Table 28

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 1999

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Procedure Code	Discharges [2] Number	Discharges [2] Per 1,000 Enrollees [3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge	Program Payments Per Day
Total All Procedures	---	6,485,090	204	45,272,645	7.0	$58,586,818	$9,200	$1,294
Leading Procedures[4]	---	3,290,905	104	20,575,450	6.3	28,399,110	8,786	1,380
Operations on the Nervous System (MPC 1)	01-05	162,810	5	1,125,300	6.9	1,471,908	9,241	1,308
Spinal Tap	03.31	35,705	1	277,885	7.8	223,299	6,389	804
Operations on the Endocrine System (MPC 2)	06-07	18,085	1	75,040	4.1	117,523	6,625	1,566
Operations on the Eye (MPC 3)	08-16	16,865	1	55,250	3.3	83,769	5,036	1,516
Operations on the Ear (MPC 4)	18-20	3,190	(5)	17,585	5.5	22,930	7,397	1,304
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	30,735	1	154,435	5.0	185,028	6,143	1,198
Operations on the Respiratory System (MPC 6)	30-34	263,380	8	3,393,685	12.9	5,053,540	19,527	1,489
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	68,770	2	686,735	10.0	618,961	9,155	901
Operations on the Cardiovascular System (MPC 7)	35-39	1,598,390	50	9,903,455	6.2	18,984,995	12,119	1,917
Removal of Coronary Artery Obstruction	36.0	253,545	8	865,560	3.4	2,871,873	11,593	3,318
Coronary Artery Bypass Graft	36.1	159,385	5	1,525,520	9.6	3,966,980	25,470	2,600
Cardiac Catheterization	37.21-37.23	288,235	9	1,242,185	4.3	1,712,976	6,073	1,379
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	130,345	4	683,130	5.2	1,497,221	11,584	2,192
Hemodialysis	39.95	143,155	5	788,870	5.5	775,929	5,574	984
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	47,110	1	405,115	8.6	477,569	10,314	1,179

See footnotes at end of table.

Table 28—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 1999

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Procedure Code	Discharges [2]		Total Days of Care		Program Payments		
		Number	Per 1,000 Enrollees [3]	Number	Per Discharge	Amount in Thousands	Per Discharge	Per Day
Operations on the Digestive System (MPC 9)	42-54	1,232,915	39	9,599,395	7.8	$9,963,431	$8,205	$1,038
Endoscopy of Small Intestine with or Without Biopsy	45.11-45.14,45.16	332,275	10	2,105,370	6.3	1,524,399	4,653	724
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	143,095	5	899,660	6.3	639,568	4,525	711
Partial Excision of Large Intestine	45.7	106,065	3	1,190,820	11.2	1,703,679	16,288	1,431
Appendectomy, Excluding Incidental	47.0	13,830	(5)	81,875	5.9	104,435	7,756	1,276
Cholecystectomy	51.2	123,430	4	755,575	6.1	1,051,988	8,660	1,392
Lysis of Peritoneal Adhesions	54.5	24,805	1	285,330	11.5	338,289	13,898	1,186
Operations on the Urinary System (MPC 10)	55-59	172,360	5	1,079,815	6.3	1,314,381	7,805	1,217
Cystoscopy with or Without Biopsy	57.31-57.33	24,810	1	192,315	7.8	134,666	5,489	700
Operations on the Male Genital Organs (MPC 11[6]	60-64	120,570	4	471,050	3.9	545,265	4,606	1,158
Prostatectomy	60.2-60.6	106,625	3	395,925	3.7	452,397	4,320	1,143
Operations on the Female Genital Organs (MPC 12[7]	65-71	111,240	4	452,625	4.1	564,153	5,179	1,246
Unilateral Oophorectomy	65.3-65.6	10,240	(5)	54,490	5.3	69,128	6,889	1,269
Hysterectomy	68.3-68.7,68.9	58,650	2	237,855	4.1	302,538	5,283	1,272
Obstetrical Procedures (MPC 13)	72-75	7,575	(5)	24,445	3.2	19,474	2,699	797
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31, 72.71,73.6	845	(5)	2,265	2.7	1,491	1,819	658
Cesarean Section and Removal of Fetus	74.0-74.2, 74.4,74.99	2,590	(5)	11,260	4.3	10,380	4,237	922
Repair of Current Obstetric Laceration	75.5-75.6	940	(5)	2,410	2.6	1,736	1,962	720
Operations on the Musculoskeletal System (MPC 14)	76-84	866,190	27	5,205,120	6.0	7,453,526	8,770	1,432
Partial Excision of Bone	76.2-76.3,77.6-77.8	11,440	(5)	91,210	8.0	117,321	10,517	1,286
Reduction of Facial Fracture	76.7,79.0-79.3	202,620	6	1,233,435	6.1	1,425,206	7,143	1,155
Open Reduction of Fracture with Internal Fixation	79.3	163,825	5	1,018,590	6.2	1,196,074	7,406	1,174
Excision or Destruction of Intervertebral Disc	80.5	33,680	1	116,595	3.5	187,966	5,760	1,612
Total Hip Replacement	81.51	85,575	3	417,830	4.9	805,545	9,591	1,928
Total Knee Replacement	81.54	152,450	5	684,565	4.5	1,421,430	9,513	2,076

See footnotes at end of table.

Table 28—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 1999

		Discharges[2]		Total Days of Care		Program Payments		
Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Procedure Code	Number	Per 1,000 Enrollees[3]	Number	Per Discharge	Amount in Thousands	Per Discharge	Per Day
Operations on the Integumentary System (MPC 15)	85-86	256,280	8	2,128,370	8.3	$2,029,744	$8,071	$954
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22,86.28	89,400	3	1,018,470	11.4	1,047,128	11,905	1,028
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,577,395	50	11,181,960	7.1	10,299,583	6,641	921
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	153,930	5	899,525	5.8	733,421	4,836	815
Arteriography and Angiocardiography Using Contrast Material	88.4-88.5	49,470	2	266,345	5.4	241,410	4,972	906
Diagnostic Ultrasound	88.7	168,765	5	971,370	5.8	821,374	4,944	846
Respiratory Therapy	93.9,96.7	205,565	6	1,815,815	8.8	2,597,611	12,844	1,431
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	61,185	2	500,285	8.2	660,777	10,965	1,321
Injection of Infusion of Cancer Chemotherapeutic Substance	99.25	49,245	2	274,360	5.6	337,545	6,983	1,230

[1]ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification. Volume 3* procedures include surgical and non-surgical procedures. Includes invalid codes not shown separately.
[2]Excludes discharges for managed care enrollees that were paid for by the managed care plan.
[3]Utilization rate is based only on fee-for-service HI enrollees; that is, Medicare enrollees in managed care plans are not included in the denominator.
[4]Specific 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.
[5]Less than 1 discharge per 1,000 enrollees.
[6]Only the male enrollment population used to calculate discharges per 1,000 HI enrollees.
[7]Only the female enrollment population used to calculate discharges per 1,000 HI enrollees.

NOTES: Medicare program payments represent fee-for-service only, that is, program payments 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 Decision Support Access Facility; data development by the Office of Research, Development, and Information.