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 calendar year 2015, 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 2015, the most recent information available to PHC4. The data 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 – 2015 Statewide Data *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		**13,453**	**$7,421**
242	Permanent Cardiac Pacemaker Implant w/ MCC	596	$22,226
243	Permanent Cardiac Pacemaker Implant w/ CC	888	$15,692
244	Permanent Cardiac Pacemaker Implant w/o CC/MCC	758	$12,491
246	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/ MCC or 4+ Vessels/Stents*	18	$20,623
247	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/o MCC*	20	$12,617
248	Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent w/ MCC or 4+ Vessels/Stents*	5	NR
249	Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent w/o MCC*	3	NR
250	Percutaneous Cardiovascular Procedure without Coronary Artery Stent w/ MCC*	120	$19,582
251	Percutaneous Cardiovascular Procedure without Coronary Artery Stent w/o MCC*	342	$13,863
258	Cardiac Pacemaker Device Replacement w/ MCC	9	NR
259	Cardiac Pacemaker Device Replacement w/o MCC	19	$12,765
260	Cardiac Pacemaker Revision Except Device Replacement w/ MCC	5	NR
261	Cardiac Pacemaker Revision Except Device Replacement w/ CC	12	$11,345
262	Cardiac Pacemaker Revision Except Device Replacement w/o CC/MCC	13	$8,508
273	Percutaneous Intracardiac Procedures w/ MCC†	43	$25,505
274	Percutaneous Intracardiac Procedures w/o MCC†	93	$17,614
286	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/ MCC	183	$13,200
287	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/o MCC	253	$6,653
308	Cardiac Arrhythmia and Conduction Disorders w/ MCC	3,020	$7,170
309	Cardiac Arrhythmia and Conduction Disorders w/ CC	3,805	$4,471
310	Cardiac Arrhythmia and Conduction Disorders w/o CC/MCC	3,248	$2,798
Chest Pain		**1,706**	**$3,691**
313	Chest Pain	1,706	$3,691
Chronic Obstructive Pulmonary Disease (COPD)		**11,182**	**$5,597**
190	Chronic Obstructive Pulmonary Disease w/ MCC	4,494	$6,678
191	Chronic Obstructive Pulmonary Disease w/ CC	4,329	$5,361
192	Chronic Obstructive Pulmonary Disease w/o CC/MCC	2,359	$3,968

* Cases with this MS-DRG were only included if they were discharged before October 2015.
† This MS-DRG did not exist before October 2015.

NR = Not Reported (10 or fewer cases)
CC = Complication or Comorbidity
MCC = Major Complication or Comorbidity

Medicare Payments

Medicare Fee-for-Service Payments – 2015 Statewide Data *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
Colorectal Procedures		**2,779**	**$17,896**
329	Major Small and Large Bowel Procedures w/ MCC	717	$29,508
330	Major Small and Large Bowel Procedures w/ CC	1,264	$15,781
331	Major Small and Large Bowel Procedures w/o CC/MCC	610	$9,724
332	Rectal Resection w/ MCC	18	$27,043
333	Rectal Resection w/ CC	97	$15,197
334	Rectal Resection w/o CC/MCC	73	$10,067
Diabetes - Medical Management		**3,741**	**$5,918**
073	Cranial and Peripheral Nerve Disorders w/ MCC	134	$8,625
074	Cranial and Peripheral Nerve Disorders w/o MCC	395	$5,612
299	Peripheral Vascular Disorders w/ MCC	30	$10,494
300	Peripheral Vascular Disorders w/ CC	77	$5,515
301	Peripheral Vascular Disorders w/o CC/MCC	5	NR
637	Diabetes w/ MCC	744	$8,802
638	Diabetes w/ CC	1,751	$5,024
639	Diabetes w/o CC/MCC	466	$3,611
698	Other Kidney and Urinary Tract Diagnoses w/ MCC	39	$9,635
699	Other Kidney and Urinary Tract Diagnoses w/ CC	81	$6,268
700	Other Kidney and Urinary Tract Diagnoses w/o CC/MCC	19	$4,636
Gallbladder Removal - Laparoscopic		**1,834**	**$9,869**
411	Cholecystectomy with Common Duct Exploration (C.D.E.) w/ MCC	3	NR
412	Cholecystectomy with C.D.E. w/ CC	5	NR
413	Cholecystectomy with C.D.E. w/o CC/MCC	5	NR
417	Laparoscopic Cholecystectomy without C.D.E. w/ MCC	398	$14,756
418	Laparoscopic Cholecystectomy without C.D.E. w/ CC	806	$9,663
419	Laparoscopic Cholecystectomy without C.D.E. w/o CC/MCC	617	$6,913

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Medicare Payments

Medicare Fee-for-Service Payments – 2015 Statewide Data *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
Heart Attack - Angioplasty/Stent		**3,100**	**$14,894**
246	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/ MCC or 4+ Vessels/Stents	725	$20,969
247	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/o MCC	1,705	$12,469
248	Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent w/ MCC or 4+ Vessels/Stents	198	$20,124
249	Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent w/o MCC	306	$11,204
250	Percutaneous Cardiovascular Procedure without Coronary Artery Stent w/ MCC	49	$19,091
251	Percutaneous Cardiovascular Procedure without Coronary Artery Stent w/o MCC	117	$11,645
Heart Attack - Medical Management		**4,333**	**$7,711**
280	Acute Myocardial Infarction, Discharged Alive w/ MCC	1,961	$10,005
281	Acute Myocardial Infarction, Discharged Alive w/ CC	1,374	$5,842
282	Acute Myocardial Infarction, Discharged Alive w/o CC/MCC	663	$4,203
283	Acute Myocardial Infarction, Expired w/ MCC	258	$10,280
284	Acute Myocardial Infarction, Expired w/ CC	61	$4,289
285	Acute Myocardial Infarction, Expired w/o CC/MCC	16	$4,092
Heart Failure		**20,033**	**$7,026**
286	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/ MCC	508	$14,499
287	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/o MCC	720	$7,232
291	Heart Failure and Shock w/ MCC	7,908	$8,921
292	Heart Failure and Shock w/ CC	8,212	$5,766
293	Heart Failure and Shock w/o CC/MCC	2,685	$3,830
Kidney and Urinary Tract Infections		**8,211**	**$4,973**
689	Kidney and Urinary Tract Infections w/ MCC	2,581	$6,231
690	Kidney and Urinary Tract Infections w/o MCC	5,630	$4,396
Kidney Failure - Acute		**9,139**	**$6,460**
682	Renal Failure w/ MCC	2,943	$9,075
683	Renal Failure w/ CC	5,313	$5,505
684	Renal Failure w/o CC/MCC	883	$3,491

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Medicare Payments

Medicare Fee-for-Service Payments – 2015 Statewide Data

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
Pneumonia - Aspiration		**3,265**	**$9,383**
177	Respiratory Infections and Inflammations w/ MCC	1,762	$11,012
178	Respiratory Infections and Inflammations w/ CC	1,213	$7,942
179	Respiratory Infections and Inflammations w/o CC/ MCC	290	$5,517
Pneumonia - Infectious		**12,640**	**$6,327**
177	Respiratory Infections and Inflammations w/ MCC	391	$11,187
178	Respiratory Infections and Inflammations w/ CC	310	$7,952
179	Respiratory Infections and Inflammations w/o CC/ MCC	43	$5,039
193	Simple Pneumonia and Pleurisy w/ MCC	4,390	$8,157
194	Simple Pneumonia and Pleurisy w/ CC	5,493	$5,395
195	Simple Pneumonia and Pleurisy w/o CC/MCC	2,013	$3,712
Respiratory Failure		**5,325**	**$10,289**
189	Pulmonary Edema and Respiratory Failure	3,971	$7,366
207	Respiratory System Diagnosis with Ventilator Support > 96 Hours	303	$33,979
208	Respiratory System Diagnosis with Ventilator Support <= 96 Hours	1,051	$14,506
Sepsis		**23,380**	**$10,756**
870	Septicemia or Severe Sepsis with Mechanical Ventilation > 96 Hours	866	$37,734
871	Septicemia or Severe Sepsis without Mechanical Ventilation > 96 Hours w/ MCC	16,740	$10,961
872	Septicemia or Severe Sepsis without Mechanical Ventilation > 96 Hours w/o MCC	5,774	$6,118
Stroke		**7,690**	**$6,913**
061	Acute Ischemic Stroke with Use of Thrombolytic Agent w/ MCC	117	$16,411
062	Acute Ischemic Stroke with Use of Thrombolytic Agent w/ CC	240	$11,056
063	Acute Ischemic Stroke with Use of Thrombolytic Agent w/o CC/MCC	71	$8,693
064	Intracranial Hemorrhage or Cerebral Infarction w/ MCC	1,777	$10,532
065	Intracranial Hemorrhage or Cerebral Infarction w/ CC or tPA in 24 Hours	3,655	$5,987
066	Intracranial Hemorrhage or Cerebral Infarction w/o CC/MCC	1,830	$4,027

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