

Table 5.6
Number of Discharges with a Procedure, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Procedure Within Major Procedure Classifications (MPCs): Calendar Year 2005

Principal ICD-9-CM Procedure ¹ Within MPC	ICD-9-CM Code	Discharges ²		Total Days of Care		Program Payments		
		Number	Per 1,000 HI Enrollees ³	Number	Per Discharge	Amount in Thousands	Per Discharge ⁴	Per Day
Total All Procedures	---	7,450,030	205	48,656,990	6.5	\$80,556,533	\$10,867	\$1,656
Leading Procedures ⁵	---	3,503,350	96	20,516,895	5.9	35,215,719	10,096	1,716
Operations on the Nervous System (MPC 1)	01-05	184,670	5	1,201,980	6.5	2,100,638	11,420	1,748
Spinal Tap	03.31	40,380	1	285,170	7.1	283,769	7,064	995
Operations on the Endocrine System (MPC 2)	06-07	25,720	1	91,120	3.5	194,586	7,585	2,135
Operations on the Eye (MPC 3)	08-16	10,290	(6)	44,150	4.3	72,748	7,115	1,648
Operations on the Ear (MPC 4)	18-20	2,710	(6)	15,105	5.6	22,823	8,437	1,511
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	32,295	1	160,650	5.0	230,255	7,192	1,433
Operations on the Respiratory System (MPC 6)	30-34	287,035	8	3,235,120	11.3	5,163,166	18,056	1,596
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	70,835	2	668,175	9.4	708,969	10,042	1,061
Operations on the Cardiovascular System (MPC 7)	35-39	1,890,790	52	11,331,915	6.0	25,429,691	13,524	2,244
Removal of Coronary Artery Obstruction	36.0	288,115	8	856,410	3.0	3,891,901	13,542	4,544
Coronary Artery Bypass Graft	36.1	116,115	3	1,167,665	10.1	3,404,454	29,421	2,916
Cardiac Catheterization	37.21-37.23	280,450	8	1,155,235	4.1	1,952,973	6,996	1,691
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	143,425	4	690,640	4.8	1,902,631	13,293	2,755
Hemodialysis	39.95	217,710	6	1,159,995	5.3	1,373,727	6,403	1,184
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	44,115	1	400,890	9.1	623,874	14,187	1,556
See footnotes at end of table.								

Table 5.6-Continued

Number of Discharges with a Procedure, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Procedure Within Major Procedure Classifications (MPCs): Calendar Year 2005

Principal ICD-9-CM Procedure ¹ Within MPC	ICD-9-CM Code	Discharges ²		Total Days of Care		Program Payments		
		Number	Per 1,000 HI Enrollees ³	Number	Per Discharge	Amount in Thousands	Per Discharge ⁴	Per Day
Operations on the Digestive System (MPC 9)	42-54	1,287,220	35	9,727,185	7.6	\$12,568,865	\$9,798	\$1,292
Endoscopy of Small Intestine with or Without Biopsy	45.11-45.14,45.16	353,980	10	2,114,905	6.0	1,888,396	5,358	893
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	138,735	4	830,160	6.0	734,170	5,309	884
Partial Excision of Large Intestine	45.7	109,810	3	1,213,970	11.1	2,123,218	19,365	1,749
Appendectomy, Excluding Incidental	47.0	19,545	1	99,380	5.1	168,259	8,635	1,693
Cholecystectomy	51.2	118,135	3	749,500	6.3	1,205,093	10,223	1,608
Lysis of Peritoneal Adhesions	54.5	30,380	1	331,365	10.9	499,776	16,481	1,508
Operations on the Urinary System (MPC 10)	55-59	201,415	6	1,258,945	6.3	1,839,375	9,166	1,461
Cystoscopy with or Without Biopsy	57.31-57.33	17,605	(6)	127,650	7.3	112,821	6,430	884
Operations on the Male Genital Organs (MPC 11) ⁷	60-64	93,435	6	332,410	3.6	490,584	5,272	1,476
Prostatectomy	60.2-60.6	81,930	5	268,800	3.3	395,580	4,846	1,472
Operations on the Female Genital Organs (MPC 12) ⁸	65-71	108,860	5	389,370	3.6	630,538	5,809	1,619
Unilateral Oophorectomy	65.3-65.6	10,650	1	52,125	4.9	78,635	7,397	1,509
Hysterectomy	68.3-68.7,68.9	56,965	3	203,840	3.6	334,091	5,881	1,639
Obstetrical Procedures (MPC 13)	72-75	12,655	1	42,755	3.4	34,524	2,742	807
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31,72.71,73.6	595	(6)	1,495	2.5	831	1,397	556
Cesarean Section and Removal of Fetus	74.0-74.2,74.4-74.99	5,340	(6)	24,170	4.5	21,561	4,080	892
Repair of Current Obstetric Laceration	75.5-75.6	1,310	(6)	3,240	2.5	2,416	1,845	746
Operations on the Musculoskeletal System (MPC 14)	76-84	1,149,760	32	6,251,030	5.4	12,257,998	10,686	1,961
Partial Excision of Bone	76.2-76.3,77.6-77.8	14,530	(6)	126,975	8.7	195,656	13,521	1,541
Reduction of Facial Fracture	76.7,79.0-79.3	205,505	6	1,204,230	5.9	1,854,267	9,038	1,540
Open Reduction of Fracture with Internal Fixation	79.3	153,510	4	906,210	5.9	1,411,044	9,205	1,557
Excision or Destruction of Intervertebral Disc	80.5	31,245	1	91,045	2.9	198,207	6,366	2,177
Total Hip Replacement	81.51	118,450	3	502,200	4.3	1,243,379	10,513	2,476
Total Knee Replacement	81.54	273,350	8	1,062,050	3.9	2,842,832	10,415	2,677

See footnotes at end of table.

Table 5.6–Continued

Number of Discharges with a Procedure, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Principal Procedure Within Major Procedure Classifications (MPCs): Calendar Year 2005

Principal ICD-9-CM Procedure ¹ Within MPC	ICD-9-CM Code	Discharges ²		Total Days of Care		Program Payments		
		Number	Per 1,000 HI Enrollees ³	Number	Per Discharge	Amount in Thousands	Per Discharge ⁴	Per Day
Operations on the Integumentary System (MPC 15)	85-86	280,065	8	2,208,905	7.9	\$2,680,405	\$9,641	\$1,213
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	96,170	3	1,019,360	10.6	1,393,967	14,599	1,367
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,671,205	46	11,310,435	6.8	13,243,579	7,980	1,171
Computerized Axial Tomography	87.03,87.41,87.71,88.01,88.38	109,290	3	552,725	5.1	634,763	5,837	1,148
Arteriography and Angiocardiology Using Contrast Mater	88.4-88.5	54,600	2	274,360	5.0	329,124	6,054	1,200
Diagnostic Ultrasound	88.7	145,625	4	777,305	5.3	858,998	5,921	1,105
Respiratory Therapy	93.9,96.7	265,620	7	2,296,315	8.6	3,691,869	14,027	1,608
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	47,100	1	371,670	7.9	522,610	11,155	1,406
Injection of Infusion of Cancer Chemotherapeutic Substanc	99.25	39,635	1	234,270	5.9	366,465	9,294	1,564

¹ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification*. Includes surgical and non-surgical procedures. Includes invalid codes not shown separately.

²Excludes discharges for managed care enrollees that were paid by the managed care plan.

³Medicare enrollees in managed care plans are not included in the denominator used to calculate utilization rates.

⁴The average program payment per discharge does not reflect discharges with covered services, but for whom no program payments were reported.

⁵Specific leading procedure categories were selected for presentation because of frequency of occurrences or because of special interest. The leading classifications were developed by the National Center for Health Statistics.

⁶Less than 1 discharge per 1,000 enrollees.

⁷Only the male enrollment population used to calculate discharges per 1,000 HI enrollees.

⁸Only the female enrollment population used to calculate discharges per 1,000 HI enrollees.

NOTES: Medicare program payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers may not add to totals because of rounding. HI is hospital insurance.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.