanded combination codes that identify the substance; poisoning, adverse effect, or underdosing; intent; and initial encounter, subsequent encounter, or sequela. Sequencing rules are unchanged.

Toxic effects of nontherapeutic substances are separately assigned to categories T51–T65 as combination codes for substance, intent, and encounter.
SECONDARY DIAGNOSIS CODING RULES

Other diagnoses are defined as: “All conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.” OCG Section III.

Other conditions (either present on admission or occurring during admission) that require:

• Clinical evaluation, or
• Therapeutic treatment, or
• Diagnostic procedures, or
• Increased nursing care/monitoring, or
• Extended length of stay

Secondary conditions which are documented but which do not meet 1 of these 5 requirements should not be coded. A review of Coding Clinic, Second Quarter 2000, pp. 20–21 indicates that chronic conditions are usually reported (coded) but should still meet at least one secondary diagnosis coding criteria.

“Chronic conditions such as, but not limited to, hypertension, congestive heart failure, asthma, emphysema, COPD, Parkinson’s disease, and diabetes mellitus are reportable”, but “need to meet the UHDDS definition of ‘other [secondary] diagnoses’ [as stated in the Official Coding Guidelines Section III].”

The CDS/coder needs to determine if the documented conditions are clinically significant and warrant code assignment. As an example, morbid obesity has been noted as “clinically significant” in Coding Clinic 2011; this condition may require “increased nursing care” at a minimum, not to mention complexity of care and high risk of medical/surgical complications. However, documentation of “CHF” on an anesthesia assessment, without any further indications of ongoing treatment, does not suggest clinical significance and thus the condition would not be coded.
SECONDARY DIAGNOSIS CODING RULES

Abnormal Findings: Lab, x-ray, EKG, pathology, and other diagnostic test results are not coded unless the provider documents their clinical significance in the medical record.

Example: “Patient with serum sodium of 125.” Do not code unless physician states “hyponatremia.”

If the x-ray report provides additional information regarding the site for a condition that the provider has already diagnosed, it is appropriate to assign a code to identify the specificity that is documented in the x-ray report. CC 2013, Q1, p. 28.

Conditions From Previous Encounters: “Documentation from the current encounter should clearly reflect those diagnoses that are current and relevant for that encounter. It is inappropriate to go back to previous encounters to retrieve a diagnosis without physician confirmation.” CC 2013, Q3, p. 27. Therefore, it would be appropriate to query the physician regarding a condition from a previous encounter if it meets the definition of a secondary diagnosis for the current encounter (being treated, clinically evaluated, etc.)

The Uncertain Diagnosis rule also applies to the assignment of secondary diagnoses per OCG Section III.C.
**Definition:** A “sign” is objective evidence of disease observed by examining the patient, a “symptom” is a subjective observation reported by the patient. A “diagnosis” is a statement of conclusion that describes the reason for a disease, illness, or problem.

Misperceptions associated with the coding of signs and symptoms are a common source of coding errors. The coding guidelines discourage assigning codes for signs and symptoms, instead of a diagnosis.

**General Guidelines:**

“Codes that describe symptoms and signs as opposed to diagnoses are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider” (OCG, General Guidelines, Section I.B.6).

“Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.” (OCG, General Coding Guidelines, Section I.B.7)

“Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.”

The determination of what signs and symptoms are “routinely associated with” every disease process encountered is one of the challenges coders face. This does not constitute “interpretation of the medical record”, but does require coders to be familiar with the signs and symptoms of disease processes. To achieve this high standard, training in pathophysiology and medical terminology combined with continuing education and experience is absolutely essential.

*Continued —*
SIGN & SYMPTOMS

Principal Diagnosis Related Guidelines:

“Codes for symptoms, signs, and ill-defined conditions from Chapter 16 are not to be used as principal diagnosis when a related definitive diagnosis has been established.” (OCG, Section II.A.)

“When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional diagnoses.” (OCG, Section II.E.)

“Symptoms, signs and ill-defined conditions in Chapter 16 characteristic of, or associated with a primary or secondary site malignancy cannot be used to replace the malignancy as the principal or first-listed diagnosis regardless of the number of counters for treatment and care of the neoplasm.”

The instructional note at the beginning of Chapter 16 is specific about the limitations placed on the assignment of codes from categories 780–796. The situations in which it may be necessary to assign a sign or symptom code are:

• “No more specific diagnosis can be made even after all the facts bearing on the case have been investigated”
• “Provisional diagnoses in a patient who failed to return [for treatment]”
• The patient was “referred elsewhere … before the diagnosis was made”
• “A more precise diagnosis was not available for any other reason”
• “Signs or symptoms … that proved to be transient and whose cause could not be determined”
• “Certain symptoms which represent important problems in medical care and which it might be desired to classify in addition to a known cause”
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S = Surgical DRG  
M = Medical DRG  
*Post-acute care transfer DRG  
GMLOS = Geometric mean length of stay