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) 2019, 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 2019. 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 2019 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		**12,127**	**$8,736**
242	Permanent Cardiac Pacemaker Implant w/ MCC	572	$23,987
243	Permanent Cardiac Pacemaker Implant w/ CC	889	$16,213
244	Permanent Cardiac Pacemaker Implant w/o CC/MCC	518	$12,994
258	Cardiac Pacemaker Device Replacement w/ MCC	NR	NR
259	Cardiac Pacemaker Device Replacement w/o MCC	NR	NR
260	Cardiac Pacemaker Revision Except Device Replacement w/ MCC	19	$26,689
261	Cardiac Pacemaker Revision Except Device Replacement w/ CC	20	$13,128
262	Cardiac Pacemaker Revision Except Device Replacement w/o CC/MCC	NR	NR
273	Percutaneous Intracardiac Procedures w/ MCC	180	$26,776
274	Percutaneous Intracardiac Procedures w/o MCC	865	$20,547
286	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/ MCC	184	$14,833
287	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/o MCC	240	$6,775
308	Cardiac Arrhythmia and Conduction Disorders w/ MCC	2,570	$7,535
309	Cardiac Arrhythmia and Conduction Disorders w/ CC	3,636	$4,586
310	Cardiac Arrhythmia and Conduction Disorders w/o CC/MCC	2,420	$2,945
Blood Clot in Lung		**2,454**	**$7,429**
175	Pulmonary Embolism with MCC	983	$9,210
176	Pulmonary Embolism without MCC	1,399	$5,456
207	Respiratory System Diagnosis with Ventilator Support >96 Hours or Peripheral Extracorporeal Membrane Oxygenation (ECMO)	13	$40,400
208	Respiratory System Diagnosis with Ventilator Support <= 96 Hours	59	$17,269
Chest Pain		**1,287**	**$4,142**
313	Chest Pain	1,287	$4,142
Chronic Obstructive Pulmonary Disease (COPD)		**8,532**	**$6,653**
190	Chronic Obstructive Pulmonary Disease w/ MCC	4,745	$7,242
191	Chronic Obstructive Pulmonary Disease w/ CC	2,622	$5,555
192	Chronic Obstructive Pulmonary Disease w/o CC/MCC	982	$4,229
207	Respiratory System Diagnosis with Ventilator Support >96 Hours or Peripheral Extracorporeal Membrane Oxygenation (ECMO)	36	$33,912
208	Respiratory System Diagnosis with Ventilator Support <= 96 Hours	147	$16,716

NR = Not Reported (too few cases)
CC = Complication or Comorbidity
MCC = Major Complication or Comorbidity

Medicare Payments

Medicare Fee-for-Service Payments – FFY 2019 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
Diabetes - Medical Management		**4,357**	**$6,632**
073	Cranial and Peripheral Nerve Disorders w/ MCC	133	$9,723
074	Cranial and Peripheral Nerve Disorders w/o MCC	301	$6,373
299	Peripheral Vascular Disorders w/ MCC	97	$10,313
300	Peripheral Vascular Disorders w/ CC	123	$6,696
301	Peripheral Vascular Disorders w/o CC/MCC	NR	NR
637	Diabetes w/ MCC	1,154	$8,980
638	Diabetes w/ CC	2,131	$5,440
639	Diabetes w/o CC/MCC	327	$3,725
698	Other Kidney and Urinary Tract Diagnoses w/ MCC	29	$10,325
699	Other Kidney and Urinary Tract Diagnoses w/ CC	47	$6,612
700	Other Kidney and Urinary Tract Diagnoses w/o CC/MCC	NR	NR
Heart Attack - Angioplasty/Stent		**3,188**	**$15,599**
246	Percutaneous Cardiovascular Procedures with Drug-Eluting Stent w/ MCC or 4+ Arteries or Stents	892	$21,797
247	Percutaneous Cardiovascular Procedures with Drug-Eluting Stent w/o MCC	2,027	$13,056
248	Percutaneous Cardiovascular Procedures with Non Drug-Eluting Stent w/ MCC or 4+ Arteries or Stents	37	$22,617
249	Percutaneous Cardiovascular Procedures with Non Drug-Eluting Stent w/o MCC	83	$12,455
250	Percutaneous Cardiovascular Procedures without Coronary Artery Stent w/ MCC	56	$17,011
251	Percutaneous Cardiovascular Procedures without Coronary Artery Stent w/o MCC	93	$10,723
Heart Attack - Medical Management		**3,298**	**$8,052**
280	Acute Myocardial Infarction, Discharged Alive w/ MCC	1,472	$10,447
281	Acute Myocardial Infarction, Discharged Alive w/ CC	1,141	$5,973
282	Acute Myocardial Infarction, Discharged Alive w/o CC/MCC	437	$4,167
283	Acute Myocardial Infarction, Expired w/ MCC	201	$11,629
284	Acute Myocardial Infarction, Expired w/ CC	34	$4,807
285	Acute Myocardial Infarction, Expired w/o CC/MCC	13	$3,092

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Medicare Payments

Medicare Fee-for-Service Payments – FFY 2019 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 Failure		**21,553**	**$8,131**
286	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/ MCC	1,219	$15,252
287	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/o MCC	359	$7,661
291	Heart Failure and Shock w/ MCC or Peripheral Extracorporeal Membrane Oxygenation (ECMO)	15,456	$8,437
292	Heart Failure and Shock w/ CC	3,352	$5,672
293	Heart Failure and Shock w/o CC/MCC	1,167	$3,854
Intestinal Obstruction		**3,159**	**$5,323**
388	GI Obstruction w/ MCC	516	$9,912
389	GI Obstruction w/ CC	1,649	$5,102
390	GI Obstruction w/o CC/MCC	994	$3,308
Kidney and Urinary Tract Infections		**7,535**	**$5,356**
689	Kidney and Urinary Tract Infections w/ MCC	2,590	$6,690
690	Kidney and Urinary Tract Infections w/o MCC	4,945	$4,658
Kidney Failure - Acute		**8,964**	**$6,895**
682	Renal Failure w/ MCC	3,222	$9,519
683	Renal Failure w/ CC	5,150	$5,652
684	Renal Failure w/o CC/MCC	592	$3,421
Pneumonia - Aspiration		**3,279**	**$10,298**
177	Respiratory Infections and Inflammations w/ MCC	2,036	$10,974
178	Respiratory Infections and Inflammations w/ CC	902	$7,614
179	Respiratory Infections and Inflammations w/o CC/MCC	184	$5,362
207	Respiratory System Diagnosis with Ventilator Support >96 Hours or Peripheral Extracorporeal Membrane Oxygenation (ECMO)	41	$40,062
208	Respiratory System Diagnosis with Ventilator Support <= 96 Hours	116	$16,631

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Medicare Payments

Medicare Fee-for-Service Payments – FFY 2019 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 - Infectious		**10,339**	**$7,055**
177	Respiratory Infections and Inflammations w/ MCC	540	$11,249
178	Respiratory Infections and Inflammations w/ CC	229	$7,413
179	Respiratory Infections and Inflammations w/o CC/MCC	28	$6,076
193	Simple Pneumonia and Pleurisy w/ MCC	4,741	$7,933
194	Simple Pneumonia and Pleurisy w/ CC	3,698	$5,298
195	Simple Pneumonia and Pleurisy w/o CC/MCC	888	$3,753
207	Respiratory System Diagnosis with Ventilator Support >96 Hours or Peripheral Extracorporeal Membrane Oxygenation (ECMO)	53	$34,901
208	Respiratory System Diagnosis with Ventilator Support <= 96 Hours	162	$16,111
Respiratory Failure		**5,920**	**$10,814**
189	Pulmonary Edema and Respiratory Failure	4,705	$8,140
207	Respiratory System Diagnosis with Ventilator Support >96 Hours or Peripheral Extracorporeal Membrane Oxygenation (ECMO)	253	$37,659
208	Respiratory System Diagnosis with Ventilator Support <= 96 Hours	962	$16,828
Sepsis		**25,682**	**$11,706**
870	Septicemia or Severe Sepsis with Mechanical Ventilation >96 Hours or Peripheral Extracorporeal Membrane Oxygenation (ECMO)	834	$42,790
871	Septicemia or Severe Sepsis without Mechanical Ventilation > 96 Hours w/ MCC	19,350	$11,877
872	Septicemia or Severe Sepsis without Mechanical Ventilation > 96 Hours w/o MCC	5,498	$6,389
Stroke		**7,225**	**$7,923**
061	Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent w/ MCC	167	$18,947
062	Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent w/ CC	318	$12,410
063	Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent w/o CC/MCC	68	$9,976
064	Intracranial Hemorrhage or Cerebral Infarction w/ MCC	1,907	$11,933
065	Intracranial Hemorrhage or Cerebral Infarction w/ CC or tPA in 24 Hours	3,588	$6,140
066	Intracranial Hemorrhage or Cerebral Infarction w/o CC/MCC	1,177	$3,971

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