# Medicare Payments

The following table includes information about payments made by Medicare for the 16 medical conditions/surgical procedures included in this *Hospital Performance Report*. This analysis is based on data from federal fiscal year (FFY) 2017, which is the most recent payment data available to PHC4. Displayed are the average amounts paid by Medicare fee-for-service for inpatient hospitalizations of Pennsylvania residents only. Payments from Medicare Advantage plans (e.g., Medicare HMOs) are not included, nor are patient liabilities (e.g., coinsurance and deductible dollar amounts).

The average Medicare fee-for-service payment is calculated using the claim payment amount based on data provided by the Centers for Medicare and Medicaid Services (CMS). The average payment is calculated by summing the payment amounts for the cases in a particular medical condition/surgical procedure and dividing the sum by the number of cases in that condition/procedure group.

***The payments analysis is based on data from federal fiscal year 2017. This information, provided by CMS, reflects the average amounts paid by Medicare fee-for-service for inpatient hospitalizations of Pennsylvania residents only.***

Most of the medical conditions and surgical procedures included in this report are defined using ICD-10-CM/PCS (International Classification of Diseases, Tenth Revision, Clinical Modification/Procedure Coding System) diagnosis and procedure codes, with a secondary requirement that they be limited to particular MS-DRGs (Medicare Severity – Diagnosis-Related Groups) – information available from the discharge data that PHC4 receives from Pennsylvania hospitals. One condition (Chest Pain) is comprised of a single MS-DRG.

In this section, average payments are displayed for the 16 medical conditions/surgical procedures included in this report – broken down by the MS-DRGs included within each condition/procedure. While the 16 conditions/procedures have been defined using diagnosis and procedure codes that represent a clinically cohesive population, the payment data is displayed by the individual MS-DRGs included within each condition to account for variations in case mix.

# Medicare Payments

| Medicare Fee-for-Service Payments – FFY 2017 Statewide Data<br>*For the 16 medical conditions/surgical procedures included in this Hospital Performance Report* | | | |
|---|---|---|---|
| MS-DRG | MS-DRG Descriptions by Medical Condition/Surgical Procedure | Medicare Fee-for-Service | |
| | | Cases | Average Payment |
| **Abnormal Heartbeat** | | **13,224** | **$7,910** |
| 242 | Permanent Cardiac Pacemaker Implant w/ MCC | 655 | $22,527 |
| 243 | Permanent Cardiac Pacemaker Implant w/ CC | 931 | $16,124 |
| 244 | Permanent Cardiac Pacemaker Implant w/o CC/MCC | 717 | $12,700 |
| 258 | Cardiac Pacemaker Device Replacement w/ MCC | 14 | $18,713 |
| 259 | Cardiac Pacemaker Device Replacement w/o MCC | 17 | $11,793 |
| 260 | Cardiac Pacemaker Revision Except Device Replacement w/ MCC | 10 | NR |
| 261 | Cardiac Pacemaker Revision Except Device Replacement w/ CC | 28 | $12,964 |
| 262 | Cardiac Pacemaker Revision Except Device Replacement w/o CC/MCC | 16 | $9,612 |
| 273 | Percutaneous Intracardiac Procedures w/ MCC | 167 | $26,445 |
| 274 | Percutaneous Intracardiac Procedures w/o MCC | 588 | $16,998 |
| 286 | Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/ MCC | 205 | $13,781 |
| 287 | Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/o MCC | 235 | $6,658 |
| 308 | Cardiac Arrhythmia and Conduction Disorders w/ MCC | 2,876 | $7,160 |
| 309 | Cardiac Arrhythmia and Conduction Disorders w/ CC | 3,831 | $4,400 |
| 310 | Cardiac Arrhythmia and Conduction Disorders w/o CC/MCC | 2,934 | $2,818 |
| **Chest Pain** | | **1,700** | **$3,873** |
| 313 | Chest Pain | 1,700 | $3,873 |
| **Chronic Obstructive Pulmonary Disease (COPD)** | | **13,227** | **$5,858** |
| 190 | Chronic Obstructive Pulmonary Disease w/ MCC | 7,691 | $6,598 |
| 191 | Chronic Obstructive Pulmonary Disease w/ CC | 3,846 | $5,216 |
| 192 | Chronic Obstructive Pulmonary Disease w/o CC/MCC | 1,690 | $3,951 |
| **Colorectal Procedures** | | **3,044** | **$18,320** |
| 329 | Major Small and Large Bowel Procedures w/ MCC | 718 | $34,073 |
| 330 | Major Small and Large Bowel Procedures w/ CC | 1,512 | $15,170 |
| 331 | Major Small and Large Bowel Procedures w/o CC/MCC | 747 | $9,992 |
| 332 | Rectal Resection w/ MCC | 7 | NR |
| 333 | Rectal Resection w/ CC | 28 | $15,203 |
| 334 | Rectal Resection w/o CC/MCC | 32 | $9,344 |

NR = Not Reported (10 or fewer cases)
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|---|---|---|---|
| MS-DRG | MS-DRG Descriptions by Medical Condition/Surgical Procedure | Medicare Fee-for-Service | |
| | | Cases | Average Payment |
| **Diabetes - Medical Management** | | **4,542** | **$6,074** |
| 073 | Cranial and Peripheral Nerve Disorders w/ MCC | 143 | $8,816 |
| 074 | Cranial and Peripheral Nerve Disorders w/o MCC | 306 | $5,603 |
| 299 | Peripheral Vascular Disorders w/ MCC | 66 | $10,423 |
| 300 | Peripheral Vascular Disorders w/ CC | 75 | $6,207 |
| 301 | Peripheral Vascular Disorders w/o CC/MCC | 5 | NR |
| 637 | Diabetes w/ MCC | 1,096 | $8,506 |
| 638 | Diabetes w/ CC | 2,246 | $5,091 |
| 639 | Diabetes w/o CC/MCC | 461 | $3,582 |
| 698 | Other Kidney and Urinary Tract Diagnoses w/ MCC | 40 | $9,305 |
| 699 | Other Kidney and Urinary Tract Diagnoses w/ CC | 91 | $6,557 |
| 700 | Other Kidney and Urinary Tract Diagnoses w/o CC/MCC | 13 | $4,600 |
| **Gallbladder Removal - Laparoscopic** | | **1,852** | **$10,079** |
| 411 | Cholecystectomy with Common Duct Exploration (C.D.E.) w/ MCC | 3 | NR |
| 412 | Cholecystectomy with C.D.E. w/ CC | 3 | NR |
| 413 | Cholecystectomy with C.D.E. w/o CC/MCC | 2 | NR |
| 417 | Laparoscopic Cholecystectomy without C.D.E. w/ MCC | 449 | $14,559 |
| 418 | Laparoscopic Cholecystectomy without C.D.E. w/ CC | 809 | $9,643 |
| 419 | Laparoscopic Cholecystectomy without C.D.E. w/o CC/MCC | 586 | $7,165 |
| **Heart Attack - Angioplasty/Stent** | | **3,519** | **$15,267** |
| 246 | Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/ MCC or 4+ Vessels/Stents | 943 | $21,100 |
| 247 | Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/o MCC | 2,100 | $12,915 |
| 248 | Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent w/ MCC or 4+ Vessels/Stents | 108 | $19,443 |
| 249 | Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent w/o MCC | 186 | $11,842 |
| 250 | Percutaneous Cardiovascular Procedure without Coronary Artery Stent w/ MCC | 74 | $18,047 |
| 251 | Percutaneous Cardiovascular Procedure without Coronary Artery Stent w/o MCC | 108 | $9,886 |

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|---|---|---|---|
| MS-DRG | MS-DRG Descriptions by Medical Condition/Surgical Procedure | Medicare Fee-for-Service | |
| | | Cases | Average Payment |
| **Heart Attack - Medical Management** | | **4,127** | **$7,666** |
| 280 | Acute Myocardial Infarction, Discharged Alive w/ MCC | 1,880 | $9,887 |
| 281 | Acute Myocardial Infarction, Discharged Alive w/ CC | 1,337 | $5,746 |
| 282 | Acute Myocardial Infarction, Discharged Alive w/o CC/MCC | 553 | $3,906 |
| 283 | Acute Myocardial Infarction, Expired w/ MCC | 275 | $10,532 |
| 284 | Acute Myocardial Infarction, Expired w/ CC | 61 | $4,049 |
| 285 | Acute Myocardial Infarction, Expired w/o CC/MCC | 21 | $3,193 |
| **Heart Failure** | | **21,422** | **$7,912** |
| 286 | Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/ MCC | 907 | $15,254 |
| 287 | Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/o MCC | 485 | $7,437 |
| 291 | Heart Failure and Shock w/ MCC | 13,561 | $8,803 |
| 292 | Heart Failure and Shock w/ CC | 4,726 | $5,569 |
| 293 | Heart Failure and Shock w/o CC/MCC | 1,743 | $3,644 |
| **Kidney and Urinary Tract Infections** | | **8,475** | **$4,992** |
| 689 | Kidney and Urinary Tract Infections w/ MCC | 2,963 | $6,106 |
| 690 | Kidney and Urinary Tract Infections w/o MCC | 5,512 | $4,393 |
| **Kidney Failure - Acute** | | **9,423** | **$6,458** |
| 682 | Renal Failure w/ MCC | 3,182 | $9,060 |
| 683 | Renal Failure w/ CC | 5,528 | $5,351 |
| 684 | Renal Failure w/o CC/MCC | 713 | $3,425 |
| **Pneumonia - Aspiration** | | **3,330** | **$9,378** |
| 177 | Respiratory Infections and Inflammations w/ MCC | 2,001 | $10,761 |
| 178 | Respiratory Infections and Inflammations w/ CC | 1,103 | $7,702 |
| 179 | Respiratory Infections and Inflammations w/o CC/MCC | 226 | $5,301 |

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|---|---|---|---|
| MS-DRG | MS-DRG Descriptions by Medical Condition/Surgical Procedure | Medicare Fee-for-Service | |
| | | Cases | Average Payment |
| **Pneumonia - Infectious** | | **9,249** | **$6,360** |
| 177 | Respiratory Infections and Inflammations w/ MCC | 432 | $10,784 |
| 178 | Respiratory Infections and Inflammations w/ CC | 170 | $7,612 |
| 179 | Respiratory Infections and Inflammations w/o CC/MCC | 37 | $5,108 |
| 193 | Simple Pneumonia and Pleurisy w/ MCC | 3,472 | $7,957 |
| 194 | Simple Pneumonia and Pleurisy w/ CC | 3,806 | $5,288 |
| 195 | Simple Pneumonia and Pleurisy w/o CC/MCC | 1,332 | $3,699 |
| **Respiratory Failure** | | **6,507** | **$9,843** |
| 189 | Pulmonary Edema and Respiratory Failure | 5,155 | $7,310 |
| 207 | Respiratory System Diagnosis with Ventilator Support > 96 Hours | 293 | $35,449 |
| 208 | Respiratory System Diagnosis with Ventilator Support <= 96 Hours | 1,059 | $15,089 |
| **Sepsis** | | **26,194** | **$10,642** |
| 870 | Septicemia or Severe Sepsis with Mechanical Ventilation > 96 Hours | 857 | $38,712 |
| 871 | Septicemia or Severe Sepsis without Mechanical Ventilation > 96 Hours w/ MCC | 19,404 | $10,829 |
| 872 | Septicemia or Severe Sepsis without Mechanical Ventilation > 96 Hours w/o MCC | 5,933 | $5,978 |
| **Stroke** | | **7,817** | **$7,193** |
| 061 | Acute Ischemic Stroke with Use of Thrombolytic Agent w/ MCC | 156 | $17,328 |
| 062 | Acute Ischemic Stroke with Use of Thrombolytic Agent w/ CC | 275 | $11,331 |
| 063 | Acute Ischemic Stroke with Use of Thrombolytic Agent w/o CC/MCC | 52 | $8,940 |
| 064 | Intracranial Hemorrhage or Cerebral Infarction w/ MCC | 1,924 | $10,806 |
| 065 | Intracranial Hemorrhage or Cerebral Infarction w/ CC or tPA in 24 Hours | 4,072 | $5,879 |
| 066 | Intracranial Hemorrhage or Cerebral Infarction w/o CC/MCC | 1,338 | $3,895 |

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