Medicare Payments

The following table includes information about payments made by Medicare for the four surgical procedures included in this *Common Procedures Report*. This analysis is based on data from Fiscal Year (FY) 2018. 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 surgical procedure and dividing the sum by the number of cases in that procedure group.

The payments analysis is based on data from FY 2018. This information, provided by CMS, reflects the average amounts paid by Medicare fee-for-service for inpatient hospitalizations of Pennsylvania residents only.

The surgical procedures included in this report are defined using ICD-10-PCS (International Classification of Diseases, Tenth Revision, Procedure Coding System) 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.

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

Medicare Payments

Medicare Fee-for-Service Payments – FY 2018 Statewide Data *For the four surgical procedures included in this Common Procedure Report*			
MS-DRG	MS-DRG Descriptions by Surgical Procedure	Medicare Fee-for-Service	
		Number of Cases	Average Payment
Knee Replacement		**10,164**	**$12,234**
003	ECMO or Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. in MDC 8	NR	NR
461	Bilateral or Multiple Major Joint Procedures of Lower Extremity with MCC	12	$31,576
462	Bilateral or Multiple Major Joint Procedures of Lower Extremity without MCC	478	$19,834
463	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders with MCC	NR	NR
464	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders with CC	NR	NR
465	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders without CC/MCC	NR	NR
469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement	188	$18,859
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC	9,483	$11,695
Hip Replacement		**5,780**	**$11,971**
003	ECMO or Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. in MDC 8	NR	NR
461	Bilateral or Multiple Major Joint Procedures of Lower Extremity with MCC	NR	NR
462	Bilateral or Multiple Major Joint Procedures of Lower Extremity without MCC	18	$20,317
463	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders with MCC	NR	NR
464	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders with CC	NR	NR
465	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders without CC/MCC	NR	NR
469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement	109	$18,336
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC	5,651	$11,822

NR = Not reported due to low volume.
CC = Complication or Comorbidity
MCC = Major Complication or Comorbidity

Medicare Payments

Medicare Fee-for-Service Payments – FY 2018 Statewide Data *For the four surgical procedures included in this Common Procedure Report*			
MS-DRG	MS-DRG Descriptions by Surgical Procedure	Medicare Fee-for-Service	
		Number of Cases	Average Payment
Spinal Fusion		**3,375**	**$27,471**
453	Combined Anterior/Posterior Spinal Fusion with MCC	62	$68,338
454	Combined Anterior/Posterior Spinal Fusion with CC	258	$46,055
455	Combined Anterior/Posterior Spinal Fusion without CC/MCC	278	$34,442
456	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions with MCC	19	$63,542
457	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions with CC	42	$46,687
458	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions without CC/MCC	27	$34,906
459	Spinal Fusion Except Cervical with MCC	102	$39,637
460	Spinal Fusion Except Cervical without MCC	1,696	$25,121
463	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders with MCC	NR	NR
464	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders with CC	NR	NR
465	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders without CC/MCC	NR	NR
471	Cervical Spinal Fusion with MCC	76	$33,576
472	Cervical Spinal Fusion with CC	421	$19,051
473	Cervical Spinal Fusion without CC/MCC	393	$14,445
Coronary Artery Bypass Graft (CABG)		**2,022**	**$34,782**
001	Heart Transplant or Implant of Heart Assist System with MCC	NR	NR
002	Heart Transplant or Implant of Heart Assist System without MCC	NR	NR
003	ECMO or Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. in MDC 5	31	$125,961
215	Other Heart Assist System Implant	NR	NR
216	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC	NR	NR

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Medicare Payments

Medicare Fee-for-Service Payments – FY 2018 Statewide Data *For the four surgical procedures included in this Common Procedure Report*			
MS-DRG	MS-DRG Descriptions by Surgical Procedure	Medicare Fee-for-Service	
		Number of Cases	Average Payment
Coronary Artery Bypass Graft (CABG) *continued*		**2,022**	**$34,782**
217	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with CC	NR	NR
218	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization without CC/MCC	NR	NR
219	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with MCC	NR	NR
220	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with CC	NR	NR
221	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization without CC/MCC	NR	NR
222	Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction/Heart Failure/Shock with MCC	NR	NR
223	Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction/Heart Failure/Shock without MCC	NR	NR
224	Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction/Heart Failure/Shock with MCC	NR	NR
225	Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction/Heart Failure/Shock without MCC	NR	NR
226	Cardiac Defibrillator Implant without Cardiac Catheterization with MCC	NR	NR
227	Cardiac Defibrillator Implant without Cardiac Catheterization without MCC	NR	NR
228	Other Cardiothoracic Procedures with MCC	23	$48,556
229	Other Cardiothoracic Procedures without MCC	21	$29,860
231	Coronary Bypass with PTCA with MCC	41	$53,908
232	Coronary Bypass with PTCA without MCC	38	$39,082
233	Coronary Bypass with Cardiac Catheterization with MCC	392	$45,023
234	Coronary Bypass with Cardiac Catheterization without MCC	483	$30,352
235	Coronary Bypass without Cardiac Catheterization with MCC	298	$36,541
236	Coronary Bypass without Cardiac Catheterization without MCC	676	$24,257

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