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**Rules of**  
**Department of Health**  
**Division 10—Office of the Director**  
**Chapter 33—Hospital and Ambulatory Surgical**  
**Center Data Disclosure**

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**Title 19—DEPARTMENT OF  
HEALTH**

**Division 10—Office of the Director  
Chapter 33—Hospital and Ambulatory  
Surgical Center Data Disclosure**

**19 CSR 10-33.010 Reporting Patient  
Abstract Data by Hospitals and Ambulato-  
ry Surgical Centers**

*PURPOSE: This rule establishes procedures for reporting patient abstract data for inpatients and outpatients by hospitals and ambulatory surgical centers to the Department of Health.*

(1) The following definitions shall be used in the interpretation of this rule:

(A) Coinvestigator means any person or organization that applies to the department to be a coinvestigator of an epidemiological study;

(B) Department means the Missouri Department of Health;

(C) Epidemiological study means research using patient abstract data to understand, promote or safeguard the health of a defined population. No marketing study or study designed to use data on a specific provider shall be considered an epidemiological study;

(D) External cause-of-injury code (E-Code) means the ICD-9-CM code for the external cause of an injury, poisoning or adverse effect;

(E) Inpatient encounter means an encounter which begins with the formal acceptance by a hospital or a distinct part of the hospital of a patient who is to receive physician, dentist or allied services while receiving room, board and continuous nursing care. It ends with the termination of the room, board and continuous nursing services, and the formal release of an inpatient from the hospital or the transfer of the patient to a different distinct hospital unit;

(F) Managed care means any form of health plan that initiates selective contracting to channel patients to a limited number of providers and that influences utilization and cost of services as well as measures outcomes. The term covers a broad spectrum of arrangements for health care delivery and financing, including managed indemnity plans (MIP), health maintenance organizations (HMO), preferred provider organizations (PPO), point-of-service plans (POS), as well as direct contracting arrangements between employers and providers.

(G) Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a

hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Charges for observation services usually are made on an hourly basis. Observation services usually do not exceed twenty-four (24) hours. However, there is no hourly limit on the extent to which they may be used;

(H) Other diagnoses means all conditions that coexist at the time of admission or develop later, which affect the treatment received or the length of stay, or both. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded. Conditions should be coded that affect patient care in terms of requiring any of the following: clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care or monitoring;

(I) Outpatient encounters means patients seen in the emergency room, patients receiving invasive procedures on an outpatient basis—CPT codes 10000-69999 and ICD-9-CM codes 01.0-86.99, inclusive—and patients receiving selected services and procedures as defined in Exhibit A of this rule;

(J) Principal diagnosis means the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care;

(K) Principal procedure means the procedure that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If two (2) procedures appear to be the principal procedure, then the one (1) most related to the principal diagnosis should be selected as the principal procedure;

(L) Procedure codes and dates mean the codes and dates for all significant procedures. A significant procedure is one that is surgical in nature, carries a procedural risk, carries an anesthetic risk or requires specialized training. Surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture and manipulation;

(M) Public health authority means a federal, state or local governmental agency which has as its mission and responsibility the promotion and safeguarding of the public's health; and

(N) Total charges for inpatient services means charges for the inpatient hospitalization, including outpatient services prior to admission to the facility or after discharge from the facility or both to the extent the claim's payer has required the bundling of outpatient services with the inpatient stay.

(2) All hospitals shall file with the department patient abstract data on patients discharged from a hospital after December 31, 1992, patients receiving an outpatient service after December 31, 1992, and patients released from observation after December 31, 1992. All ambulatory surgical centers shall file with the department patient abstract data on patients receiving an outpatient service after December 31, 1993.

(3) Data which meet the completeness, validity and consistency criteria in subsections (3)(A) and (B) of this rule shall be submitted to the department on a quarterly basis within five (5) months following the end of a calendar quarter in which the discharge or outpatient service occurred.

(A) Each data element shall have an acceptable code in at least ninety-nine percent (99%) of the records. Each data element shall be missing or unknown in less than one percent (1%) of records.

(B) The following data elements shall be at least ninety-nine percent (99%) consistent within an individual record: date of birth, sex, diagnoses, E-Codes, procedures; state of residence, zip code, county; and admission date, procedure dates, discharge date, date of birth.

(4) The patient abstract data shall include the data elements and conform to the specifications listed in Exhibit B of this rule and shall be submitted on magnetic media. Acceptable magnetic media include the following:

(A) IBM-3480 compatible one-half-inch (1/2") eighteen (18) track tape uncompressed (3480) or compressed (3490);

(B) Floppy disk (MS-DOS/PC-DOS compatible). Three and one-half-inch (3 1/2") eighty (80) tracks per side, eighteen (18) sectors per track, double-sided (1.44 Mb). Shall be on media rated at least 135 tpi with 2.0 Mb total rating; or

(C) Other magnetic media may be acceptable with prior approval of the department.

(5) Providers shall be allowed fifteen (15) working days to correct data submission errors identified by the department. Revisions of data originally filed shall be filed on magnetic media and contain the entire logical record for each record changed.

(6) Providers shall notify the department by January 1 of each year if they plan to submit the required data to the department through an association or related organization with which the department has a binding agreement to obtain data. Providers selecting this option are responsible for ensuring that the

data meet the quality criteria of completeness, validity and consistency in subsections (3)(A) and (B) of this rule, and are submitted to the association or related organization so the time schedule in section (3) of this rule is met. The association or related organization is responsible for ensuring that the data are provided to the department on acceptable magnetic media, conform to the specifications listed in Exhibit B of this rule, meeting the time schedule of section (3) of this rule.

(7) Providers may submit data directly to the department or through a third party acting as their agent, other than one with which the department has a binding agreement. Providers selecting this option are responsible for ensuring that all data specifications conform to the requirements of this rule.

(8) The department shall develop and publish reports pertaining to individual hospitals and ambulatory surgical centers. The reports may include information on charges and quality of care indicators. The reports and the data they contain shall be public information and may be released on magnetic media. The department shall make the reports and data available for a reasonable charge based on incurred costs.

(9) The department shall use statistical rules to minimize random fluctuations and extreme outliers in publishing provider-specific reports on charges. The rules may vary by publication but shall include the following:

(A) The most appropriate measure of central tendency shall be used. Whenever the average charge is used it shall be computed only upon cases that are within 1.96 standard deviations of the average of the entire distribution; and

(B) Average charges shall not be published on fewer than twenty (20) events.

(10) The department may develop reports and release data upon request which do not directly or indirectly identify patients, physicians or providers. The reports and data shall be public information and may be released on magnetic media. The department shall make the reports and data available for a reasonable charge based upon incurred costs.

(11) The department may release patient abstract data to a public health authority to assist the agency in fulfilling its public health mission. This data shall not be rereleased in any form by the public health authority without the prior authorization of the department. Authorization for subsequent release of the data shall be considered only if the proposed release does not identify a patient, physician

or provider. However, the department may authorize contact with the patient, physician or provider based upon the information supplied. The physician and provider that provided care to a patient shall be informed by the public health authority of any proposed contact with a patient.

(12) Any person may apply to the department to be a coinvestigator of an epidemiological study using patient abstract data. A research protocol shall be submitted which includes all of the following:

(A) A description of the proposed study;  
 (B) The purpose of the study;  
 (C) A description of the data elements needed for the study;  
 (D) A description of a tape or a report if either is required;

(E) A statement indicating whether the study protocol has been reviewed and approved by an institutional review board;

(F) A description of data security procedures, including who shall have access to the data; and

(G) A description of the proposed use and release of the data.

(13) The director of the department shall appoint a data release advisory committee composed of three (3) persons representing the health care industry and three (3) persons representing researchers and consumers. The advisory committee shall review all research protocols of persons applying to be a coinvestigator of an epidemiological study using patient abstract data. The advisory committee shall make a recommendation to the director whether the coinvestigator protocol should be accepted, accepted with conditions, or rejected. The committee shall consider:

(A) The review made by the staff of the department;

(B) Whether the proposed study meets the definition of an epidemiological study;

(C) The potential for the coinvestigator or any other person to use the data for nonepidemiological purposes;

(D) The professional expertise of the applicant to conduct the study;

(E) The appropriateness of the proposed study design;

(F) The willingness and ability of the applicant to protect the identity of any patient, physician or provider; and

(G) The data security measures and final disposition of the data proposed.

(14) The coinvestigator shall agree to the confidentiality, security and release of data requirements imposed by the department and

shall agree to the review and oversight requirements imposed by the department.

(15) Data released to the coinvestigator shall not be rereleased in any form by the coinvestigator without the prior authorization of the department. Authorization for subsequent release of the data shall be considered only if the proposed release does not identify a patient, physician or provider.

(16) The following data elements permit identification of a patient, physician or provider, and are not to be rereleased by a coinvestigator: patient name; patient Social Security number; any datum which applies to fewer than three (3) patients, physicians or providers; physician number; provider number; and a quantity figure if one (1) entity contributes more than sixty percent (60%) of the amount.

(17) The department shall release only those patient abstract data elements to the coinvestigator which the department determines are essential to the study. The Unique Physician Identification Number (UPIN) associated with any patient abstract data shall not be released to any coinvestigator. If the research being conducted by a coinvestigator requires a physician number, the department may create a unique number which is not the UPIN. The department shall not provide information which links the unique number to the name of the physician.

(18) No epidemiological study conducted with a coinvestigator shall be approved unless the department determines that—

(A) The epidemiological study has public benefit sufficient to warrant the department to expend resources necessary to oversee the project with the coinvestigator;

(B) The department has sufficient resources available to oversee the project with the coinvestigator; and

(C) The data release advisory committee reviewed the study and the director of the department authorized approval.

(19) Public health authorities and coinvestigators receiving data shall be informed by the department of the penalty for violating section 192.067, RSMo.

(20) The department shall store the patient abstract data tapes and files to limit access of the data only to employees of the department who are designated to have access to the files. The name and Social Security number of the patient and the physician number shall not be retained on a file with the rest of the patient

abstract data but shall be retained on a separate file. A patient identification number may be retained on both files to facilitate linkage when a study is conducted requiring patient or physician identification.

(21) Any provider which determines it temporarily will be unable to comply with any of the provisions of this rule or with the provisions of a previously-submitted plan of correction can provide the department with written notification of the expected deficiencies and a written plan of correction. This notification and plan of correction shall include the section number and text of the rule in question, specific reasons why the provider cannot comply with the rule, an explanation of any extenuating factors which may be relevant, the means the provider will employ for correcting the expected deficiency, and the date by which each corrective measure will be completed.

(22) Any provider which is not in compliance with these rules shall be notified in writing by the department. The notification shall specify the deficiency and the action which must be taken to be in compliance. The chief executive officer or designee shall have ten (10) working days following receipt of the written notification of noncompliance to provide the department with a written plan for correcting the deficiency. The plan of correction shall specify the means the provider will employ for correcting the cited deficiency and the date that each corrective measure will be completed.

(23) Upon receipt of a required plan of correction, the department shall review the plan to determine the appropriateness of the corrective action. If the plan is acceptable, the department shall notify the chief executive officer or designee in writing and indicate that implementation of the plan should proceed. If the plan is not acceptable, the department shall notify the chief executive officer or designee in writing and indicate the reasons why the plan was not accepted. A revised, acceptable plan of correction shall be provided to the department within ten (10) working days.

(24) Failure of the provider to submit an acceptable plan of correction within the required time shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the department.

(25) Failure of any provider to follow its accepted plan of correction shall be considered continued and substantial noncompli-

ance with this rule unless determined otherwise by the director of the department.

(26) Any provider in continued and substantial noncompliance with this rule shall be notified by registered mail and reported by the department to its Bureau of Hospital Licensing and Certification, Bureau of Narcotics and Dangerous Drugs, Bureau of Emergency Medical Services, Bureau of Home Health Licensing and Certification, Bureau of Radiological Health, State Public Health Laboratory, Bureau of Special Health Care Needs, the Division of Medical Services of the Department of Social Services, the Division of Vocational Rehabilitation of the Department of Elementary and Secondary Education and to other state agencies that administer a program with provider participation. The department shall notify the agencies that the provider is no longer eligible for participation in a state program.

(27) Any provider that has been declared to be ineligible for participation in a state program shall be eligible for reinstatement by correcting the deficiencies and making written application for reinstatement to the Department of Health. Any provider meeting the requirements for reinstatement shall be notified by registered mail. The Department of Health shall notify state agencies that administer a program with provider participation that the provider's eligibility for participation in a state program has been reinstated.

*AUTHORITY: section 192.667, RSMo Supp. 1997.\* Emergency rule filed Nov. 4, 1992, effective Nov. 14, 1992, expired March 13, 1993. Emergency rule filed March 4, 1993, effective March 14, 1993, expired July 11, 1993. Original rule filed Nov. 4, 1992, effective June 7, 1993. Emergency amendment filed April 1, 1993, effective April 11, 1993, expired Aug. 8, 1993. Emergency amendment filed Aug. 10, 1993, effective Aug. 20, 1993, expired Nov. 18, 1993. Amended: Filed April 1, 1993, effective Dec. 9, 1993. Amended: Filed May 15, 1998, effective Nov. 30, 1998.*

*\*Original authority 1992, 1993, 1995.*

### **19 CSR 30-33.020 Reporting Charges for Leading Diagnoses and Procedures by Hospitals and Ambulatory Surgical Centers**

*PURPOSE: This rule establishes procedures for reporting charges for leading diagnoses and procedures by hospitals and ambulatory surgical centers to the Department of Health.*

(1) Hospitals and ambulatory surgical centers shall report to the Department of Health by March 1 of each year, the charges as of December 31 of the previous year for the diagnoses and procedures listed in Exhibit C of this rule.

(2) The Department of Health may develop and publish reports pertaining to individual providers. The reports and the data they contain shall be public information and may be released on magnetic media. The Department of Health shall make the reports and data available for a reasonable charge based upon incurred costs.

(3) The Department of Health may develop reports and release data upon request which do not directly or indirectly identify individual providers. The reports and data shall be public information and may be released on magnetic media. The Department of Health shall make the reports and data available for a reasonable charge based upon incurred costs.

(4) Any provider which determines it temporarily will be unable to comply with any part of this rule or with the provisions of a previously submitted plan of correction can provide the Department of Health with written notification of the expected deficiencies and a written plan of correction. The notification and plan of correction shall include the section number and text of the rule in question, specific reasons why the provider cannot comply with the rule, an explanation of any extenuating factors which may be relevant, the means the provider will employ for correcting the expected deficiency, and the date by which each corrective measure will be completed.

(5) Any provider which is not in compliance with this rule shall be notified in writing by the Department of Health. The notification shall specify the deficiency and the action which must be taken to be in compliance. The chief executive officer or designee shall have ten (10) working days following receipt of the written notification of noncompliance to provide the Department of Health with a written plan for correcting the deficiency. The plan of correction shall specify the means the provider will employ for correcting the cited deficiency and the date that each corrective measure will be completed.

(6) Upon receipt of a required plan of correction, the Department of Health shall review the plan to determine the appropriateness of the corrective action. If the plan is acceptable, the Department of Health shall notify

the chief executive officer or designee in writing and indicate that implementation of the plan should proceed. If the plan is not acceptable, the Department of Health shall notify the chief executive officer or designee in writing and indicate the reasons why the plan was not accepted. A revised, acceptable plan of correction shall be provided to the Department of Health within ten (10) working days.

(7) Failure of the provider to submit an acceptable plan of correction within the required time shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the Department of Health.

(8) Failure of any provider to follow its accepted plan of correction shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the Department of Health.

(9) Any provider in continued and substantial noncompliance with this rule shall be notified by registered mail and reported by the Department of Health to its Bureau of Hospital Licensing and Certification, Bureau of Narcotics and Dangerous Drugs, Bureau of Emergency Medical Services, Bureau of Home Health Licensing and Certification, Bureau of Radiological Health, State Public Health Laboratory, Bureau of Special Health Care Needs, the Division of Medical Services of the Department of Social Services, the Division of Vocational Rehabilitation of the Department of Elementary and Secondary Education and to other state agencies that administer a program with provider participation. The Department of Health shall notify the agencies that the provider is no longer eligible for participation in a state program.

(10) Any provider that has been declared to be ineligible for participation in a state program shall be eligible for reinstatement by correcting the deficiencies and making written application for reinstatement to the Department of Health. Any provider meeting the requirements for reinstatement shall be notified by registered mail. The Department of Health shall notify state agencies that administer a program with provider participation that the provider's eligibility for participation in a state program has been reinstated.

*AUTHORITY: section 192.667, RSMo Supp. 1992.\* Emergency rule filed Nov. 4, 1992, effective Nov. 14, 1992, expired March 13, 1993. Emergency rule filed March 4, 1993,*

*effective March 14, 1993, expired July 11, 1993. Original rule filed Nov. 4, 1992, effective June 7, 1993. Emergency amendment filed April 1, 1993, effective April 11, 1993, expired Aug. 8, 1993. Emergency amendment filed Aug. 10, 1993, effective Aug. 20, 1993, expired Nov. 18, 1993. Amended: Filed April 1, 1993, effective Dec. 9, 1993.*

*\*Original authority 1992.*

**19 CSR 30-33.030 Reporting Financial Data by Hospitals**

*PURPOSE: This rule establishes procedures for reporting financial data by hospitals to the Department of Health.*

(1) Hospitals shall report the financial data listed in Exhibit D of this rule for the previous fiscal year to the Department of Health by April 15 of each year starting in 1993. If any data element has been submitted previously to the Division of Medical Services of the Department of Social Services, the hospital does not have to report that data to the Department of Health. The Department of Health shall notify each hospital what data elements are not available from the Division of Medical Services.

(2) Hospitals may provide the financial data directly or through an association to the Department of Health from the financial section of the annual licensing survey.

(3) The Department of Health shall develop and publish reports pertaining to individual hospitals. The reports and the data they contain shall be public information and may be released on magnetic media. The Department of Health shall make the reports and data available for a reasonable charge based upon incurred costs.

(4) The Department of Health may develop reports and release data upon request which do not directly or indirectly identify individual hospitals. The reports and data shall be public information and may be released on magnetic media. The Department of Health shall make the reports and data available for a reasonable charge based upon incurred costs.

(5) Any provider which determines it temporarily will be unable to comply with any of the provisions of this rule or with the provisions of a previously-submitted plan of correction can provide the Department of Health with written notification of the expected defi-

ciencies and a written plan of correction. The notification and plan of correction shall include the section number and text of the rule in question, specific reasons why the provider cannot comply with the rule, an explanation of any extenuating factors which may be relevant, the means the provider will employ for correcting the expected deficiency and the date by which each corrective measure will be completed.

(6) Any provider which is not in compliance with this rule shall be notified in writing by the Department of Health. The notification shall specify the deficiency and the action which must be taken to be in compliance. The chief executive officer or designee shall have ten (10) working days following receipt of the written notification of noncompliance to provide the Department of Health with a written plan for correcting the deficiency. The plan of correction shall specify the means the provider will employ for correcting the cited deficiency and the date that each corrective measure will be completed.

(7) Upon receipt of a required plan of correction, the Department of Health shall review the plan to determine the appropriateness of the corrective action. If the plan is acceptable, the Department of Health shall notify the chief executive officer or designee in writing and indicate that implementation of the plan should proceed. If the plan is not acceptable, the Department of Health shall notify the chief executive officer or designee in writing and indicate the reasons why the plan was not accepted. A revised, acceptable plan of correction shall be provided to the Department of Health within ten (10) working days.

(8) Failure of the provider to submit an acceptable plan of correction within the required time shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the Department of Health.

(9) Failure of any provider to follow its accepted plan of correction shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the Department of Health.

(10) Any provider in continued and substantial noncompliance with this rule shall be notified by registered mail and reported by the Department of Health to its Bureau of Hospital Licensing and Certification, Bureau of Narcotics and Dangerous Drugs, Bureau of Emergency Medical Services, Bureau of

Home Health Licensing and Certification, Bureau of Radiological Health, State Public Health Laboratory, Bureau of Special Health Care Needs, the Division of Medical Services of the Department of Social Services, the Division of Vocational Rehabilitation of the Department of Elementary and Secondary Education and to other state agencies that administer a program with provider participation. The Department of Health shall notify the agencies that the provider is no longer eligible for participation in a state program.

(11) Any provider that has been declared to be ineligible for participation in a state program shall be eligible for reinstatement by correcting the deficiencies and making written application for reinstatement to the Department of Health. Any provider meeting the requirements for reinstatement shall be notified by registered mail. The Department of Health shall notify state agencies that administer a program with provider participation that the provider's eligibility for participation in a state program has been reinstated.

*AUTHORITY: section 192.667, RSMo Supp. 1992.\* Emergency rule filed Nov. 4, 1992, effective Nov. 14, 1992, expired March 13, 1993. Emergency rule filed March 4, 1993, effective March 14, 1993, expired July 11, 1993. Original rule filed Nov. 4, 1992, effective June 7, 1993. Emergency amendment filed April 1, 1993, effective April 11, 1993, expired Aug. 8, 1993. Emergency amendment filed Aug. 10, 1993, effective Aug. 20, 1993, expired Nov. 18, 1993. Amended: Filed April 1, 1993, effective Dec. 9, 1993.*

*\*Original authority 1992.*



**EXHIBIT A**  
**Selected Services and Procedures: Computed Tomography, Magnetic Resonance Imaging, Lithotripsy**

(\* means for example)

CPT-4 Code	Description	ICD-9-CM Equiv.	CPT-4 Code	Description	ICD-9-CM Equiv.	CPT-4 Code	Description	ICD-9-CM Equiv.
43265	Endoscopic retrograde cholangiopancreatography (ERCP), with or without biopsy or collection of specimen, or both; for destruction lithotripsy of stone, any method	51.10	71260	with contrast material(s)	87.41	73202	without contrast material, followed by contrast material(s) and further sections	88.38
50080	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation endoscopy, lithotripsy, stenting or basket extraction; up to 2 cm	55.03	71270	without contrast material, followed by contrast material(s) and further sections	87.41	73220	Magnetic resonance (*proton) imaging, upper extremity, other than joint	88.94
50081	over 2 cm	55.03	71550	Magnetic resonance (*proton) imaging, chest (for example, evaluation of hilar and mediastinal lymphadenopathy)	88.92	73221	Magnetic resonance (*proton) imaging, any joint of upper extremity	88.94
50590	Lithotripsy, extracorporeal shock wave	98.51	72125	Computerized axial tomography, cervical spine; without contrast material	88.38	73700	Computerized axial tomography, lower extremity; without contrast material	88.38
52337	Cystourethroscopy, with ureteroscopy or pyeloscopy, or both (includes dilation of the ureter by any method); with lithotripsy (ureteral catheterization is included)	56.0	72126	with contrast material	88.38	73701	with contrast material(s)	88.38
70336	Magnetic resonance (*proton) imaging, temporomandibular joint	88.97	72127	without contrast material, followed by contrast material(s) and further sections	88.38	73702	without contrast material, followed by contrast material(s) and further sections	88.38
70450	Computerized axial tomography, head or brain; without contrast material	87.03	72128	Computerized axial tomography, thoracic spine; without contrast material	88.38	73720	Magnetic resonance (*proton) imaging, lower extremity, other than joint	88.94
70460	with contrast material(s)	87.03	72129	with contrast material	88.38	73721	Magnetic resonance (*proton) imaging, any joint of lower extremity	88.94
70470	without contrast material, followed by contrast material(s) and further sections	87.03	72130	without contrast material, followed by contrast material(s) and further sections	88.38	74150	Computerized axial tomography, abdomen; without contrast material	88.01
70480	Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	87.03	72131	Computerized axial tomography, lumbar spine; without contrast material	88.38	74160	with contrast material(s)	88.01
70481	with contrast material(s)	87.03	72132	with contrast material	88.38	74170	without contrast material, followed by contrast material(s) and further sections	88.01
70482	without contrast material, followed by contrast material(s) and further sections	87.03	72133	without contrast material, followed by contrast material(s) and further sections	88.38	74181	Magnetic resonance (*proton) imaging, abdomen	88.97
70486	Computerized axial tomography, maxillofacial area; without contrast material	87.03	72141	Magnetic resonance (*proton) imaging, spinal canal and contents, cervical; without contrast material	88.93	75552	Magnetic resonance (*proton) imaging, myocardium	88.92
70487	with contrast material(s)	87.03	72142	with contrast material(s)	88.93	76070	Computerized tomography, bone density study	88.98
70488	without contrast material, followed by contrast material(s) and further sections	87.03	72146	Magnetic resonance (*proton) imaging, spinal canal and contents, thoracic; without contrast material	88.93	76355	Computerized tomography guidance for stereotactic localization	87.03
70490	Computerized axial tomography, soft tissue neck; without contrast material	88.38	72147	with contrast material(s)	88.93	76360	Computerized tomography guidance for needle biopsy, radiological supervision and interpretation	88.38
70491	with contrast material(s)	88.38	72148	Magnetic resonance (*proton) imaging, spinal canal and contents, lumbar; without contrast material	88.93	76365	Computerized tomography guidance for cyst aspiration, radiological supervision and interpretation	88.38
70492	without contrast material followed by contrast material(s) and further sections	88.38	72149	with contrast material(s)	88.93	76370	Computerized tomography guidance for placement of radiation therapy fields	88.38
70540	Magnetic resonance (*proton) imaging; orbit, face, and neck	88.97	72156	Magnetic resonance (*proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	88.93	76375	Computerized tomography, coronal, sagittal, multiplanar, oblique or three (3)-dimensional reconstruction, or any combination of these	88.38
70551	Magnetic resonance (*proton) imaging, brain (including brain stem); without contrast material	88.91	72157	thoracic	88.93	76380	Computerized tomography, limited or localized follow-up study	88.38
70552	with contrast material(s)	88.91	72158	lumbar	88.93	76400	Magnetic resonance (*proton) imaging, bone marrow blood supply	88.94
70553	without contrast material, followed by contrast material(s) and further sequences	88.91	72192	Computerized axial tomography, pelvis; without contrast material	88.38			
71250	Computerized axial tomography, thorax; without contrast material	87.41	72193	with contrast material(s)	88.38			
			72194	without contrast material, followed by contrast material(s) and further sections	88.38			
			72196	Magnetic resonance (*proton) imaging, pelvis	88.95			
			73200	Computerized axial tomography, upper extremity; without contrast material	88.38			
			73201	with contrast material(s)	88.38			

**EXHIBIT B**  
**Patient Abstract System**  
**A-Record**  
**(Master Record)**

Field Name	Relative Position	Field Length	Format	Justify	Description
Record type	1	1	A	L	Constant "A"
Hospital identifier	2—7	6	N	R	Medicare provider number (or state assigned)
Unique patient identifier	8—27	20	A	L	Unique within hospital for each record
Type of encounter	28	1	N	R	Status at discharge 1 = Inpatient; 2 = Outpatient.
Place of service	29	1	N	R	<u>For hospital inpatients</u> 1 = Acute-care unit; 2 = Psychiatric unit; 3 = Rehabilitation unit; 4 = SNF/ICF/Other LTC unit; 5 = Swing bed; 6 = Hospice; 7 = Other. <u>For hospital outpatients</u> 1 = Emergency room; 2 = Outpatient surgery; 3 = Observation only; 4 = Other.
Patient name	30—59	30	A/N	L	Not to be reported for patients receiving treatment for alcohol or drug abuse. Last name, first name and middle initial of the patient. Use a comma to separate last and first names. No space should be left between a prefix and a name as in MacBeth. Titles (for example, Sir, Msgr., Dr.) should not be recorded. Record hyphenated names with the hyphen, as in Smith-Jones, Rebecca. To record suffix, write the last name, leave a space and write the suffix, then write the first name as in Snyder III, Harold.
Patient Social Security Number	60—68	9	N	R	Not to be reported for patients receiving treatment for alcohol or drug abuse. If patient refuses, code as 999999999
Patient birthdate	69—76	8	N	R	MMDDYYYY
Patient sex	77	1	N	R	Patient sex at time of admission or start of care: M = Male; F = Female; U = Unknown/indeterminate.
Patient race/ethnicity	78	1	N	R	1 = White, not Hispanic; 2 = Black, not Hispanic; 3 = American Indian/Eskimo/Aleut; 4 = Hispanic; 5 = Asian/Pacific Islander; 6 = Other; 9 = Unknown or patient refused.
State of residence	79—80	2	N	R	FIPS codes
Zip code	81—85	5	A/N	L	First five digits
County code	86—88	3	N	R	Required if patient resides in Missouri, using FIPS codes



Field Name	Relative Position	Field Length	Format	Justify	Description
Admission date	89—94	6	N	R	MMDDYY
Admission hour	95—96	2	N	R	Required for inpatient records only 00 = 12:00—12:59 Midnight; 01 = 1:00— 1:59; 02 = 2:00— 2:59; 03 = 3:00— 3:59; 04 = 4:00— 4:59; 05 = 5:00— 5:59; 06 = 6:00— 6:59; 07 = 7:00— 7:59; 08 = 8:00— 8:59; 09 = 9:00— 9:59; 10 = 10:00—10:59; 11 = 11:00—11:59; 12 = 12:00—12:59 Noon; 13 = 1:00— 1:59; 14 = 2:00— 2:59; 15 = 3:00— 3:59; 16 = 4:00— 4:59; 17 = 5:00— 5:59; 18 = 6:00— 6:59; 19 = 7:00— 7:59; 20 = 8:00— 8:59; 21 = 9:00— 9:59; 22 = 10:00—10:59; 23 = 11:00—11:59; 99 = Unknown.
Source of admission/referral	97	1	A	L	Required for inpatient records only <u>Code Structure for Adult/Pediatric Patients</u> 1 = Direct admission or referral (UB-92 codes 1,2 and 3). The patient was admitted to this facility or referred for services upon the recommendation of a physician. For emergency room patients, includes self-referral; 2 = Transfer from other hospital (UB-92 code 4). The patient was transferred for services to this facility or referred from another hospital; 3 = Transfer from long-term care facility (UB-92 codes 5 and 6). The patient was transferred from or referred for services by an SNF or other long-term care facility; 4 = Emergency room admission or referral (UB-92 code 7). The patient was admitted to this facility or referred for outpatient services through the emergency room; 8 = Other (UB-92 code 8); 9 = Unknown/Information not available. <u>Code Structure for Newborns:</u> 1 = Normal birth—A baby delivered without complications; 2 = Premature birth—A baby delivered with time or weight factors, or both, qualifying it for premature status; 3 = Sick baby—A baby delivered with medical complications other than those related to premature status; 4 = Extramural birth—A newborn born in a nonsterile

Field Name	Relative Position	Field Length	Format	Justify	Description
					environment; 9 = Information not available.
Type of admission	98	1	N	R	Required for inpatient records only 1 = Emergency—The patient requires immediate intervention as a result of severe, life threatening or potentially disabling conditions; 2 = Urgent/Elective—(UB-92 codes 2 and 3); 4 = Newborn—Use of this code requires special source of admission codes for newborns.
Discharge date	99—104	6	N	R	Required for inpatient records only MMDDYY
Discharge hour	105—106	2	N	R	Required for inpatient records only 00 = 12:00—12:59 Midnight; 01 = 1:00— 1:59; 02 = 2:00— 2:59; 03 = 3:00— 3:59; 04 = 4:00— 4:59; 05 = 5:00— 5:59; 06 = 6:00— 6:59; 07 = 7:00— 7:59; 08 = 8:00— 8:59; 09 = 9:00— 9:59; 10 = 10:00—10:59; 11 = 11:00—11:59; 12 = 12:00—12:59 Noon; 13 = 1:00— 1:59; 14 = 2:00— 2:59; 15 = 3:00— 3:59; 16 = 4:00— 4:59; 17 = 5:00— 5:59; 18 = 6:00— 6:59; 19 = 7:00— 7:59; 20 = 8:00— 8:59; 21 = 9:00— 9:59; 22 = 10:00—10:59; 23 = 11:00—11:59; 99 = Unknown.
Observation units	107—109	3	N	R	The number of hours spent by a patient held for observation
Disposition of patient	110—111	2	N	R	Required for inpatient records only Designation of the circumstances associated with the patient's discharge. 01 = Discharged to home or self-care (routine discharge); 02 = Discharged/transferred to another short-term general hospital for inpatient care; 03 = Discharged/transferred to skilled nursing facility (SNF); 04 = Discharged/transferred to an intermediate care facility (ICD); 05 = Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution; 06 = Discharged/transferred to home under care of organized home health service organization; 07 = Left against medical advice or discontinued care;



Field Name	Relative Position	Field Length	Format	Justify	Description
					08 = Discharged/transferred to home under care of a Home IV provider; 09 = Admitted as an inpatient to this hospital; 20 = Expired
Medical/Health record number	112—128	17	A/N	L	Number assigned to the patient's medical/health record by the provider
Principal diagnosis code	129—133	5	A/N	L	ICD-9-CM code
Other diagnosis codes	134—173	40 (8 X 5)	A/N	L	ICD-9-CM code. Include E-Code for place of occurrence and any additional E-Codes
E-Code External cause of injury	174—178	5	A/N	L	The ICD-9-CM code for the external cause of injury, poisoning or adverse effect
Procedure coding method used	179	1	N	R	9 = ICD-9-CM 4 = CPT-4
Principal procedure code/date Code Date	180—192	13 (7) (6)	A/N N	L R	ICD-9-CM code or CPT-4 code MMDDYY
Other procedure codes and dates Code Date	193—257	65 (5 X 13) (7) (6)	A/N N	L R	All significant procedures are to be reported First 7 positions of each 13 position field: The ICD-9-CM code(s) or CPT-4 code(s) for the other procedures Next 6 positions of each 13 position field: MMDDYY
Total charges	258—264	7	N	R	Total charges (those associated with revenue code 001) rounded to the nearest dollar
Expected sources of payment	265—273	9 (3 X 3)	A/N	L	Payment sources expected to pay for the hospitalization or the ambulatory service being recorded, with the primary payer listed first: 001 = Medicare, not managed care; 002 = Medicaid, not managed care; 003 = Other government, not managed care; 005 = Workers' Compensation, not managed care; 006 = Self pay; 007 = All commercial payers, not managed care; 008 = No charge; 010 = Other, not managed care; 011 = Medicare managed care; 012 = Medicaid managed care; 013 = Other government managed care; 015 = Workers' Compensation managed care; 017 = All commercial payers managed care; 010 = Other managed care; 999 = Unknown
Attending physician ID	274—279	6	A/N	L	The Unique Physician Identification Number (UPIN) of the physician who would normally be expected to certify and recertify the medical necessity of the services rendered or has primary responsibility for the patient's medical care and treatment, or both. Will accept Missouri license number.
Principal procedure physician ID	280—285	6	A/N	L	The UPIN of the physician who performed the principal procedure. Will accept Missouri license number.

**B-Record  
(Continuation Record)**

**To be used when there are more diagnoses and/or procedures than will fit on the A-Record**

Field Name	Relative Position	Field Length	Format	Justify	Description
Record type	1	1	A	L	Constant "B"
Hospital identifier	2—7	6	N	R	Medicare provider number (or state assigned)
Unique patient identifier	8—27	20	A	L	Unique within hospital for each record
Other diagnosis codes	28—97	70 (14 X 5)	A/N	L	ICD-9-CM code
Additional procedures	98—279	182 (14 X 13) (7)	A/N	L	First 7 positions of each 13 position field: The ICD-9-CM code(s) or CPT-4 code(s) for the other procedures
Procedure code				R	Next 6 positions of each 13 position field: MMDDYY
Procedure date		(6)	N		
Filler	280—285	6			Six spaces

**EXHIBIT C****List of Diagnoses and Procedures List of Inpatient Diagnoses**

Cesarean section without complications or comorbidities, or both

Four-day stay  
DRG 371

Vaginal delivery without complicating diagnoses

Two-day stay  
DRG 373

Normal newborn

Two-day stay  
DRG 391

**List of Outpatient Procedures\***

Operations on the Nervous System

Epidural pain block

CPT-4 62278 Injection of anesthetic substance (including narcotics), diagnostic or therapeutic; lumbar or caudal epidural, single  
ICD-9 03.91 Injection of anesthetic into spinal canal for analgesia

Carpal tunnel release

CPT-4 64721 Neuroplasty or transposition, or both; median nerve at carpal tunnel  
ICD-9 04.43 Release of carpal tunnel

Operations on the Eye

Radial keratotomy (surgical correction of myopia)

CPT-4 65771 Radial keratotomy  
ICD-9 11.75 Radial keratotomy

Cataract removal, with intraocular lens implant

CPT-4 66983 Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)  
CPT-4 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (for example, irrigation and aspiration or phacoemulsification)  
ICD-9 13.19 Other intracapsular extraction of lens, plus  
ICD-9 13.71 Insertion of intraocular lens prosthesis at time of cataract extraction, one (1) stage  
ICD-9 13.59 Other extracapsular extraction of lens, plus  
ICD-9 13.71 Insertion of intraocular lens prosthesis at time of cataract extraction, one (1) stage

Removal of secondary cataract

CPT-4 66821 Discussion of secondary membranous cataract (opacified posterior lens capsule, anterior haloid, or both); laser surgery (for example, YAG laser) (one (1) or more stages)  
ICD-9 13.64 Discussion of secondary membrane (after cataract)

Secondary insertion of intraocular lens/Exchange of intraocular lens

CPT-4 66985 Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal  
CPT-4 66986 Exchange of intraocular lens  
ICD-9 13.72 Secondary insertion of intraocular lens prosthesis

Operations on the Ear, Nose, Mouth and Pharynx

Myringotomy, with or without tubes

CPT-4 69421 Myringotomy including aspiration or eustachian tube inflation, or both, requiring general anesthesia  
CPT-4 69436 Tympanostomy (requiring insertion of ventilating tube), general anesthesia  
ICD-9 20.01 Myringotomy with insertion of tube

Nasal fracture, closed reduction

CPT-4 21320 Manipulative treatment, nasal bone fracture; with stabilization  
ICD-9 21.71 Closed reduction of nasal fracture

Septoplasty

CPT-4 30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft  
ICD-9 21.88 Other septoplasty

Tonsillectomy without adenoidectomy

CPT-4 42825 Tonsillectomy, primary or secondary; under age 12  
CPT-4 42826 age 12 or over  
ICD-9 28.2 Tonsillectomy without adenoidectomy

Tonsillectomy with adenoidectomy

CPT-4 42820 Tonsillectomy and adenoidectomy; under age 12  
CPT-4 42821 age 12 or over  
ICD-9 28.3 Tonsillectomy with adenoidectomy

**Operations on the Cardiovascular System**

## Cardiac catheterization, left heart

CPT-4 93510 Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous

CPT-4 93511 by cutdown

CPT-4 93514 Left heart catheterization by left ventricular puncture

CPT-4 93524 Combined transeptal and retrograde left heart catheterization

ICD-9 37.22 Left heart cardiac catheterization

## Varicose vein ligation and stripping

CPT-4 37720 Ligation and division and complete stripping of long or short saphenous veins

ICD-9 38.5 Ligation and stripping of varicose veins

**Endoscopic Procedures**

## Bronchoscopy, diagnostic

CPT-4 31622 Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing or brushing

ICD-9 33.22 Fiber-optic bronchoscopy

ICD-9 33.23 Other bronchoscopy

## Dilation of esophagus

CPT-4 43455 Dilation of esophagus, by balloon or dilator; under fluoroscopic guidance

CPT-4 43456 retrograde

ICD-9 42.92 Dilation of esophagus

## Upper GI endoscopy, diagnostic

CPT-4 43235 Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum, jejunum, or both, as appropriate; complex diagnostic

ICD-9 44.13 Other endoscopy of small intestine

## Endoscopy of small intestine, diagnostic

CPT-4 44360 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; diagnostic

ICD-9 45.13 Other endoscopy of small intestine

## Colonoscopy, diagnostic

CPT-4 45378 Colonoscopy, fiber-optic, beyond splenic flexure; diagnostic, with or without colon decompression

ICD-9 45.23 Colonoscopy

## Sigmoidoscopy, diagnostic

CPT-4 45330 Sigmoidoscopy, flexible fiber-optic; diagnostic

ICD-9 45.24 Flexible sigmoidoscopy

**Operations on the Digestive System**

## Cholecystectomy (gall bladder removal)

CPT-4 49310 Laparoscopy, surgical; cholecystectomy (any method)

ICD-9 51.23 Laparoscopic cholecystectomy

## Inguinal hernia repair

CPT-4 49500 Repair inguinal hernia, under age 5 years, with or without hydrocelectomy

CPT-4 49505 Repair inguinal hernia, age 5 or over

ICD-9 53.00 Unilateral repair of inguinal hernia, not otherwise specified

ICD-9 53.01 Repair of direct inguinal hernia

ICD-9 53.02 Repair of indirect inguinal hernia

## Diagnostic laparoscopy

CPT-4 58980 Laparoscopy, diagnostic (separate procedure)

ICD-9 54.21 Laparoscopy

## Cystoscopy

CPT-4 52000 Cystourethroscopy (separate procedure)

ICD-9 57.32 Other cystoscopy

**Sterilization**

## Vasectomy

CPT-4 55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)

ICD-9 63.73 Vasectomy

## Tubal ligation

CPT-4 58982 Laparoscopy, surgical; with fulguration of oviducts (with or without transection)

CPT-4 58983 with occlusion of oviducts by device (for example, band, clip, or Falope ring)

ICD-9 66.21 Bilateral endoscopic ligation and crushing of fallopian tubes

ICD-9 66.22 Bilateral endoscopic ligation and division of fallopian tubes

ICD-9 66.29 Other bilateral endoscopic destruction or occlusion of fallopian tubes

**Gynecological Operations**

## Conization of cervix

CPT-4 57520 Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair (any method)

ICD-9 67.2 Conization of cervix

## Laser destruction of cervical lesion

CPT-4 57513 Cauterization of cervix; laser ablation

ICD-9 67.39 Other excision or destruction of lesion or tissue of cervix

## Diagnostic D &amp; C

CPT-4 58120 Dilation and curettage, diagnostic therapeutic (nonobstetrical), or both

ICD-9 69.09 Other dilation and curettage

**Operations on the Musculoskeletal System**

## Bunionectomy

CPT-4 28110 Osteotomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)

CPT-4 28290 Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)

CPT-4 28292 Keller, McBride or Mayo type procedure

CPT-4 28293 resection of joint with implant

CPT-4 28294 with tendon transplants (Joplin type procedure)

CPT-4 28296 with metatarsal osteotomy (for example, Mitchell, Chevron, or concentric type procedures)

CPT-4 28297 Lapidus type procedure

CPT-4 28298 by phalanx osteotomy

CPT-4 28299 by other methods (for example, double osteotomy)

ICD-9 77.51 Bunionectomy with soft tissue correction and osteotomy of the first metatarsal

ICD-9 77.52 Bunionectomy with soft tissue correction and arthrodesis

ICD-9 77.53 Other bunionectomy with soft tissue correction

ICD-9 77.54 Excision or correction of bunionette

ICD-9 77.57 Repair of claw toe

ICD-9 77.58 Other excision, fusion and repair of toes

ICD-9 77.59 Other bunionectomy

## Hammertoe correction

CPT-4 28285 Hammertoe operation; one toe (for example, interphalangeal fusion, filleting, phalangectomy)

ICD-9 77.56 Repair of hammertoe

## Knee arthroscopy, diagnostic

CPT-4 29870 Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)

ICD-9 80.26 Arthroscopy, knee

ICD-9 80.36 Biopsy of joint structure, knee

## Knee arthroscopy, removal of cartilage

CPT-4 29881 Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral including any meniscal shaving)

ICD-9 80.6 Excision of semilunar cartilage of knee

## Ganglionectomy, hand or wrist

CPT-4 25111 Excision of ganglion, wrist (dorsal or volar); primary

CPT-4 26160 Excision of lesion of tendon sheath or capsule (for example, cyst, mucous cyst, or ganglion), hand or finger

ICD-9 82.21 Excision of lesion of tendon sheath of hand

**Operations on the Integumentary System**

## Breast biopsy, incisional

CPT-4 19101 Biopsy of breast; incisional

ICD-9 85.12 Open biopsy of breast

## Removal of breast lesion

CPT-4 19120 Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion or nipple lesion (except 19140), male or female, one or more lesions

ICD-9 85.21 Local excision of lesion of breast



## Miscellaneous Diagnostic and Therapeutic Procedures

CAT scan of head, without contrast

CPT-4 70450 Computerized axial tomography, head or brain; without contrast material

ICD-9 87.03 Computerized axial tomography of head

CAT scan of head, with and without contrast

CPT-4 70470 Computerized axial tomography, head or brain; without contrast material, followed by contrast material(s) and further sections

ICD-9 87.03 Computerized axial tomography of head

Contrast myelogram of spine

CPT-4 61055 Cisternal or lateral cervical (C1-C2) puncture; with injection of drug or other substance for diagnosis or treatment (C1-C2) or

CPT-4 62284 Injection procedure for myelography or computerized axial tomography, or both, spinal (other than C1-C2 and posterior fossa), plus

CPT-4 72270 Myelography, entire spinal canal, radiological supervision and interpretation

ICD-9 87.21 Contrast myelogram

Mammography

CPT-4 76092 Screening mammography, bilateral (two view film study of each breast)

ICD-9 87.37 Other mammography (X-ray imaging of the breast, other than xerography)

CAT scan of abdomen, without contrast

CPT-4 74150 Computerized axial tomography, abdomen; without contrast material

ICD-9 88.01 Computerized axial tomography of abdomen

CAT scan of abdomen, with and without contrast

CPT-4 74170 Computerized axial tomography, abdomen; without contrast material, followed by contrast material(s) and further sections

ICD-9 88.01 Computerized axial tomography of abdomen

Diagnostic ultrasound, abdomen and retroperitoneum

CPT-4 76700 Echography, abdominal, B-scan or real time with image documentation, or both; complete

CPT-4 76770 Echography, retroperitoneal (for example, renal, aorta, nodes), B-scan or real time with image documentation, or both; complete

ICD-9 88.76 Diagnostic ultrasound of abdomen and retroperitoneum

Diagnostic ultrasound, gravid uterus

CPT-4 76805 Echography, pregnant uterus, B-scan or real time with image documentation, or both; complete (complete fetal and maternal evaluation)

CPT-4 76810 complete (complete fetal and maternal evaluation), multiple gestation, after the first trimester

ICD-9 88.78 Diagnostic ultrasound of gravid uterus

Magnetic resonance imaging, brain, without contrast

CPT-4 70551 Magnetic resonance (for example, proton) imaging, brain (including brain stem); without contrast material

ICD-9 88.91 Magnetic resonance imaging of brain and brain stem

Magnetic resonance imaging, brain, with and without contrast

CPT-4 70553 Magnetic resonance (for example, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences

ICD-9 88.91 Magnetic resonance imaging of brain and brain stem

Magnetic resonance imaging, spinal canal, without contrast

CPT-4 72141 Magnetic resonance (for example, proton) imaging, spinal canal and contents, cervical; without contrast material

CPT-4 72146 Magnetic resonance (for example, proton) imaging, spinal canal and contents, thoracic; without contrast material

CPT-4 72148 Magnetic resonance (for example, proton) imaging, spinal canal and contents, lumbar; without contrast material

ICD-9 88.93 Magnetic resonance imaging of spinal canal

Magnetic resonance imaging, spinal canal, with and without contrast

CPT-4 72156 Magnetic resonance (for example, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical

CPT-4 72157 thoracic

CPT-4 72158 lumbar

ICD-9 88.93 Magnetic resonance imaging of spinal canal

Treadmill stress test

CPT-4 93015 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise or pharmacological stress, or both; continuous electrocardiographic monitoring, with interpretation and report

ICD-9 89.41 Cardiovascular stress test using treadmill

Electrocardiogram

CPT-4 93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

ICD-9 89.52 Electrocardiogram

Extracorporeal shockwave lithotripsy, kidney, ureter or bladder, or any combination of these

CPT-4 50590 Lithotripsy, extracorporeal shockwave

ICD-9 98.51 Extracorporeal shock wave lithotripsy (ESWL) of the kidney, ureter or bladder, or any combination of these



\*Charges for outpatient procedures shall include the facility's total customary charges for a specific procedure or group of procedures defined according to ICD-9-CM or CPT-4 codes. Charges shall include fees associated with the preparation of the patient (preoperative phase), performance of the procedure (intraoperative phase) and recovery (postoperative phase): Preoperative phase includes those services and procedures that prepare the patient for the surgical procedure. It shall include, but is not limited to, charges for standard preoperative diagnostic laboratory testing, radiological services, preparatory pharmaceuticals (preoperative medications), skin preparation supplies, and the like. Intraoperative phase includes those services and procedures during the period of time of the actual surgical procedure itself (as identified by ICD-9-CM or CPT-4 code) as performed to eliminate or improve the patient's diagnostic condition. It shall include, but is not limited to, room charges for the surgery suite, anesthesia and other intraoperative pharmaceuticals, equipment and supplies (drapes/barriers, electrocautery tips and grounding pads, specialized scalpel blades, dressing materials, casting materials and orthopedic supplies, and the like). Postoperative phase includes those services and procedures that are provided to the patient from the point at which the patient exits the surgery suite to the point at which the patient is discharged from the facility. It shall include, but is not limited to, charges for use of the recovery room, dressings, pharmaceuticals, respiratory therapy, supplies and the like. Professional fees for facility-based radiologists, pathologists, anesthesiologists and the like, if they are reported by the facility, shall be reported separately.

**EXHIBIT D**

**Financial Data Elements**

**BALANCE SHEET\***

1a.	Cash and cash equivalents	_____	
1b.	Net patient accounts receivable	_____	
1c.	Other current assets	_____	
1d.	Total current assets	_____	
2a.	Fixed assets at cost	_____	
2b.	Less: accumulated depreciation	_____	
2c.	Fixed assets (net)	_____	
3.	Other assets	_____	
4.	Total assets	_____	
5.	Current liabilities	_____	
6.	Long-term debt	_____	
7.	Other long-term liabilities	_____	
8.	Fund balance	_____	
9.	Total liabilities and fund balance	_____	

**INCOME STATEMENT\*\***

1a.	Inpatient revenue	_____	
1b.	Outpatient revenue	_____	
1c.	Total gross patient revenue	_____	
2a.	Charity care	_____	
2b.	Other allowances and deductions	_____	
2c.	Total deductions and allowances	_____	
3.	Net patient revenue	_____	
4.	Other revenue	_____	
5.	Total revenue	_____	
6a.	Payroll expenses	_____	
6b.	Employee benefits	_____	
6c.	Depreciation expense	_____	
6d.	Bad debt expense	_____	
6e.	All other operating expenses	_____	
6f.	Total operating expenses	_____	
7.	Net income from operations	_____	
8a.	Investment income	_____	
8b.	Contributions	_____	
8c.	Tax support and other subsidies	_____	
8d.	Miscellaneous gains and losses	_____	
8e.	Nonoperating gains and losses	_____	
9.	Net income before extraordinary and other nonrecurring items	_____	
10.	Extraordinary gains and losses	_____	
11.	Net income	_____	

**SUPPLEMENTAL ITEMS\*\*\***

1.	If depreciation is funded, balance at end of reporting period	_____	
2a.	Medicare gross patient revenue	_____	
2b.	Medicaid gross patient revenue	_____	
2c.	Other government patient revenue	_____	
2d.	Nongovernment patient revenue	_____	

**Definitions for Exhibit D**

## Balance Sheet\*

- 1a. *Cash and cash equivalents* means money on hand, and includes money in checking accounts, time deposits, temporary cash investments and uninvested funds held by investment custodians.
- 1b. *Net patient accounts receivable* means accounts receivable, net of estimated uncollectibles.
- 1c. *Other current assets* means other accounts receivable, notes receivable and may include the current portion of assets whose use is limited, prepaid expenses, inventory and short-term investments.
- 1d. *Total current assets* means the sum of lines 1a. through 1c.
- 2a. *Fixed assets at cost* means land, land improvements, buildings and improvements, leasehold improvements, equipment (fixed and movable), leased property and equipment, and construction in progress, at cost.
- 2b. *Accumulated depreciation* means depreciation and amortization.
- 2c. *Fixed assets (net)* means fixed assets at cost (line 2a.) less accumulated depreciation (line 2b.).
3. *Other assets* means all other assets, and may include deferred financing costs, unamortized bond issue costs, investment in affiliated company, deferred third-party reimbursement and other assets.
4. *Total assets* means the sum of lines 1d., 2c. and 3.
5. *Current liabilities* means those which will be discharged with current assets, and may include notes payable to banks; the current portion of long-term debt; accounts payable; advances from and amounts payable to third-party payers for estimated and final reimbursement settlements; refunds to and deposits from patients and others; deferred revenue; accrued salaries and payroll taxes; and other accruals such as pension or profit-sharing contributions, compensated absences, and income and other taxes.
6. *Long-term debt* means notes payable, mortgages payable, capital leases, bonds payable and loans/contracts payable.
7. *Other long-term liabilities* means other long-term obligations, and may include estimated malpractice costs, deferred compensation payable, deferred third-party reimbursement and accrued pension/deferred pension liability.
8. *Fund balance* means the excess of assets over liabilities (net equity). An excess of liabilities over assets is reflected as a deficit.
9. *Total liabilities and fund balance* means the sum of lines 5.–8. Must agree with total assets, line 4.

*Income Statement\*\**

- 1a. *Inpatient revenue* means full hospital charges for all hospital services to inpatients.
- 1b. *Outpatient revenue* means full hospital charges for all hospital services to outpatients.
- 1c. *Total gross patient revenue* means the sum of lines 1a. and 1b. Full hospital charges for all hospital patient services before considering any deductions for charity care or contractual allowances.
- 2b. *Other allowances and deductions* means revenue deductions incurred in treating patients other than charity patients, including Medicare, Medicaid, other insured and uninsured patients. It includes courtesy discounts given to employees and others. It does not include bad debt expense, which is to be reported as an operating expense (line 6d.).
- 2c. *Total allowance and deductions* means the sum of lines 2a. and 2b.
3. *Net patient revenue* means total gross revenue (line 2.) less total allowances and deductions (line 2c.).
4. *Other revenue* means revenue from services other than health care provided to patients and residents, and includes sales and services to nonpatients. This revenue arises from the normal day-to-day operations of the health care entity. Other revenues may include: revenue such as gifts, grants, or endowment income restricted by donors to finance charity care; revenue from educational programs; revenue from research and other gifts and grants; revenue from miscellaneous sources, such as rental of facility space, sales of medical and pharmacy supplies, fees charged for transcripts for attorneys, insurance companies and others, proceeds from the sale of cafeteria meals and guest trays, proceeds from the sale of scrap, used X-ray film, and proceeds from sales at gift shops, snack bars, newsstands, parking lots, vending machines and other service facilities operated by the health care entity.
5. *Total revenue* means the sum of lines 3. and 4.
- 6a. *Payroll expenses* means salaries and wages paid to employees of the health care entity.
- 6b. *Employee benefits* means Social Security, group insurance, retirement benefits, Workers' Compensation, unemployment insurance and others.
- 6c. *Depreciation expense* means depreciation and amortization of property and equipment recorded for the reporting period.
- 6d. *Bad debt expense* means revenue amounts deemed uncollectible primarily because of a patient's unwillingness to pay as determined after collection efforts based upon sound credit and collection policies. It does not include charity care, which is to be reported on line 2a.
- 6e. *All other operating expenses* means expenses for professional fees, interest, supplies, purchased services, utilities, income taxes, operating losses and any other expenses not included in the above categories.
- 6f. *Total operating expenses* means the sum of lines 6a.–6e.
7. *Income from operations* means total revenue (line 5.) less total operating expenses (line 6f.).
- 8a. *Investment income* means return on investments of general funds, except that investment income and realized gains and losses on borrowed funds held by a trustee, investment income on malpractice trust funds and investment income that is essential to the ongoing major or central operations are included in other revenue (line 4.).
- 8b. *Contributions* means contributions, donations and bequests for general operating purposes from foundations, similar groups or individuals, or any combination of these.
- 8c. *Tax support and other subsidies* means tax levies and other subsidies from governmental or community agencies received for general support of the entity.
- 8d. *Miscellaneous gains and losses* means all other gains and losses from a provider's peripheral or incidental transactions, such as gain or loss on sale of health care entity properties; net rentals of facilities used in the operation of the entity; and term endowment funds that are available for general operating purposes upon termination of restrictions.
- 8e. *Nonoperating gains and losses* means the sum of lines 8a.–8d.
9. *Net income before extraordinary and other nonrecurring items* means the sum of net income from operations (line 7.) and nonoperating gains and losses (line 8e.).
10. *Extraordinary gains and losses* means gains or losses unusual in amount and nonrecurring in nature that do not result from normal operating activities. Events or transactions that occur frequently in the health care environment, such as large, unrestricted gifts, cannot be regarded as extraordinary, regardless of their financial effect, and are to be included in ordinary income.



11. *Net income* means the sum of lines 9. and 10.

Supplemental Items\*\*\*

1. *Funded depreciation* means cash resources which have been set aside and accumulated for the purpose of financing the renewal or replacement of plant assets.

2a. *Medicare gross patient revenue* means full hospital charges for all hospital services provided to Medicare patients.

2b. *Medicaid gross patient revenue* means full hospital charges for all hospital services provided to Medicaid patients.

2c. *Other government patient revenue* means full hospital charges for all hospital services provided to other government patients, including CHAMPUS, government retirement and Crippled Children's Service.

2d. *Nongovernment patient revenue* means full hospital charges for all hospital services provided to nongovernment patients, including those with private insurance, those belonging to HMOs or PPOs, and those without insurance.