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, 2021 through December 31, 2021. 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, 2021 through December 31, 2021. 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 2021 Statewide Data *For the three procedures included in this Common Procedures Report*			
MS-DRG	**MS-DRG Title**	**Number of Cases**	**Average Payment**
Spinal Fusion		**2,589**	**$32,996**
453	Combined Anterior and Posterior Spinal Fusion with MCC	70	$70,097
454	Combined Anterior and Posterior Spinal Fusion with CC	440	$47,565
455	Combined Anterior and Posterior Spinal Fusion without CC/MCC	365	$35,107
456	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with MCC	13	$62,806
457	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with CC	28	$47,932
458	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions without CC/MCC	22	$35,211
459	Spinal Fusion Except Cervical with MCC	54	$46,238
460	Spinal Fusion Except Cervical without MCC	1,036	$27,505
471	Cervical Spinal Fusion with MCC	67	$38,253
472	Cervical Spinal Fusion with CC	345	$22,206
473	Cervical Spinal Fusion without CC/MCC	149	$17,635
Total Hip Replacement		**2,286**	**$12,051**
003	ECMO or Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. Procedures	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	47	$21,941
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC	2,219	$11,756
Total Knee Replacement		**4,209**	**$12,429**
003	ECMO or Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. Procedures	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	216	$20,387

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

Medicare Payments

Medicare Fee-for-Service Payments – CY 2021 Statewide Data *For the three procedures included in this Common Procedures Report*			
MS-DRG	**MS-DRG Title**	**Number of Cases**	**Average Payment**
Total Knee Replacement *Continued*			
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	3,894	$11,710

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