



THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

January 27, 2005

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

**GRANT AWARD FROM QUEENSCARE FOR INPATIENT SERVICES AT
DEPARTMENT OF HEALTH SERVICES HOSPITALS (All Districts) (3 Votes)**

IT IS RECOMMENDED THAT YOUR BOARD:

Accept a grant award, substantially similar to Exhibit 1, from QueensCare to the Department of Health Services (DHS) for the provision of inpatient services to low-income patients who reside in the QueensCare primary service area at Department of Health Services' hospitals. The maximum award under this grant is \$800,000, for the period of January 1, 2005 through December 31, 2005.

PURPOSE/JUSTIFICATION OF THE RECOMMENDED ACTIONS:

Acceptance of this grant will provide \$800,000 in reimbursement through QueensCare to support inpatient services provided at DHS hospitals to indigent patient who reside in the QueensCare catchment area.

BOARD OF SUPERVISORS

Gloria Molina
First District

Yvonne Brathwaite Burke
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

FISCAL IMPACT/FINANCING:

The QueensCare grant provides for up to \$800,000 in revenue for the period of January 1, 2005 through December 31, 2005, to offset the cost of providing inpatient services at DHS hospitals to individuals who reside in the QueensCare catchment area.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS:

QueensCare approached the Department in March 2004 about providing reimbursement to offset the cost of providing inpatient services at its hospitals to indigent patients who reside in the QueensCare catchment area. At QueensCare's behest, the Department submitted a request for an \$800,000 grant for this purpose and QueensCare notified the Department on January 6, 2005, of its decision to approve the grant request. The QueensCare service area is identified as the following zip codes: 90004, 90005, 90006, 90020, 90026, 90027, 90028, 90029, 90038, and 90057. The scope of services covered under this grant includes all covered inpatient diagnostic related groups, with the exception of those in conflict with the Catholic Bishop's Directive.

In September 2001, QueensCare made a grant of \$1.2 million to the Office of Women's Health to provide reimbursement for the provision of invasive cervical cancer treatment at DHS hospitals to women residing in the QueensCare catchment area, for the period of June 1, 2001 through September 30, 2002. The Women's Health grant was amended in October 2002 to extend the term to December 31, 2003, and to add other reproductive cancers, such as uterine, ovarian, vaginal, and fallopian tube cancer, as well as breast cancer to the scope of covered services. In July 2003, the grant was amended again to expand the scope of services to include all covered inpatient diagnostic related groups, with the exception of those in conflict with the Catholic Bishop's Directive.
90057.

Under this grant, QueensCare will provide reimbursement for services rendered to indigent patients whose incomes are below 200 percent of the federal poverty level and who are ineligible for other coverage programs, such as Medi-Cal and Medicare.

CONTRACTING PROCESS:

Not applicable.

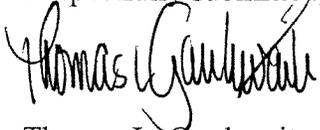
IMPACT ON CURRENT SERVICES (OR PROJECTS):

Acceptance of this grant will provide \$800,000 in reimbursement through QueensCare to support inpatient services provided at DHS hospitals indigent patient who reside in the QueensCare service area.

Honorable Board of Supervisors
January 27, 2005
Page 3

When approved, this Department requires one signed copy of the Board's action.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Thomas L. Garthwaite". The signature is written in a cursive style with a large initial "T".

Thomas L. Garthwaite, MD
Director and Chief Medical Officer

TLG:ak

Attachments

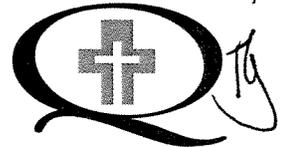
c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

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QueensCare

"Bringing Healthcare to the Community"



TERRY A. BONECUTTER
President & CEO

BARBARA BRANDLIN PULLEY
Senior Vice President
Chair, Management Committee

January 6, 2005

J.J. BRANDLIN
Co-Chair, Planning Committee

ARTHUR W. BARRON
Chair
Finance Committee

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Barbara Brandlin Pulley
Joan Seidel
Ray Sweet

Mr. Thomas Garthwaite
Director
County of Los Angeles
Department of Health Services
313 N. Figueroa
Los Angeles, CA 90012

SUBJECT: \$800,000 Grant Agreement

Dear Mr. Garthwaite,

We are pleased to inform you that the Board of Directors of QueensCare has approved a grant in the amount of \$800,000 to the Los Angeles County Department of Health Services for inpatient health care for 2005 as that grant period described below. The terms and conditions of the grant are as follows:

CHARITABLE
DIVISION BOARD

Hon. Newton R. Russell
Chair

Lois Saffian
Vice Chair

J. Norman O'Neill, Jr.,
Secretary

Joan Sanders Baker
Mary Elizabeth Barron
Les Benson
Bernice Z. Brown, M.D.

Guillermo Gonzalez
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Rev. Msgr. Jeremiah Murphy
John B. Orr, Ph.D.
Tom Owenson

John B. Rauen, Jr.
Madeleine Stoner, Ph.D.
Peter J. Taylor

David Walsh
Hon. Michael Woo
Mary Carlotia Woodward

1) Payment: This grant is payable in monthly disbursements as billed for services subject to the satisfactory progress of your program. You are not required to open a separate account for our grant monies, but you are required to account fully for their expenditure. This grant is subject to audit at our expense.

2) Purpose: The grant must be used to provide indigent hospital health care to patients who are residents of the QueensCare primary service area as described in your proposal dated March 29, 2004, and subsequent correspondence. Inpatient care means that type of care provided at a general acute care hospital and does not include any type of outpatient care. No substantial changes may be made without prior written approval of QueensCare. In all cases, beneficiaries of services provided by this funding must be medically indigent which is defined as those whose family's annual income is at or below 200% of the federal poverty level and who does not qualify for reimbursement from any payor including governmental reimbursement programs.

No portion of this funding may be used to provide heterologous fertilization, artificial insemination, abortion, the destruction of human embryos, direct sterilization, and similar procedures, except when in the absolute discretion of QueensCare ethicist, the operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant women are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.

3) Grant Period: The period of this grant is from January 1, 2005 to December 31, 2005 or until the funds are expended. QueensCare has a policy of not considering an additional request from an organization which has an open grant.

4) Tax Status: You warrant that you are exempt from income tax under Section 501 (c) (3) of the Internal Revenue Code and are not a private foundation as described in Section 509 (a). Any change in this status shall be communicated to us immediately. You further warrant that this grant will not result in your becoming a private foundation under the public support test, if such test is applicable to your organization.

5) Lobbying: You also warrant that none of the funds will be used to influence legislation unless permitted by law.

6) Reporting: You agree to provide any requested information in the event that QueensCare is audited by the Attorney General or any other oversight authority. For this purpose, you are required to maintain supporting documents, in an auditable condition, for a period of not less than seven years. You will submit a narrative qualitative report at the end of the grant period highlighting successes and challenges, and include service statistics as appropriate.

Please send report and correspondence to:

Eleanor Aguilar
Vice President, Programs
QueensCare
1300 N. Vermont Avenue, Suite 1002
Los Angeles, California 90027

7) Publicity: QueensCare reserves the right to publicize the grant in any manner which it deems appropriate. Should you choose to release a public announcement pertaining to this grant, the proposed release must be submitted to QueensCare in advance for review and comment. All printed material with substantial reference to the program will acknowledge QueensCare's support.

8) Compliance: Failure to comply with any of the terms of this agreement may result in one or more of the following actions.

- QueensCare may terminate the grant and/or suspend future grant payments until compliance can once again be verified.
- QueensCare may require reimbursement of any of the funds not used for approved purposes.
- QueensCare may require repayment of all unexpended grant funds.

It is the policy of QueensCare to discourage grantees from making gifts to QueensCare personnel, giving honoraria in any form, or sending plaques or other memorabilia.

We wish you continuing success in meeting healthcare needs in our community. If you have any further questions, feel free to call at your convenience. If these terms meet your approval, please sign the enclosed copy of this letter and return to the address shown above. The original is for your records. Thank you.

Yours truly,

A handwritten signature in black ink, appearing to read "Terry A. Bonecutter". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Terry A. Bonecutter
President
Chief Executive Officer

TAB/ea

Accepted:

Name: _____

Title: _____

Date: _____

EXHIBIT A: MEDICALLY INDIGENT QUALIFICATIONS UNDER QUEENSCARE ARTICLES OF INCORPORATION

To qualify as a QueensCare Patient or a Provider Patient, the person must be -

- Medically Indigent,
- receiving Inpatient Healthcare, at a Qualified Hospital Recipient and
- reside within the Service Area as those terms are defined in QueensCare Articles of Incorporation, a portion of which follows.

ARTICLE III (a) DEFINITIONS (not necessarily in order)

- (8) Medically Indigent. An adult person or emancipated minor shall be regarded as “Medically Indigent” if (A) his or her family has an annual gross household income at or below 200% of the federal income level applicable to him or her based on the size of his or her family, as set forth in the “Poverty Income Guidelines” published in the Federal Register, and (B) the Medical Care he or she needs does not qualify for reimbursement from any payor including governmental reimbursement programs (including but not limited to Medicare and Medi-Cal programs). An unemancipated minor shall be regarded as “Medically Indigent if his or her parent or legal guardian is considered “Medically Indigent.”
- (4) Inpatient Healthcare. (A) Medical Care provided to inpatient at a general acute care hospital operated by a Qualified Hospital Recipient in the Service Area; and (B) purchasing or funding inpatient health care insurance that covers Medical Care provided to Medically Indigent persons residing in the Service Area.
- (11) Qualified Hospital Recipient. A California nonprofit corporation that operates a general acute care hospital licensed under California Health and Safety Code section 1250, that is exempt from federal income taxation under 501(a) of the Code, because it is described in Section 501(c)(3) of the Code; or a political subdivision, instrumentality or agency of the State of California, the County of Los Angeles, or any city within the County of Los Angeles that operates a general acute care hospital within the Service Area.
- (17) Service Area. The Primary Service Area plus the Secondary Service Area plus the Remainder Service Area.
- (9) Primary Service Area. The geographical area and population contained within the ten zip codes immediately surrounding the Hospital *. The ten zip codes immediately surrounding the Hospital * are: 90004, 90005, 90006, 90020, 90026, 90027, 90028, 90029, 90038, and 90057.
- (14) Remainder Service Area. The geographical area and population of Los Angeles County not part of the Primary Service Area or the Secondary Service Area.

(15) Secondary Service Area. The geographical area and population encompassed by all of the zip codes any part of any of which are within a ten-mile radius of the Hospital *, but excluding the zip codes constituting the Primary Service Area. Note: the Secondary Service Area includes:

90001	90018	90036	90058	90089	90305	91108	91214	91523
90003	90019	90037	90062	90095	90640	91125	91352	91601
90007	90021	90039	90063	90201	91001	91126	91401	91602
90008	90022	90041	90064	90210	91020	91201	91403	91604
90010	90023	90042	90065	90211	91030	91202	91423	91605
90011	90024	90043	90066	90212	91040	91203	91501	91606
90012	90025	90044	90067	90230	91042	91204	91502	91607
90013	90031	90046	90068	90232	91101	91205	91504	91608
90014	90032	90047	90069	90255	91103	91206	91505	91754
90015	90033	90048	90071	90270	91104	91207	91506	91801
90016	90034	90049	90073	90301	91105	91208	91521	91803
90017	90035	90056	90077	90302	91106	91210	91522	

* As the Hospital is defined in Article III as Queen of Angels - Hollywood Presbyterian Medical Center located at 1300 North Vermont Avenue, Los Angeles, CA 90027.

EXHIBIT B: PAYMENT RATE FOR HOSPITAL PATIENTS

Services rendered to a hospital inpatient will be charged against the grant amount using the following formula on a per patient basis:

Current Hospital Medicare Diagnostic Related Groups (“DRG”) Rate * x Current DRG weight

* The DRG Rate shall exclude the following components:

- All capital
- All Medical Education of Interns and Residents
- Cost Outliers
- Day Outliers

In addition, preadmission services normally subject to Section 1886(a)(4) of the Social Security Act if the patient was Medicare, are to be included in the above payment, that is, bundled in the above payment. Only DRG’s which are covered on the attached Exhibit B, Addendum A, shall be paid. For any DRG’s not listed as covered on the attached Exhibit B, Addendum A, no payment shall be made under this agreement.

If a patient is treated by a QueensCare Panel Specialist, that physician’s professional component will be funded separately under the contract with the physician involved. All other physicians’ professional components are the responsibility of the Provider. An additional fifteen percent (15%) will be added to the above DRG computation to cover such payment. Other notes:

- Services submitted for charging against the grant amount via a UB92.
- Payor Box 50 on the UB92 (HCFA-1450) to state the following: QueensCare Contract “Number”. The Contract “Number” is the “Authorization #” from the QueensCare Referral Request & Authorization Form (see Exhibit E)
- The relative weighting factor to be updated periodically to match the most current weight published by the Medicare Program.
- Hospital to provide all correspondence and supporting documentation from the Medicare Program necessary to substantiate current DRG rate as determined by QueensCare.
- Any QueensCare Panel Specialist will submit his charges directly to QueensCare via a HCFA form 1500. In Box 11.c. (Insurance Plan Name or Program Name) please enter the following Payor Information: “QueensCare Contract «ContractNo».” The Provider will inform the physician of this procedure. These charges will be paid at 80% of current Medicare rate.
- The above payment is payment in full. No billing to or collection from the patient, by any entity including the physician, is allowed. The Provider will inform the physician of this.

All of the above charges to be submitted monthly to the following address:

QueensCare Billing Department
P.O. Box 27005
Los Angeles, California 90027-6005



**QueensCare Contracted Hospital: Good Samaritan
REFERRAL REQUEST & AUTHORIZATION**

Section A PATIENT INFORMATION

Patient Name (First) (Middle) (Last) Authorization #: _____
Address: _____ MR #: _____
City: _____ Zip Code: _____ ICD #: _____
Phone: _____ Birth Date: _____

Section B REFERRAL INFORMATION

Referred to: **QueensCare Specialist Network**
Referred from (Name of Clinic and/or Physician) _____
Primary Care Physician: _____
Appointment Date: _____ Appointment made by: _____
Means of Transportation: _____

Section C SPECIALIST and/or PROCEDURE REQUESTED

Section D CHIEF COMPLAINT/DIAGNOSIS

NOTICE: *QueensCare has authorized this referral for the services requested. Rendering services to this patient indicates your agreement to accept QueensCare contract rates as payment in full. Balance billing of the patient is not permitted. Any service rendered beyond those authorized, without prior written approval from the Medical Director will be subject to denial of payment.*

FOR PAYMENT:

All of the following items must be provided or reimbursement cannot be made:

- A. An itemized bill including RBRVS/CPT/HCPCS
- B. A copy of this referral authorization with Medical Director's signature.
- C. A medical summary report.
- D. Claims will be submitted for review before payment

MAIL CLAIM & FORMS TO:

QueensCare Family Clinics
Attn: Suite 307
P.O. Box 27005
Los Angeles, CA 90027-0005

Section E

Consultation Consultation plus 2 visits Surgery Management this problem

ف APPROVED ف DENIED ف MODIFIED

By Medical Director _____ Date: _____



QueensCare Contracted Hospital
REFERRAL REQUEST & AUTHORIZATION

Section A PATIENT INFORMATION

Patient Name (First) _____ (Middle) _____ (Last) _____
Address: _____ City: _____ Zip Code: _____
Phone: _____ Birth Date: _____

Section B REFERRAL INFORMATION

Referred to: **QueensCare Specialist Network**
Referred from (Name of Church/Agency) _____ Code: _____
Parish Nurse: _____ Phone Number: _____

Section C CHIEF COMPLAINT/DIAGNOSIS

Section D SERVICE REQUESTED/JUSTIFICATION

Section E MEDICAL DIRECTORS COMMENTS

NOTICE: *QueensCare has authorized this referral for the services requested. Rendering services to this patient indicates your agreement to accept QueensCare contract rates as payment in full. Balance billing of the patient is not permitted. Any service rendered beyond those authorized, without prior written approval from the Medical Director will be subject to denial of payment.*

FOR PAYMENT:
All of the following items must be provided or reimbursement cannot be made:
E. An itemized bill including RBRVS/CPT/HCPCS
F. A copy of this referral authorization with Medical Director's signature.
G. A medical summary report.
H. Claims will be submitted for review before payment

MAIL CLAIM & FORMS TO:
QueensCare Family Clinics
Attn: Suite 307
P.O. Box 27005
Los Angeles, CA 90027-0005

Section F
 Consultation Consultation plus 2 visits DME OTHER _____

ف APPROVED ف DENIED ف MODIFIED

By Medical Director _____ Date: _____

QueensCare Grant
DRG List Effective 10/1/04

DRGNo(A)	DRG Descr	Coverage
001	CRANIOTOMY AGE W CC	Covered
002	CRANIOTOMY AGE W/O CC	Covered
003	CRANIOTOMY AGE 0-17	Covered
004	NO LONGER VALID	Non-Covered
005	NO LONGER VALID	Non-Covered
006	CARPAL TUNNEL RELEASE	Covered
007	PERIPH CRANIAL NERVE OTHER NERV SYST PROC W CC	Covered
008	PERIPH CRANIAL NERVE OTHER NERV SYST PROC W/O CC	Covered
009	SPINAL DISORDERS INJURIES	Covered
010	NERVOUS SYSTEM NEOPLASMS W CC	Covered
011	NERVOUS SYSTEM NEOPLASMS W/O CC	Covered
012	DEGENERATIVE NERVOUS SYSTEM DISORDERS	Covered
013	MULTIPLE SCLEROSIS CEREBELLAR ATAXIA	Covered
014	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	Covered
015	NONSPECIFIC CVA PRECEREBRAL OCCLUSION W/O INFARCT	Covered
016	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	Covered
017	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	Covered
018	CRANIAL PERIPHERAL NERVE DISORDERS W CC	Covered
019	CRANIAL PERIPHERAL NERVE DISORDERS W/O CC	Covered
020	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	Covered
021	VIRAL MENINGITIS	Covered
022	HYPERTENSIVE ENCEPHALOPATHY	Covered
023	NONTRAUMATIC STUPOR COMA	Covered
024	SEIZURE HEADACHE AGE W CC	Covered
025	SEIZURE HEADACHE AGE W/O CC	Covered
026	SEIZURE HEADACHE AGE 0-17	Covered
027	TRAUMATIC STUPOR COMA, COMA HR	Covered
028	TRAUMATIC STUPOR COMA, COMA HR AGE W CC	Covered
029	TRAUMATIC STUPOR COMA, COMA HR AGE W/O CC	Covered
030	TRAUMATIC STUPOR COMA, COMA HR AGE 0-17	Covered
031	CONCUSSION AGE W CC	Covered
032	CONCUSSION AGE W/O CC	Covered
033	CONCUSSION AGE 0-17	Covered
034	OTHER DISORDERS OF NERVOUS SYSTEM W CC	Covered
035	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	Covered
036	RETINAL PROCEDURES	Covered
037	ORBITAL PROCEDURES	Covered
038	PRIMARY IRIS PROCEDURES	Covered
039	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	Covered
040	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE	Covered
041	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	Covered
042	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS LENS	Covered
043	HYPHEMA	Covered
044	ACUTE MAJOR EYE INFECTIONS	Covered
045	NEUROLOGICAL EYE DISORDERS	Covered
046	OTHER DISORDERS OF THE EYE AGE W CC	Covered
047	OTHER DISORDERS OF THE EYE AGE W/O CC	Covered
048	OTHER DISORDERS OF THE EYE AGE 0-17	Covered
049	MAJOR HEAD NECK PROCEDURES	Covered
050	SIALOADENECTOMY	Covered

QueensCare Grant
DRG List Effective 10/1/04

DRGNo(A)	DRG Descr	Coverage
051	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	Covered
052	CLEFT LIP PALATE REPAIR	Covered
053	SINUS MASTOID PROCEDURES AGE	Covered
054	SINUS MASTOID PROCEDURES AGE 0-17	Covered
055	MISCELLANEOUS EAR, NOSE, MOUTH THROAT PROCEDURES	Covered
056	RHINOPLASTY	Covered
057	TPROC, EXCEPT TONSILLECTOMY ADENOIDECTOMY ONLY, AGE	Covered
058	TPROC, EXCEPT TONSILLECTOMY ADENOIDECTOMY ONLY, AGE 0-17	Covered
059	TONSILLECTOMY ADENOIDECTOMY ONLY, AGE	Covered
060	TONSILLECTOMY ADENOIDECTOMY ONLY, AGE 0-17	Covered
061	MYRINGOTOMY W TUBE INSERTION AGE	Covered
062	MYRINGOTOMY W TUBE INSERTION AGE 0-17	Covered
063	OTHER EAR, NOSE, MOUTH THROAT O.R. PROCEDURES	Covered
064	EAR, NOSE, MOUTH THROAT MALIGNANCY	Covered
065	DYSEQUILIBRIUM	Covered
066	EPISTAXIS	Covered
067	EPIGLOTTITIS	Covered
068	OTITIS MEDIA URI AGE W CC	Covered
069	OTITIS MEDIA URI AGE W/O CC	Covered
070	OTITIS MEDIA URI AGE 0-17	Covered
071	LARYNGOTRACHEITIS	Covered
072	NASAL TRAUMA DEFORMITY	Covered
073	OTHER EAR, NOSE, MOUTH THROAT DIAGNOSES AGE	Covered
074	OTHER EAR, NOSE, MOUTH THROAT DIAGNOSES AGE 0-17	Covered
075	MAJOR CHEST PROCEDURES	Covered
076	OTHER RESP SYSTEM O.R. PROCEDURES W CC	Covered
077	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	Covered
078	PULMONARY EMBOLISM	Covered
079	RESPIRATORY INFECTIONS INFLAMMATIONS AGE W CC	Covered
080	RESPIRATORY INFECTIONS INFLAMMATIONS AGE W/O CC	Covered
081	RESPIRATORY INFECTIONS INFLAMMATIONS AGE 0-17	Covered
082	RESPIRATORY NEOPLASMS	Covered
083	MAJOR CHEST TRAUMA W CC	Covered
084	MAJOR CHEST TRAUMA W/O CC	Covered
085	PLEURAL EFFUSION W CC	Covered
086	PLEURAL EFFUSION W/O CC	Covered
087	PULMONARY EDEMA RESPIRATORY FAILURE	Covered
088	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	Covered
089	SIMPLE PNEUMONIA PLEURISY AGE W CC	Covered
090	SIMPLE PNEUMONIA PLEURISY AGE W/O CC	Covered
091	SIMPLE PNEUMONIA PLEURISY AGE 0-17	Covered
092	INTERSTITIAL LUNG DISEASE W CC	Covered
093	INTERSTITIAL LUNG DISEASE W/O CC	Covered
094	PNEUMOTHORAX W CC	Covered
095	PNEUMOTHORAX W/O CC	Covered
096	BRONCHITIS ASTHMA AGE W CC	Covered
097	BRONCHITIS ASTHMA AGE W/O CC	Covered
098	BRONCHITIS ASTHMA AGE 0-17	Covered
099	RESPIRATORY SIGNS SYMPTOMS W CC	Covered
100	RESPIRATORY SIGNS SYMPTOMS W/O CC	Covered

QueensCare Grant
DRG List Effective 10/1/04

DRGNo(A)	DRG Descr	Coverage
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	Covered
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	Covered
103	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	Covered
104	CARDIAC VALVE OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	Covered
105	CARDIAC VALVE OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	Covered
106	CORONARY BYPASS W PTCA	Covered
107	CORONARY BYPASS W CARDIAC CATH	Covered
108	OTHER CARDIOTHORACIC PROCEDURES	Covered
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	Covered
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	Covered
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	Covered
112	NO LONGER VALID	Non-Covered
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB TOE	Covered
114	UPPER LIMB TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	Covered
115	PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR	Covered
116	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	Covered
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	Covered
118	CARDIAC PACEMAKER DEVICE REPLACEMENT	Covered
119	VEIN LIGATION STRIPPING	Covered
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	Covered
121	CIRCULATORY DISORDERS W AMI MAJOR COMP, DISCHARGED ALIVE	Covered
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	Covered
123	CIRCULATORY DISORDERS W AMI, EXPIRED	Covered
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH COMPLEX DIAG	Covered
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	Covered
126	ACUTE SUBACUTE ENDOCARDITIS	Covered
127	HEART FAILURE SHOCK	Covered
128	DEEP VEIN THROMBOPHLEBITIS	Covered
129	CARDIAC ARREST, UNEXPLAINED	Covered
130	PERIPHERAL VASCULAR DISORDERS W CC	Covered
131	PERIPHERAL VASCULAR DISORDERS W/O CC	Covered
132	ATHEROSCLEROSIS W CC	Covered
133	ATHEROSCLEROSIS W/O CC	Covered
134	HYPERTENSION	Covered
135	CARDIAC CONGENITAL VALVULAR DISORDERS AGE W CC	Covered
136	CARDIAC CONGENITAL VALVULAR DISORDERS AGE W/O CC	Covered
137	CARDIAC CONGENITAL VALVULAR DISORDERS AGE 0-17	Covered
138	CARDIAC ARRHYTHMIA CONDUCTION DISORDERS W CC	Covered
139	CARDIAC ARRHYTHMIA CONDUCTION DISORDERS W/O CC	Covered
140	ANGINA PECTORIS	Covered
141	SYNCOPE COLLAPSE W CC	Covered
142	SYNCOPE COLLAPSE W/O CC	Covered
143	CHEST PAIN	Covered
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	Covered
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	Covered
146	RECTAL RESECTION W CC	Covered
147	RECTAL RESECTION W/O CC	Covered
148	MAJOR SMALL LARGE BOWEL PROCEDURES W CC	Covered
149	MAJOR SMALL LARGE BOWEL PROCEDURES W/O CC	Covered
150	PERITONEAL ADHESIOLYSIS W CC	Covered

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DRGNo(A)	DRG Descr	Coverage
151	PERITONEAL ADHESIOLYSIS W/O CC	Covered
152	MINOR SMALL LARGE BOWEL PROCEDURES W CC	Covered
153	MINOR SMALL LARGE BOWEL PROCEDURES W/O CC	Covered
154	STOMACH, ESOPHAGEAL DUODENAL PROCEDURES AGE W CC	Covered
155	STOMACH, ESOPHAGEAL DUODENAL PROCEDURES AGE W/O CC	Covered
156	STOMACH, ESOPHAGEAL DUODENAL PROCEDURES AGE 0-17	Covered
157	ANAL STOMAL PROCEDURES W CC	Covered
158	ANAL STOMAL PROCEDURES W/O CC	Covered
159	HERNIA PROCEDURES EXCEPT INGUINAL FEMORAL AGE W CC	Covered
160	HERNIA PROCEDURES EXCEPT INGUINAL FEMORAL AGE W/O CC	Covered
161	INGUINAL FEMORAL HERNIA PROCEDURES AGE W CC	Covered
162	INGUINAL FEMORAL HERNIA PROCEDURES AGE W/O CC	Covered
163	HERNIA PROCEDURES AGE 0-17	Covered
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	Covered
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	Covered
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	Covered
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	Covered
168	MOUTH PROCEDURES W CC	Covered
169	MOUTH PROCEDURES W/O CC	Covered
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	Covered
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	Covered
172	DIGESTIVE MALIGNANCY W CC	Covered
173	DIGESTIVE MALIGNANCY W/O CC	Covered
174	G.I. HEMORRHAGE W CC	Covered
175	G.I. HEMORRHAGE W/O CC	Covered
176	COMPLICATED PEPTIC ULCER	Covered
177	UNCOMPLICATED PEPTIC ULCER W CC	Covered
178	UNCOMPLICATED PEPTIC ULCER W/O CC	Covered
179	INFLAMMATORY BOWEL DISEASE	Covered
180	G.I. OBSTRUCTION W CC	Covered
181	G.I. OBSTRUCTION W/O CC	Covered
182	ESOPHAGITIS, GASTROENT MISC DIGEST DISORDERS AGE W CC	Covered
183	ESOPHAGITIS, GASTROENT MISC DIGEST DISORDERS AGE W/O CC	Covered
184	ESOPHAGITIS, GASTROENT MISC DIGEST DISORDERS AGE 0-17	Covered
185	DENTAL ORAL DIS EXCEPT EXTRACTIONS RESTORATIONS, AGE	Covered
186	DENTAL ORAL DIS EXCEPT EXTRACTIONS RESTORATIONS, AGE 0-17	Covered
187	DENTAL EXTRACTIONS RESTORATIONS	Covered
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE W CC	Covered
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE W/O CC	Covered
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	Covered
191	PANCREAS, LIVER SHUNT PROCEDURES W CC	Covered
192	PANCREAS, LIVER SHUNT PROCEDURES W/O CC	Covered
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	Covered
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	Covered
195	CHOLECYSTECTOMY W C.D.E. W CC	Covered
196	CHOLECYSTECTOMY W C.D.E. W/O CC	Covered
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	Covered
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	Covered
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	Covered
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	Covered

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DRGNo(A)	DRG Descr	Coverage
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	Covered
202	CIRRHOSIS ALCOHOLIC HEPATITIS	Covered
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	Covered
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	Covered
205	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	Covered
206	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC	Covered
207	DISORDERS OF THE BILIARY TRACT W CC	Covered
208	DISORDERS OF THE BILIARY TRACT W/O CC	Covered
209	MAJOR JOINT LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	Covered
210	HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE W CC	Covered
211	HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE W/O CC	Covered
212	HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	Covered
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM CONN TISSUE DISORDERS	Covered
214	NO LONGER VALID	Non-Covered
215	NO LONGER VALID	Non-Covered
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM CONNECTIVE TISSUE	Covered
217	WND DEBRID SKN GRFT EXCEPT HAND, FOR MUSCSKELET CONN TISS DIS	Covered
218	LOWER EXTREM HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE W CC	Covered
219	LOWER EXTREM HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE W/O CC	Covered
220	LOWER EXTREM HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	Covered
221	NO LONGER VALID	Non-Covered
222	NO LONGER VALID	Non-Covered
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	Covered
224	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	Covered
225	FOOT PROCEDURES	Covered
226	SOFT TISSUE PROCEDURES W CC	Covered
227	SOFT TISSUE PROCEDURES W/O CC	Covered
228	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	Covered
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	Covered
230	LOCAL EXCISION REMOVAL OF INT FIX DEVICES OF HIP FEMUR	Covered
231	NO LONGER VALID	Non-Covered
232	ARTHROSCOPY	Covered
233	OTHER MUSCULOSKELET SYS CONN TISS O.R. PROC W CC	Covered
234	OTHER MUSCULOSKELET SYS CONN TISS O.R. PROC W/O CC	Covered
235	FRACTURES OF FEMUR	Covered
236	FRACTURES OF HIP PELVIS	Covered
237	SPRAINS, STRAINS, DISLOCATIONS OF HIP, PELVIS THIGH	Covered
238	OSTEOMYELITIS	Covered
239	PATHOLOGICAL FRACTURES MUSCULOSKELETAL CONN TISS MALIGNANCY	Covered
240	CONNECTIVE TISSUE DISORDERS W CC	Covered
241	CONNECTIVE TISSUE DISORDERS W/O CC	Covered
242	SEPTIC ARTHRITIS	Covered
243	MEDICAL BACK PROBLEMS	Covered
244	BONE DISEASES SPECIFIC ARTHROPATHIES W CC	Covered
245	BONE DISEASES SPECIFIC ARTHROPATHIES W/O CC	Covered
246	NON-SPECIFIC ARTHROPATHIES	Covered
247	SIGNS SYMPTOMS OF MUSCULOSKELETAL SYSTEM CONN TISSUE	Covered
248	TENDONITIS, MYOSITIS BURSITIS	Covered
249	AFTERCARE, MUSCULOSKELETAL SYSTEM CONNECTIVE TISSUE	Covered
250	FX, SPRN, STRN DISL OF FOREARM, HAND, FOOT AGE W CC	Covered

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DRGNo(A)	DRG Descr	Coverage
251	FX, SPRN, STRN DISL OF FOREARM, HAND, FOOT AGE W/O CC	Covered
252	FX, SPRN, STRN DISL OF FOREARM, HAND, FOOT AGE 0-17	Covered
253	FX, SPRN, STRN DISL OF UPARM, LOW LEG EX FOOT AGE W CC	Covered
254	FX, SPRN, STRN DISL OF UPARM, LOW LEG EX FOOT AGE W/O CC	Covered
255	FX, SPRN, STRN DISL OF UPARM, LOW LEG EX FOOT AGE 0-17	Covered
256	OTHER MUSCULOSKELETAL SYSTEM CONNECTIVE TISSUE DIAGNOSES	Covered
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC	Covered
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	Covered
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	Covered
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	Covered
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY LOCAL EXCISION	Covered
262	BREAST BIOPSY LOCAL EXCISION FOR NON-MALIGNANCY	Covered
263	SKIN GRAFT DEBRID FOR SKN ULCER OR CELLULITIS W CC	Covered
264	SKIN GRAFT DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	Covered
265	SKIN GRAFT DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	Covered
266	SKIN GRAFT DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	Covered
267	PERIANAL PILONIDAL PROCEDURES	Covered
268	SKIN, SUBCUTANEOUS TISSUE BREAST PLASTIC PROCEDURES	Covered
269	OTHER SKIN, SUBCUT TISS BREAST PROC W CC	Covered
270	OTHER SKIN, SUBCUT TISS BREAST PROC W/O CC	Covered
271	SKIN ULCERS	Covered
272	MAJOR SKIN DISORDERS W CC	Covered
273	MAJOR SKIN DISORDERS W/O CC	Covered
274	MALIGNANT BREAST DISORDERS W CC	Covered
275	MALIGNANT BREAST DISORDERS W/O CC	Covered
276	NON-MALIGANT BREAST DISORDERS	Covered
277	CELLULITIS AGE W CC	Covered
278	CELLULITIS AGE W/O CC	Covered
279	CELLULITIS AGE 0-17	Covered
280	TRAUMA TO THE SKIN, SUBCUT TISS BREAST AGE W CC	Covered
281	TRAUMA TO THE SKIN, SUBCUT TISS BREAST AGE W/O CC	Covered
282	TRAUMA TO THE SKIN, SUBCUT TISS BREAST AGE 0-17	Covered
283	MINOR SKIN DISORDERS W CC	Covered
284	MINOR SKIN DISORDERS W/O CC	Covered
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT,METABOL DISORDERS	Covered
286	ADRENAL PITUITARY PROCEDURES	Covered
287	SKIN GRAFTS WOUND DEBRID FOR ENDOC, NUTRIT METAB DISORDERS	Covered
288	O.R. PROCEDURES FOR OBESITY	Covered
289	PARATHYROID PROCEDURES	Covered
290	THYROID PROCEDURES	Covered
291	THYROGLOSSAL PROCEDURES	Covered
292	OTHER ENDOCRINE, NUTRIT METAB O.R. PROC W CC	Covered
293	OTHER ENDOCRINE, NUTRIT METAB O.R. PROC W/O CC	Covered
294	DIABETES AGE	Covered
295	DIABETES AGE 0-35	Covered
296	NUTRITIONAL MISC METABOLIC DISORDERS AGE W CC	Covered
297	NUTRITIONAL MISC METABOLIC DISORDERS AGE W/O CC	Covered
298	NUTRITIONAL MISC METABOLIC DISORDERS AGE 0-17	Covered
299	INBORN ERRORS OF METABOLISM	Covered
300	ENDOCRINE DISORDERS W CC	Covered

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DRGNo(A)	DRG Descr	Coverage
301	ENDOCRINE DISORDERS W/O CC	Covered
302	KIDNEY TRANSPLANT	Covered
303	KIDNEY, URETER MAJOR BLADDER PROCEDURES FOR NEOPLASM	Covered
304	KIDNEY, URETER MAJOR BLADDER PROC FOR NON-NEOPL W CC	Covered
305	KIDNEY, URETER MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	Covered
306	PROSTATECTOMY W CC	Covered
307	PROSTATECTOMY W/O CC	Covered
308	MINOR BLADDER PROCEDURES W CC	Covered
309	MINOR BLADDER PROCEDURES W/O CC	Covered
310	TRANSURETHRAL PROCEDURES W CC	Covered
311	TRANSURETHRAL PROCEDURES W/O CC	Covered
312	URETHRAL PROCEDURES, AGE W CC	Covered
313	URETHRAL PROCEDURES, AGE W/O CC	Covered
314	URETHRAL PROCEDURES, AGE 0-17	Covered
315	OTHER KIDNEY URINARY TRACT O.R. PROCEDURES	Covered
316	RENAL FAILURE	Covered
317	ADMIT FOR RENAL DIALYSIS	Covered
318	KIDNEY URINARY TRACT NEOPLASMS W CC	Covered
319	KIDNEY URINARY TRACT NEOPLASMS W/O CC	Covered
320	KIDNEY URINARY TRACT INFECTIONS AGE W CC	Covered
321	KIDNEY URINARY TRACT INFECTIONS AGE W/O CC	Covered
322	KIDNEY URINARY TRACT INFECTIONS AGE 0-17	Covered
323	URINARY STONES W CC, ESW LITHOTRIPSY	Covered
324	URINARY STONES W/O CC	Covered
325	KIDNEY URINARY TRACT SIGNS SYMPTOMS AGE W CC	Covered
326	KIDNEY URINARY TRACT SIGNS SYMPTOMS AGE W/O CC	Covered
327	KIDNEY URINARY TRACT SIGNS SYMPTOMS AGE 0-17	Covered
328	URETHRAL STRICTURE AGE W CC	Covered
329	URETHRAL STRICTURE AGE W/O CC	Covered
330	URETHRAL STRICTURE AGE 0-17	Covered
331	OTHER KIDNEY URINARY TRACT DIAGNOSES AGE W CC	Covered
332	OTHER KIDNEY URINARY TRACT DIAGNOSES AGE W/O CC	Covered
333	OTHER KIDNEY URINARY TRACT DIAGNOSES AGE 0-17	Covered
334	MAJOR MALE PELVIC PROCEDURES W CC	Covered
335	MAJOR MALE PELVIC PROCEDURES W/O CC	Covered
336	TRANSURETHRAL PROSTATECTOMY W CC	Covered
337	TRANSURETHRAL PROSTATECTOMY W/O CC	Covered
338	TESTES PROCEDURES, FOR MALIGNANCY	Covered
339	TESTES PROCEDURES, NON-MALIGNANCY AGE	Covered
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	Covered
341	PENIS PROCEDURES	Covered
342	CIRCUMCISION AGE	Covered
343	CIRCUMCISION AGE 0-17	Covered
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	Covered
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	Covered
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	Covered
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	Covered
348	BENIGN PROSTATIC HYPERTROPHY W CC	Covered
349	BENIGN PROSTATIC HYPERTROPHY W/O CC	Covered
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	Covered

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DRGNo(A)	DRG Descr	Coverage
351	STERILIZATION, MALE	Non-Covered
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	Covered
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY RADICAL VULVECTOMY	Covered
354	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	Covered
355	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	Covered
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	Covered
357	UTERINE ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	Covered
358	UTERINE ADNEXA PROC FOR NON-MALIGNANCY W CC	Covered
359	UTERINE ADNEXA PROC FOR NON-MALIGNANCY W/O CC	Covered
360	VAGINA, CERVIX VULVA PROCEDURES	Covered
361	LAPAROSCOPY INCISIONAL TUBAL INTERRUPTION	Non-Covered
362	ENDOSCOPIC TUBAL INTERRUPTION	Non-Covered
363	DCONIZATION RADIO-IMPLANT, FOR MALIGNANCY	Covered
364	DCONIZATION EXCEPT FOR MALIGNANCY	Covered
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	Covered
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	Covered
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	Covered
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	Covered
369	MENSTRUAL OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	Covered
370	CESAREAN SECTION W CC	Covered
371	CESAREAN SECTION W/O CC	Covered
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	Covered
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	Covered
374	VAGINAL DELIVERY W STERILIZATION D	Covered
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL D	Covered
376	POSTPARTUM POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	Covered
377	POSTPARTUM POST ABORTION DIAGNOSES W O.R. PROCEDURE	Non-Covered
378	ECTOPIC PREGNANCY	Covered
379	THREATENED ABORTION	Covered
380	ABORTION W/O D	Non-Covered
381	ABORTION W DASPIRATION CURETTAGE OR HYSTEROTOMY	Non-Covered
382	FALSE LABOR	Covered
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	Covered
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	Covered
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	Covered
386	EXTREME IMMATURETY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	Covered
387	PREMATURITY W MAJOR PROBLEMS	Covered
388	PREMATURITY W/O MAJOR PROBLEMS	Covered
389	FULL TERM NEONATE W MAJOR PROBLEMS	Covered
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	Covered
391	NORMAL NEWBORN	Covered
392	SPLENECTOMY AGE	Covered
393	SPLENECTOMY AGE 0-17	Covered
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	Covered
395	RED BLOOD CELL DISORDERS AGE	Covered
396	RED BLOOD CELL DISORDERS AGE 0-17	Covered
397	COAGULATION DISORDERS	Covered
398	RETICULOENDOTHELIAL IMMUNITY DISORDERS W CC	Covered
399	RETICULOENDOTHELIAL IMMUNITY DISORDERS W/O CC	Covered
400	NO LONGER VALID	Non-Covered

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DRGNo(A)	DRG Descr	Coverage
401	LYMPHOMA NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	Covered
402	LYMPHOMA NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	Covered
403	LYMPHOMA NON-ACUTE LEUKEMIA W CC	Covered
404	LYMPHOMA NON-ACUTE LEUKEMIA W/O CC	Covered
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	Covered
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	Covered
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	Covered
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	Covered
409	RADIOTHERAPY	Covered
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	Covered
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY	Covered
412	HISTORY OF MALIGNANCY W ENDOSCOPY	Covered
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	Covered
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	Covered
415	O.R. PROCEDURE FOR INFECTIOUS PARASITIC DISEASES	Covered
416	SEPTICEMIA AGE	Covered
417	SEPTICEMIA AGE 0-17	Covered
418	POSTOPERATIVE POST-TRAUMATIC INFECTIONS	Covered
419	FEVER OF UNKNOWN ORIGIN AGE W CC	Covered
420	FEVER OF UNKNOWN ORIGIN AGE W/O CC	Covered
421	VIRAL ILLNESS AGE	Covered
422	VIRAL ILLNESS FEVER OF UNKNOWN ORIGIN AGE 0-17	Covered
423	OTHER INFECTIOUS PARASITIC DISEASES DIAGNOSES	Covered
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	Covered
425	ACUTE ADJUSTMENT REACTION PSYCHOSOCIAL DYSFUNCTION	Covered
426	DEPRESSIVE NEUROSES	Covered
427	NEUROSES EXCEPT DEPRESSIVE	Covered
428	DISORDERS OF PERSONALITY IMPULSE CONTROL	Covered
429	ORGANIC DISTURBANCES MENTAL RETARDATION	Covered
430	PSYCHOSES	Covered
431	CHILDHOOD MENTAL DISORDERS	Covered
432	OTHER MENTAL DISORDER DIAGNOSES	Covered
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	Covered
434	NO LONGER VALID	Non-Covered
435	NO LONGER VALID	Non-Covered
436	NO LONGER VALID	Non-Covered
437	NO LONGER VALID	Non-Covered
438	NO LONGER VALID	Non-Covered
439	SKIN GRAFTS FOR INJURIES	Covered
440	WOUND DEBRIDEMENTS FOR INJURIES	Covered
441	HAND PROCEDURES FOR INJURIES	Covered
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	Covered
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	Covered
444	TRAUMATIC INJURY AGE W CC	Covered
445	TRAUMATIC INJURY AGE W/O CC	Covered
446	TRAUMATIC INJURY AGE 0-17	Covered
447	ALLERGIC REACTIONS AGE	Covered
448	ALLERGIC REACTIONS AGE 0-17	Covered
449	POISONING TOXIC EFFECTS OF DRUGS AGE W CC	Covered
450	POISONING TOXIC EFFECTS OF DRUGS AGE W/O CC	Covered

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DRGNo(A)	DRG Descr	Coverage
451	POISONING TOXIC EFFECTS OF DRUGS AGE 0-17	Covered
452	COMPLICATIONS OF TREATMENT W CC	Covered
453	COMPLICATIONS OF TREATMENT W/O CC	Covered
454	OTHER INJURY, POISONING TOXIC EFFECT DIAG W CC	Covered
455	OTHER INJURY, POISONING TOXIC EFFECT DIAG W/O CC	Covered
456	NO LONGER VALID	Non-Covered
457	NO LONGER VALID	Non-Covered
458	NO LONGER VALID	Non-Covered
459	NO LONGER VALID	Non-Covered
460	NO LONGER VALID	Non-Covered
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	Covered
462	REHABILITATION	Covered
463	SIGNS SYMPTOMS W CC	Covered
464	SIGNS SYMPTOMS W/O CC	Covered
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	Covered
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	Covered
467	OTHER FACTORS INFLUENCING HEALTH STATUS	Covered
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	Covered
469	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	Non-Covered
470	UNGROUPABLE	Non-Covered
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	Covered
472	NO LONGER VALID	Non-Covered
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE	Covered
474	NO LONGER VALID	Non-Covered
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	Covered
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	Covered
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	Covered
478	OTHER VASCULAR PROCEDURES W CC	Covered
479	OTHER VASCULAR PROCEDURES W/O CC	Covered
480	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT	Covered
481	BONE MARROW TRANSPLANT	Covered
482	TRACHEOSTOMY FOR FACE, MOUTH NECK DIAGNOSES	Covered
483	NO LONGER VALID	Non-Covered
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	Covered
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA	Covered
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	Covered
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	Covered
488	HIV W EXTENSIVE O.R. PROCEDURE	Covered
489	HIV W MAJOR RELATED CONDITION	Covered
490	HIV W OR W/O OTHER RELATED CONDITION	Covered
491	MAJOR JOINT LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	Covered
492	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	Covered
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	Covered
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	Covered
495	LUNG TRANSPLANT	Covered
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	Covered
497	SPINAL FUSION EXCEPT CERVICAL W CC	Covered
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	Covered
499	BACK NECK PROCEDURES EXCEPT SPINAL FUSION W CC	Covered
500	BACK NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	Covered

QueensCare Grant
DRG List Effective 10/1/04

DRGNo(A)	DRG Descr	Coverage
501	KNEE PROCEDURES W PDX OF INFECTION W CC	Covered
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC	Covered
503	KNEE PROCEDURES W/O PDX OF INFECTION	Covered
504	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/SKIN GFT	Covered
505	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/O SKIN GFT	Covered
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	Covered
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	Covered
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	Covered
509	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	Covered
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	Covered
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	Covered
512	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	Covered
513	PANCREAS TRANSPLANT	Covered
514	NO LONGER VALID	Non-Covered
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	Covered
516	PERCUTANEOUS CARDIOVASC PROC W AMI	Covered
517	PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	Covered
518	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	Covered
519	CERVICAL SPINAL FUSION W CC	Covered
520	CERVICAL SPINAL FUSION W/O CC	Covered
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	Covered
522	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC	Covered
523	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC	Covered
524	TRANSIENT ISCHEMIA	Covered
525	OTHER HEART ASSIST SYSTEM IMPLANT	Covered
526	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI	Covered
527	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI	Covered
528	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	Covered
529	VENTRICULAR SHUNT PROCEDURES W CC	Covered
530	VENTRICULAR SHUNT PROCEDURES W/O CC	Covered
531	SPINAL PROCEDURES W CC	Covered
532	SPINAL PROCEDURES W/O CC	Covered
533	EXTRACRANIAL PROCEDURES W CC	Covered
534	EXTRACRANIAL PROCEDURES W/O CC	Covered
535	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	Covered
536	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	Covered
537	LOCAL EXCIS REMOV OF INT FIX DEV EXCEPT HIP FEMUR W CC	Covered
538	LOCAL EXCIS REMOV OF INT FIX DEV EXCEPT HIP FEMUR W/O CC	Covered
539	LYMPHOMA LEUKEMIA W MAJOR OR PROCEDURE W CC	Covered
540	LYMPHOMA LEUKEMIA W MAJOR OR PROCEDURE W/O CC	Covered
541	TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH, NECK DX W/MAJ OR	Covered
542	TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH, NECK DX W/O MJ OR	Covered
543	CRANIOTOMY W/IMPLANT OF CHEMO AGENT OR ACUTE COMPLEX CNS PDX	Covered



A Public Benefit Charity
Certification of Family Size, Net
Income, and Service Area (Effective
for services rendered after 2/13/2004
until superceded)

Hospital/Clinic/Office: _____
 Contract Number: _____

Section A: Patient Information

Patient Name (please print): _____ MR # _____ Acct # _____ Visit Date _____

Section B: Household Income Information

Please check the box which describes your family size and financial circumstances.

Family Members living in the house	Net Monthly Family Income Table 1/ & 2/	Family Members living in the house	Net Monthly Family Income Table 1/
1 <input type="checkbox"/>	at or below \$ 1,034	1 <input type="checkbox"/>	\$ 1,035 through \$ 1,552
2 <input type="checkbox"/>	at or below \$ 1,388	2 <input type="checkbox"/>	\$ 1,389 through \$ 2,082
3 <input type="checkbox"/>	at or below \$ 1,741	3 <input type="checkbox"/>	\$ 1,742 through \$ 2,612
4 <input type="checkbox"/>	at or below \$ 2,094	4 <input type="checkbox"/>	\$ 2,095 through \$ 3,142
5 <input type="checkbox"/>	at or below \$ 2,448	5 <input type="checkbox"/>	\$ 2,449 through \$ 3,672
6 <input type="checkbox"/>	at or below \$ 2,801	6 <input type="checkbox"/>	\$ 2,802 through \$ 4,202
7 <input type="checkbox"/>	at or below \$ 3,154	7 <input type="checkbox"/>	\$ 3,155 through \$ 4,732
8 <input type="checkbox"/>	at or below \$ 3,508	8 <input type="checkbox"/>	\$ 3,509 through \$ 5,262
9 <input type="checkbox"/>	at or below \$ 3,861	9 <input type="checkbox"/>	\$ 3,862 through \$ 5,792
10 <input type="checkbox"/>	at or below \$ 4,214	10 <input type="checkbox"/>	\$ 4,215 through \$ 6,322
11 or more <input type="checkbox"/>	Enter total net monthly income (for each additional member, add \$353 to limit): _____	11 or more <input type="checkbox"/>	Enter total net monthly income (for each additional member, add \$354 to lower limit & \$530 to upper limit): _____
Enter Total #: _____		Enter Total #: _____	

1/ Net family income means the income received by the patient and the patient's responsible relatives less taxes.
 2/ Please indicate why not covered by Medi-Cal or other county programs on reverse side of this form. Attach available documentation (POE, POS printout, AVS, etc) for proof.

Section C: Zip Code Information

Please check the box which lists your zip code.

Primary <input type="checkbox"/>	Secondary <input type="checkbox"/>									Remainder <input type="checkbox"/>
90004	90001 90018	90036	90049	90073	90280	91104	91207	91506	91755	All other zip codes in Los Angeles County, please list zip code if applicable: _____
90005	90003 90019	90037	90056	90077	90301	91105	91208	91521	91801	
90006	90007 90021	90039	90058	90089	90302	91106	91210	91522	91802	
90020	90008 90022	90040	90062	90095	90305	91108	91214	91523	91803	
90026	90010 90023	90041	90063	90201	90640	91125	91352	91601		
90027	90011 90024	90042	90064	90210	91001	91126	91401	91602		
90028	90012 90025	90043	90065	90211	91020	91201	91403	91604		
90029	90013 90031	90044	90066	90212	91030	91202	91423	91605		
90038	90014 90032	90045	90067	90230	91040	91203	91501	91606		
90057	90015 90033	90046	90068	90232	91042	91204	91502	91607		
	90016 90034	90047	90069	90255	91101	91205	91504	91608		
	90017 90035	90048	90071	90270	91103	91206	91505	91754		

Section D: Certification & Signature

I certify that, as of today's date, I do not have Medi-Cal, Medicare, or coverage through Los Angeles County's Public/Private Partnership Program, or private health insurance. If a change in my health care coverage, family size, or net income occurs later, I promise to immediately report that fact to the hospital/clinic/office where I receive my care.

I further certify and declare under penalty of perjury under the laws of the State of California that I understand this form and that the information provided above is true, correct, and complete.

Patient Signature _____ Date: _____

Responsible Relative Signature _____ Date: _____

Section E: Indigency Determination

Patient is indigent: Yes No _____
 Hospital/Clinic/Office Reviewer _____ Date _____



Un Beneficio Público de Caridad

Certificación del Tamaño de Familia, Ingreso neto, y Area de Servicio (Por servicios dados después de 2/13/2004)

Hospital/Clinica/ Oficina: _____

Número del contrato: _____

Seccion A: Información del paciente

Nombre del paciente (favor de imprimir): _____

Archivo Medico

MR # _____ Acct # _____ Fecha de Visita _____

Seccion B: Información de Ingresos Familiares

Por favor marque abajo el cuadro que describe el numero de personas en la familia y las circunstancias financieras.

Miembros de Familia viviendo en casa	Publicación mensual del precio neto Mesa del Ingreso Familiar 1/ & 2/	Miembros de Familia viviendo en casa	Publicación mensual del precio neto Mesa del Ingreso Familiar 1/
1 <input type="checkbox"/>	\$ 1,034 o menos	1 <input type="checkbox"/>	\$ 1,035 hasta \$ 1,552
2 <input type="checkbox"/>	\$ 1,388 o menos	2 <input type="checkbox"/>	\$ 1,389 hasta \$ 2,082
3 <input type="checkbox"/>	\$ 1,741 o menos	3 <input type="checkbox"/>	\$ 1,742 hasta \$ 2,612
4 <input type="checkbox"/>	\$ 2,094 o menos	4 <input type="checkbox"/>	\$ 2,095 hasta \$ 3,142
5 <input type="checkbox"/>	\$ 2,448 o menos	5 <input type="checkbox"/>	\$ 2,449 hasta \$ 3,672
6 <input type="checkbox"/>	\$ 2,801 o menos	6 <input type="checkbox"/>	\$ 2,802 hasta \$ 4,202
7 <input type="checkbox"/>	\$ 3,154 o menos	7 <input type="checkbox"/>	\$ 3,155 hasta \$ 4,732
8 <input type="checkbox"/>	\$ 3,508 o menos	8 <input type="checkbox"/>	\$ 3,509 hasta \$ 5,262
9 <input type="checkbox"/>	\$ 3,861 o menos	9 <input type="checkbox"/>	\$ 3,862 hasta \$ 5,792
10 <input type="checkbox"/>	\$ 4,214 o menos	10 <input type="checkbox"/>	\$ 4,215 hasta \$ 6,322
11 o más <input type="checkbox"/>	Entre precio neto del total ingreso mensual (por cada miembro adicional, agregue \$353 limitar): _____	11 o más <input type="checkbox"/>	Entre precio neto del total ingreso mensual (por cada miembro adicional, agregue \$354 bajar límite & \$530 a límite superior): _____

1/ Ingreso neto familiar significa los ingresos recibidos mensualmente por el paciente y sus familiares responsables menos los impuestos.
 2/ Favor de indicar porqué no calificó por Medi-Cal u otro programas del condado en la parte de atrás de esta forma. Incluya documentación disponible (POE, POS copia impresa, AVS, [etc]) como prueba.

Seccion C: Codigo Postal

Por favor marque abajo el cuadro de su codigo postal.

Primario <input type="checkbox"/>	Secundario <input type="checkbox"/>	Resto <input type="checkbox"/>
90004	90001 90018 90036 90049 90073 90280 91104 91207 91506 91755	Cualquier otro codigo postal marquelo abajo: _____
90005	90003 90019 90037 90056 90077 90301 91105 91208 91521 91801	
90006	90007 90021 90039 90058 90089 90302 91106 91210 91522 91802	
90020	90008 90022 90040 90062 90095 90305 91108 91214 91523 91803	
90026	90010 90023 90041 90063 90201 90640 91125 91352 91601	
90027	90011 90024 90042 90064 90210 91001 91126 91401 91602	
90028	90012 90025 90043 90065 90211 91020 91201 91403 91604	
90029	90013 90031 90044 90066 90212 91030 91202 91423 91605	
90038	90014 90032 90045 90067 90230 91040 91203 91501 91606	
90057	90015 90033 90046 90068 90232 91042 91204 91502 91607	
	90016 90034 90047 90069 90255 91101 91205 91504 91608	
	90017 90035 90048 90071 90270 91103 91206 91505 91754	

Seccion D: Certificación & Firma

Certifico que hasta está fecha, yo no califico para reembolso de ningun programa incluyendo programas de reembolso del gobierno, pero no limitados a Medi-Cal o Medicare, si algun cambio en mi cubrimiento de salud, el tamaño de mi familia, o en el ingreso neto mensual familiar ocurre en el futuro, prometo reportar el cambio inmediatamente a la clinica donde me estan atendiendo.

Ademas certifico y declaro bajo pena de perjurio ante la ley del estado de California que yo entiendo éste formulario y que la información proveida arriba es verdadera, correcta y completa.

Firma del Paciente: _____ Fecha: _____

Firma del Familiar Responsable: _____ Fecha: _____

Seccion E: Determinación Indigente/Confirmación del Entrevistador: Hospital, Clínica, u Oficina

Paciente es indigente: Sí No

Entrevistador: Hospital, Clínica, u Oficina

Fecha _____