Medicare Payments

The following table includes information about payments made by Medicare for the 14 medical conditions/surgical procedures included in this *Hospital Performance Report*. This analysis is based on data from federal fiscal year (FFY) 2020, 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 2020. 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 14 medical conditions/surgical procedures included in this report – broken down by the MS-DRGs included within each condition/procedure. While the 14 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 2020 Statewide Data

For the 14 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		**10,311**	**$9,260**
242	Permanent Cardiac Pacemaker Implant w/ MCC	443	$24,454
243	Permanent Cardiac Pacemaker Implant w/ CC	810	$16,493
244	Permanent Cardiac Pacemaker Implant w/o CC/MCC	486	$13,311
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	17	$25,790
261	Cardiac Pacemaker Revision Except Device Replacement w/ CC	25	$12,716
262	Cardiac Pacemaker Revision Except Device Replacement w/o CC/MCC	16	$11,347
273	Percutaneous Intracardiac Procedures w/ MCC	166	$31,859
274	Percutaneous Intracardiac Procedures w/o MCC	798	$22,486
286	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/ MCC	133	$15,350
287	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/o MCC	212	$7,029
308	Cardiac Arrhythmia and Conduction Disorders w/ MCC	2,238	$7,722
309	Cardiac Arrhythmia and Conduction Disorders w/ CC	3,088	$4,551
310	Cardiac Arrhythmia and Conduction Disorders w/o CC/MCC	1,864	$2,986
Blood Clot in Lung		**2,083**	**$7,604**
175	Pulmonary Embolism with MCC or Acute Cor Pulmonale	961	$9,610
176	Pulmonary Embolism without MCC	1,074	$5,099
207	Respiratory System Diagnosis with Ventilator Support >96 Hours	NR	NR
208	Respiratory System Diagnosis with Ventilator Support <= 96 Hours	NR	NR
Chest Pain		**976**	**$4,294**
313	Chest Pain	976	$4,294
Chronic Obstructive Pulmonary Disease (COPD)		**5,686**	**$6,698**
190	Chronic Obstructive Pulmonary Disease w/ MCC	3,306	$7,246
191	Chronic Obstructive Pulmonary Disease w/ CC	1,761	$5,520
192	Chronic Obstructive Pulmonary Disease w/o CC/MCC	507	$4,051
207	Respiratory System Diagnosis with Ventilator Support >96 Hours	19	$37,290
208	Respiratory System Diagnosis with Ventilator Support <= 96 Hours	93	$17,684

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

Medicare Payments

Medicare Fee-for-Service Payments – FFY 2020 Statewide Data

For the 14 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		**3,690**	**$7,000**
073	Cranial and Peripheral Nerve Disorders w/ MCC	112	$10,097
074	Cranial and Peripheral Nerve Disorders w/o MCC	231	$6,718
299	Peripheral Vascular Disorders w/ MCC	100	$9,557
300	Peripheral Vascular Disorders w/ CC	103	$6,699
301	Peripheral Vascular Disorders w/o CC/MCC	NR	NR
637	Diabetes w/ MCC	1,174	$9,276
638	Diabetes w/ CC	1,659	$5,513
639	Diabetes w/o CC/MCC	216	$3,559
698	Other Kidney and Urinary Tract Diagnoses w/ MCC	27	$10,453
699	Other Kidney and Urinary Tract Diagnoses w/ CC	52	$6,522
700	Other Kidney and Urinary Tract Diagnoses w/o CC/MCC	NR	NR
Heart Attack - Angioplasty/Stent		**2,910**	**$15,789**
246	Percutaneous Cardiovascular Procedures with Drug-Eluting Stent w/ MCC or 4+ Arteries or Stents	799	$22,245
247	Percutaneous Cardiovascular Procedures with Drug-Eluting Stent w/o MCC	1,903	$13,240
248	Percutaneous Cardiovascular Procedures with Non Drug-Eluting Stent w/ MCC or 4+ Arteries or Stents	32	$22,756
249	Percutaneous Cardiovascular Procedures with Non Drug-Eluting Stent w/o MCC	46	$12,161
250	Percutaneous Cardiovascular Procedures without Coronary Artery Stent w/ MCC	48	$16,861
251	Percutaneous Cardiovascular Procedures without Coronary Artery Stent w/o MCC	82	$10,708
Heart Attack - Medical Management		**2,511**	**$8,109**
280	Acute Myocardial Infarction, Discharged Alive w/ MCC	1,067	$10,598
281	Acute Myocardial Infarction, Discharged Alive w/ CC	898	$5,920
282	Acute Myocardial Infarction, Discharged Alive w/o CC/MCC	332	$4,188
283	Acute Myocardial Infarction, Expired w/ MCC	177	$12,419
284	Acute Myocardial Infarction, Expired w/ CC	NR	NR
285	Acute Myocardial Infarction, Expired w/o CC/MCC	NR	NR

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Medicare Payments

Medicare Fee-for-Service Payments – FFY 2020 Statewide Data

For the 14 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		**18,048**	**$8,544**
286	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/ MCC	1,029	$16,111
287	Circulatory Disorders Except Acute Myocardial Infarction, with Cardiac Catheterization w/o MCC	328	$8,210
291	Heart Failure and Shock w/ MCC	13,431	$8,753
292	Heart Failure and Shock w/ CC	2,737	$5,608
293	Heart Failure and Shock w/o CC/MCC	523	$3,881
Intestinal Obstruction		**2,895**	**$5,395**
388	GI Obstruction w/ MCC	495	$9,984
389	GI Obstruction w/ CC	1,520	$5,166
390	GI Obstruction w/o CC/MCC	880	$3,208
Kidney and Urinary Tract Infections		**6,289**	**$5,508**
689	Kidney and Urinary Tract Infections w/ MCC	2,330	$6,884
690	Kidney and Urinary Tract Infections w/o MCC	3,959	$4,699
Kidney Failure - Acute		**7,244**	**$6,959**
682	Renal Failure w/ MCC	2,694	$9,579
683	Renal Failure w/ CC	4,120	$5,607
684	Renal Failure w/o CC/MCC	430	$3,505
Respiratory Failure		**4,833**	**$11,481**
189	Pulmonary Edema and Respiratory Failure	3,719	$8,342
207	Respiratory System Diagnosis with Ventilator Support >96 Hours	209	$41,649
208	Respiratory System Diagnosis with Ventilator Support <= 96 Hours	905	$17,412
Sepsis		**22,017**	**$12,314**
870	Septicemia or Severe Sepsis with Mechanical Ventilation >96 Hours	838	$44,290
871	Septicemia or Severe Sepsis without Mechanical Ventilation > 96 Hours w/ MCC	16,458	$12,349
872	Septicemia or Severe Sepsis without Mechanical Ventilation > 96 Hours w/o MCC	4,721	$6,519

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Medicare Payments

Medicare Fee-for-Service Payments – FFY 2020 Statewide Data *For the 14 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
Stroke		**6,334**	**$8,254**
061	Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent w/ MCC	149	$19,603
062	Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent w/ CC	283	$13,216
063	Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent w/o CC/MCC	60	$10,618
064	Intracranial Hemorrhage or Cerebral Infarction w/ MCC	1,725	$12,226
065	Intracranial Hemorrhage or Cerebral Infarction w/ CC or tPA in 24 Hours	3,153	$6,312
066	Intracranial Hemorrhage or Cerebral Infarction w/o CC/MCC	964	$4,139

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