Medicare and Medicaid Payments

The following table includes information about payments made by Medicare and Medicaid for the 17 medical conditions/surgical procedures included in this *Hospital Performance Report*. This analysis is based on data from 2014, which is the most recent payment data available to PHC4. Displayed separately are the average amounts paid by Medicare fee-for-service, Medicaid fee-for-service, and Medicaid managed care organizations 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 Medicaid fee-for-service and managed care organization payments are calculated separately and are based on the claim-payment amounts obtained from the Pennsylvania Department of Human Services. The average payment for each payer category 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 for the given payer.

The payments analysis is based on data from 2014, the most recent information available to PHC4. Displayed separately are the average amounts paid by Medicare fee-for-service, Medicaid fee-for-service, and Medicaid managed care organizations for inpatient hospitalizations of Pennsylvania residents only.

Most of the medical conditions and surgical procedures included in this report are defined using ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis and procedure codes, with a secondary requirement that they be limited to particular MS-DRGs (Medicare Severity – Diagnosis-Related Group) – information available from the discharge data that PHC4 receives from Pennsylvania hospitals. Two conditions (Chest Pain and Hypotension and Fainting) are comprised of single MS-DRGs.

In this section, average payments are displayed for the 17 medical conditions/surgical procedures included in this report – broken down by the MS-DRGs included within each condition/procedure. While the 17 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. Differences in the approaches used by Medicare and Medicaid in determining payments may account for some of the variation seen across these payers.

Medicare and Medicaid Payments

Medicare and Medicaid Payments – 2014 Statewide Data *For the 17 medical conditions/surgical procedures included in this Hospital Performance Report*							
MS-DRG	MS-DRG Descriptions by Medical Condition/Surgical Procedure	Medicare Fee-for-Service		Medicaid Fee-for-Service		Medicaid Managed Care	
		Cases	Average Payment	Cases	Average Payment	Cases	Average Payment
Abnormal Heartbeat		**13,918**	**$7,348**	**408**	**$9,304**	**1,013**	**$9,564**
242	Permanent Cardiac Pacemaker Implant w/ MCC	568	$21,736	11	$51,155	13	$27,950
243	Permanent Cardiac Pacemaker Implant w/ CC	1,054	$15,668	15	$18,121	33	$20,805
244	Permanent Cardiac Pacemaker Implant w/o CC/MCC	855	$12,551	20	$13,159	25	$15,977
246	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/ MCC or 4+ Vessels/Stents	21	$20,093	2	NR	1	NR
247	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/o MCC	20	$13,301	3	NR	2	NR
248	Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent w/ MCC or 4+ Vessels/Stents	13	$18,369	0	NR	1	NR
249	Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent w/o MCC	8	NR	0	NR	0	NR
250	Percutaneous Cardiovascular Procedure without Coronary Artery Stent w/ MCC	141	$21,123	7	NR	21	$24,825
251	Percutaneous Cardiovascular Procedure without Coronary Artery Stent w/o MCC	461	$13,902	33	$11,194	72	$14,179
258	Cardiac Pacemaker Device Replacement w/ MCC	2	NR	0	NR	0	NR
259	Cardiac Pacemaker Device Replacement w/o MCC	14	$11,881	0	NR	0	NR
260	Cardiac Pacemaker Revision Except Device Replacement w/ MCC	3	NR	1	NR	0	NR
261	Cardiac Pacemaker Revision Except Device Replacement w/ CC	11	$10,620	0	NR	0	NR
262	Cardiac Pacemaker Revision Except Device Replacement w/o CC/MCC	7	NR	0	NR	2	NR
286	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/ MCC	155	$14,002	22	$16,655	11	$14,022
287	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/o MCC	288	$6,357	20	$7,965	43	$9,183
308	Cardiac Arrhythmia and Conduction Disorders w/ MCC	2,795	$7,163	65	$8,852	140	$9,641
309	Cardiac Arrhythmia and Conduction Disorders w/ CC	3,909	$4,493	98	$6,012	341	$8,149
310	Cardiac Arrhythmia and Conduction Disorders w/o CC/MCC	3,593	$2,849	111	$3,859	308	$6,207
Chest Pain		**2,181**	**$3,718**	**94**	**$3,558**	**658**	**$5,355**
313	Chest Pain	2,181	$3,718	94	$3,558	658	$5,355

Note: Differences in the approaches used by Medicare and Medicaid in determining payments may account for some of the variation seen across these payers for a given condition.

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Medicare and Medicaid Payments

Medicare and Medicaid Payments – 2014 Statewide Data *For the 17 medical conditions/surgical procedures included in this Hospital Performance Report*							
MS-DRG	MS-DRG Descriptions by Medical Condition/Surgical Procedure	Medicare Fee-for-Service		Medicaid Fee-for-Service		Medicaid Managed Care	
		Cases	Average Payment	Cases	Average Payment	Cases	Average Payment
Chronic Obstructive Pulmonary Disease (COPD)		**10,006**	**$5,575**	**372**	**$6,173**	**2,015**	**$8,771**
190	Chronic Obstructive Pulmonary Disease w/ MCC	3,952	$6,660	134	$8,290	589	$10,121
191	Chronic Obstructive Pulmonary Disease w/ CC	3,740	$5,398	122	$5,570	804	$8,606
192	Chronic Obstructive Pulmonary Disease w/o CC/MCC	2,314	$4,010	116	$4,362	622	$7,708
Colorectal Procedures		**3,073**	**$18,007**	**229**	**$20,201**	**592**	**$23,473**
329	Major Small and Large Bowel Procedures w/ MCC	816	$30,067	89	$28,810	117	$30,099
330	Major Small and Large Bowel Procedures w/ CC	1,324	$15,254	107	$15,934	262	$24,861
331	Major Small and Large Bowel Procedures w/o CC/MCC	646	$9,692	24	$8,280	167	$16,961
332	Rectal Resection w/ MCC	42	$27,906	1	NR	6	NR
333	Rectal Resection w/ CC	149	$15,014	6	NR	32	$21,291
334	Rectal Resection w/o CC/MCC	96	$9,728	2	NR	8	NR
Congestive Heart Failure (CHF)		**18,800**	**$6,714**	**607**	**$10,550**	**1,541**	**$12,149**
286	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/ MCC	322	$15,129	38	$21,448	63	$18,099
287	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/o MCC	718	$7,165	100	$10,222	152	$11,840
291	Heart Failure and Shock w/ MCC	6,255	$8,793	165	$12,606	404	$14,164
292	Heart Failure and Shock w/ CC	8,556	$5,836	261	$8,694	768	$11,072
293	Heart Failure and Shock w/o CC/MCC	2,949	$3,826	43	$5,061	154	$10,110
Diabetes - Medical Management		**3,856**	**$5,753**	**786**	**$6,461**	**2,497**	**$7,601**
073	Cranial and Peripheral Nerve Disorders w/ MCC	149	$8,001	8	NR	36	$11,312
074	Cranial and Peripheral Nerve Disorders w/o MCC	422	$5,530	59	$6,148	314	$8,127
299	Peripheral Vascular Disorders w/ MCC	36	$9,338	2	NR	2	NR
300	Peripheral Vascular Disorders w/ CC	91	$5,797	5	NR	8	NR
301	Peripheral Vascular Disorders w/o CC/MCC	1	NR	0	NR	4	NR
637	Diabetes w/ MCC	724	$8,428	108	$11,926	255	$10,328
638	Diabetes w/ CC	1,801	$4,988	393	$5,800	1,176	$7,398
639	Diabetes w/o CC/MCC	509	$3,483	189	$4,242	641	$6,224
698	Other Kidney and Urinary Tract Diagnoses w/ MCC	28	$10,998	6	NR	7	NR
699	Other Kidney and Urinary Tract Diagnoses w/ CC	87	$6,717	12	$6,485	45	$9,162
700	Other Kidney and Urinary Tract Diagnoses w/o CC/MCC	8	NR	4	NR	9	NR

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Medicare and Medicaid Payments

Medicare and Medicaid Payments – 2014 Statewide Data *For the 17 medical conditions/surgical procedures included in this Hospital Performance Report*							
MS-DRG	MS-DRG Descriptions by Medical Condition/Surgical Procedure	Medicare Fee-for-Service		Medicaid Fee-for-Service		Medicaid Managed Care	
		Cases	Average Payment	Cases	Average Payment	Cases	Average Payment
Gallbladder Removal - Laparoscopic		**1,904**	**$9,968**	**457**	**$6,687**	**956**	**$11,469**
411	Cholecystectomy with Common Duct Exploration (C.D.E.) w/ MCC	2	NR	0	NR	1	NR
412	Cholecystectomy with C.D.E. w/ CC	4	NR	1	NR	3	NR
413	Cholecystectomy with C.D.E. w/o CC/MCC	1	NR	1	NR	0	NR
417	Laparoscopic Cholecystectomy without C.D.E. w/ MCC	455	$14,921	44	$11,928	116	$16,444
418	Laparoscopic Cholecystectomy without C.D.E. w/ CC	814	$9,554	155	$7,149	329	$12,354
419	Laparoscopic Cholecystectomy without C.D.E. w/o CC/MCC	628	$6,867	256	$5,511	507	$9,739
Gallbladder Removal - Open		**336**	**$14,900**	**48**	**$11,745**	**98**	**$15,239**
411	Cholecystectomy with C.D.E. w/ MCC	5	NR	0	NR	0	NR
412	Cholecystectomy with C.D.E. w/ CC	10	NR	1	NR	2	NR
413	Cholecystectomy with C.D.E. w/o CC/MCC	8	NR	0	NR	2	NR
414	Cholecystectomy Except by Laparoscope without C.D.E. w/ MCC	105	$22,621	11	$19,149	16	$23,592
415	Cholecystectomy Except by Laparoscope without C.D.E. w/ CC	135	$12,519	18	$10,931	38	$15,448
416	Cholecystectomy Except by Laparoscope without C.D.E. w/o CC/MCC	73	$8,172	18	$8,060	40	$11,749
Heart Attack - Angioplasty/Stent		**2,996**	**$14,126**	**531**	**$14,259**	**472**	**$22,445**
246	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/ MCC or 4+ Vessels/Stents	558	$20,229	64	$17,906	62	$29,147
247	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/o MCC	1,607	$12,283	300	$12,934	264	$21,857
248	Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent w/ MCC or 4+ Vessels/Stents	211	$18,495	23	$23,379	29	$22,430
249	Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent w/o MCC	449	$11,069	126	$14,020	83	$20,158
250	Percutaneous Cardiovascular Procedure without Coronary Artery Stent w/ MCC	62	$18,231	3	NR	6	NR
251	Percutaneous Cardiovascular Procedure without Coronary Artery Stent w/o MCC	109	$11,848	15	$13,328	28	$19,273

Note: Differences in the approaches used by Medicare and Medicaid in determining payments may account for some of the variation seen across these payers for a given condition.

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Medicare and Medicaid Payments

Medicare and Medicaid Payments – 2014 Statewide Data

For the 17 medical conditions/surgical procedures included in this Hospital Performance Report

MS-DRG	MS-DRG Descriptions by Medical Condition/Surgical Procedure	Medicare Fee-for-Service		Medicaid Fee-for-Service		Medicaid Managed Care	
		Cases	Average Payment	Cases	Average Payment	Cases	Average Payment
Heart Attack - Medical Management		**4,443**	**$7,753**	**159**	**$9,299**	**298**	**$15,404**
280	Acute Myocardial Infarction, Discharged Alive w/ MCC	1,990	$10,017	54	$13,112	98	$17,556
281	Acute Myocardial Infarction, Discharged Alive w/ CC	1,374	$6,042	48	$7,944	103	$14,680
282	Acute Myocardial Infarction, Discharged Alive w/o CC/MCC	685	$4,179	52	$5,789	84	$13,612
283	Acute Myocardial Infarction, Expired w/ MCC	284	$10,318	3	NR	9	NR
284	Acute Myocardial Infarction, Expired w/ CC	77	$4,268	2	NR	2	NR
285	Acute Myocardial Infarction, Expired w/o CC/MCC	33	$2,750	0	NR	2	NR
Hypotension and Fainting		**3,676**	**$4,229**	**112**	**$4,576**	**358**	**$6,139**
312	Syncope and Collapse	3,676	$4,229	112	$4,576	358	$6,139
Kidney and Urinary Tract Infections		**8,800**	**$5,042**	**315**	**$6,145**	**1,090**	**$7,587**
689	Kidney and Urinary Tract Infections w/ MCC	2,694	$6,406	70	$10,672	171	$9,194
690	Kidney and Urinary Tract Infections w/o MCC	6,106	$4,440	245	$4,852	919	$7,288
Kidney Failure - Acute		**9,124**	**$6,537**	**396**	**$10,092**	**1,208**	**$10,414**
682	Renal Failure w/ MCC	2,848	$9,200	114	$14,765	273	$13,009
683	Renal Failure w/ CC	5,363	$5,628	254	$8,305	755	$9,861
684	Renal Failure w/o CC/MCC	913	$3,565	28	$7,276	180	$8,800
Pneumonia - Aspiration		**3,440**	**$9,545**	**119**	**$12,829**	**237**	**$13,387**
177	Respiratory Infections and Inflammations w/ MCC	1,794	$11,261	56	$13,776	98	$14,309
178	Respiratory Infections and Inflammations w/ CC	1,358	$8,140	58	$12,195	104	$13,377
179	Respiratory Infections and Inflammations w/o CC/MCC	288	$5,482	5	NR	35	$10,833
Pneumonia - Infectious		**12,775**	**$6,370**	**542**	**$6,715**	**1,833**	**$10,026**
177	Respiratory Infections and Inflammations w/ MCC	432	$11,538	12	$11,694	32	$14,817
178	Respiratory Infections and Inflammations w/ CC	314	$7,775	13	$8,821	35	$15,997
179	Respiratory Infections and Inflammations w/o CC/MCC	39	$5,897	3	NR	4	NR
193	Simple Pneumonia and Pleurisy w/ MCC	4,318	$8,214	178	$8,461	486	$11,968
194	Simple Pneumonia and Pleurisy w/ CC	5,565	$5,465	219	$6,382	902	$9,429
195	Simple Pneumonia and Pleurisy w/o CC/MCC	2,107	$3,720	117	$3,955	374	$7,897

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MS-DRG	MS-DRG Descriptions by Medical Condition/Surgical Procedure	Medicare Fee-for-Service		Medicaid Fee-for-Service		Medicaid Managed Care	
		Cases	Average Payment	Cases	Average Payment	Cases	Average Payment
Septicemia		**21,303**	**$10,913**	**1,612**	**$15,560**	**3,030**	**$15,475**
870	Septicemia or Severe Sepsis with Mechanical Ventilation 96+ Hours	856	$37,892	136	$30,543	204	$34,394
871	Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours w/ MCC	14,980	$11,101	938	$17,376	1,726	$16,053
872	Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours w/o MCC	5,467	$6,174	538	$8,607	1,100	$11,059
Stroke		**7,917**	**$6,981**	**616**	**$9,783**	**802**	**$13,437**
061	Acute Ischemic Stroke with Use of Thrombolytic Agent w/ MCC	133	$17,178	9	NR	8	NR
062	Acute Ischemic Stroke with Use of Thrombolytic Agent w/ CC	245	$11,208	27	$8,941	35	$19,148
063	Acute Ischemic Stroke with Use of Thrombolytic Agent w/o CC/MCC	89	$8,432	5	NR	11	$16,776
064	Intracranial Hemorrhage or Cerebral Infarction w/ MCC	1,837	$10,481	116	$18,470	150	$16,832
065	Intracranial Hemorrhage or Cerebral Infarction w/ CC or tPA in 24 Hours	3,618	$6,114	293	$8,519	403	$12,845
066	Intracranial Hemorrhage or Cerebral Infarction w/o CC/MCC	1,995	$4,066	166	$5,801	195	$10,572

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