

Medicare Payments

The following table includes information about payments made by Medicare for the procedures included in the **Hospital Results** section of the *Common Procedures Report* – 1) spinal fusion, 2) total hip replacement, and 3) total knee replacement. This analysis is based on data from January 1, 2024 through December 31, 2024. Displayed are the average amounts paid by Medicare fee-for-service for inpatient acute care 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. 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 procedures included in the **Hospital Results** section of the 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 MDC (Major Diagnostic Category) where appropriate – information available from the claims data that PHC4 receives from Pennsylvania hospitals. Technical Notes relevant to this report provide additional detail and are accessible from PHC4's website at www.phc4.org.

Average payments by MS-DRGs are displayed for the procedures included in the **Hospital Results** section of this report. While these procedures have been defined using ICD-10-PCS codes that represent a clinically cohesive population, the payment data is displayed by the individual MS-DRGs included within each procedure group to account for variations in case mix.

Common Procedures Report

October 1, 2024 through September 30, 2025 Data

Medicare Fee-for-Service Payments - CY 2024 Statewide Data For the procedures included in this Common Procedures Report			
MS-DRG	MS-DRG Title	Number of Cases	Average Payment
Spinal Fusion		2,556	\$34,957
402	Single Level Combined Anterior and Posterior Spinal Fusion Except Cervical	87	\$31,057
426	Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with MCC or Custom-made Anatomically Designed Interbody Fusion Device	NR	NR
427	Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with CC	75	\$59,259
428	Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical without CC/MCC	36	\$42,304
429	Combined Anterior and Posterior Cervical Spinal Fusion with MCC	NR	NR
430	Combined Anterior and Posterior Cervical Spinal Fusion without MCC	NR	NR
447	Multiple Level Spinal Fusion Except Cervical with MCC or Custom-made Anatomically Designed Interbody Fusion Device	NR	NR
448	Multiple Level Spinal Fusion Except Cervical without MCC	114	\$32,593
450	Single Level Spinal Fusion Except Cervical with MCC or Custom-made Anatomically Designed Interbody Fusion Device	NR	NR
451	Single Level Spinal Fusion Except Cervical without MCC	106	\$23,948
453	Combined Anterior and Posterior Spinal Fusion with MCC	51	\$78,957
454	Combined Anterior and Posterior Spinal Fusion with CC	385	\$49,338
455	Combined Anterior and Posterior Spinal Fusion without CC/MCC	287	\$35,397
456	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with MCC	14	\$72,935
457	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with CC	50	\$50,782
458	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions without CC/MCC	23	\$34,702
459	Spinal Fusion Except Cervical with MCC	42	\$44,099
460	Spinal Fusion Except Cervical without MCC	653	\$28,229
471	Cervical Spinal Fusion with MCC	62	\$42,282
472	Cervical Spinal Fusion with CC	425	\$23,493
473	Cervical Spinal Fusion without CC/MCC	117	\$18,168

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

Common Procedures Report

October 1, 2024 through September 30, 2025 Data

Medicare Fee-for-Service Payments - CY 2024 Statewide Data For the procedures included in this Common Procedures Report			
MS-DRG	MS-DRG Title	Number of Cases	Average Payment
Total Hip Replacement		993	\$13,834
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	50	\$25,036
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC	929	\$13,133
Total Knee Replacement		1,894	\$13,659
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	112	\$20,127
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	1,727	\$12,867

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