Medicare Payments

The following table includes information about payments made by Medicare for the three procedures included in this *Common Procedures Report* – spinal fusion, total hip replacement and total knee replacement. This analysis is based on data from January 1, 2020 through December 31, 2020. 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 procedure group and dividing the sum by the number of cases in that procedure group.

The payments analysis is based on data from January 1, 2020 through December 31, 2020. This information, provided by CMS, reflects the average amounts paid by Medicare fee-for-service for inpatient hospitalizations of Pennsylvania residents only.

The procedure groups 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) and Major Diagnostic Category (MDC) where appropriate – information available from the discharge data that PHC4 receives from Pennsylvania hospitals. Technical Notes relevant to this report provide additional detail. They are posted to PHC4's website at **www.phc4.org**.

In this section, average payments by MS-DRGs are displayed for the three procedures included in this report. While these procedures have been defined using ICD-CM-PCS 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 – CY 2020 Statewide Data *For the three procedures included in this Common Procedure Report*			
		Medicare Fee-for-Service	
MS-DRG	MS-DRG Title	Number of Cases	Average Payment
Spinal Fusion		**2,847**	**$31,590**
453	Combined Anterior/Posterior Spinal Fusion with MCC	42	$75,415
454	Combined Anterior/Posterior Spinal Fusion with CC	454	$45,962
455	Combined Anterior/Posterior Spinal Fusion without CC/MCC	420	$33,996
456	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions with MCC	15	$62,562
457	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions with CC	57	$47,211
458	Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions without CC/MCC	45	$34,445
459	Spinal Fusion Except Cervical with MCC	58	$47,526
460	Spinal Fusion Except Cervical without MCC	1,098	$26,835
471	Cervical Spinal Fusion with MCC	62	$37,206
472	Cervical Spinal Fusion with CC	390	$21,522
473	Cervical Spinal Fusion without CC/MCC	206	$17,098
Total Hip Replacement		**3,248**	**$12,159**
003	ECMO or Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R.	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	NR	NR
469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement	71	$20,432
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC	3,159	$11,922
Total Knee Replacement		**5,237**	**$12,294**
003	ECMO or Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R.	NR	NR
461	Bilateral or Multiple Major Joint Procedures of Lower Extremity with MCC	NR	NR

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

Medicare Payments

Medicare Fee-for-Service Payments – CY 2020 Statewide Data *For the three procedures included in this Common Procedure Report*			
		Medicare Fee-for-Service	
MS-DRG	MS-DRG Title	Number of Cases	Average Payment
Total Knee Replacement *Continued*			
462	Bilateral or Multiple Major Joint Procedures of Lower Extremity without MCC	252	$20,047
469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement	NR	NR
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC	4,898	$11,743

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