Table 70

Hospital Outpatient Procedures, Covered Charges, and Program Payments for Medicare Beneficiaries, by the Leading Principal HCPCS Surgical Procedures: Calendar Year 1999

Principal HCPCS Procedure	HCPCS Code	Number of Procedures
Total All Procedures	---	3,038,360
Total Leading Principal HCPCS Surgical Procedures [1]	---	1,937,900
Extracapsular Cataract Removal with Insertion of Intraocular Lens Prosthesis (One Stage Procedure), Manual or Mechanical Technique	66984	556,620
Colonoscopy, Fiberoptic, Beyond Splenic Flexure; Diagnostic, with or without Colon Decompression	45378	268,160
Injection of Substance Other than Anesthetic, Contrast or Neurolytic Solutions; Lumbar or Caudal Epidural	62289	163,400
Discission of Secondary Membranous Cataract (After Cataract) and/or Anterior Hyaloid; Laser Surgery (One or More Stages)	66821	123,820
Debridement; Skin, and Subcutaneous Tissue	11042	83,140
Upper Gastrointestinal Endoscopy Including Esophagus, Stomach, and Either the Duodenum and/or Jejunum as Appropriate; Complex Diagnostic	43235	79,240
Injection of Anesthetic Substance (Including Narcotics), Diagnostic or Therapeutic; Lumbar or Caudal Epidural, Single	62278	70,280
Sigmoidoscopy, Flexible Fiberoptic; Diagnostic	45330	67,140
Debridement; Skin, Partial Thickness	11040	56,620
Upper Gastrointestinal Endoscopy Including Esophagus, Stomach, and Either the Duodenum and/or Jejunum as Appropriate; for Biopsy and/or Collection of Specimen by Brushing or Washing	43239	53,140
Simple Repair of Superficial Wounds of Scalp, Neck, Axillae, External Genitalia, Trunk and/or Extremities (Including Hands and Feet); 2.5 cm or Less	12001	45,840
Cystourethroscopy (Separate Procedure)	52000	42,000
Debridement; Skin, Full Thickness	11041	37,500
Injection, Tendon Sheath, Ligament, Trigger Points or Ganglion Cyst	20550	33,600

See footnotes at end of table.

Table 70—Continued

Hospital Outpatient Procedures, Covered Charges, and Program Payments for Medicare Beneficiaries, by the Leading Principal HCPCS Surgical Procedures: Calendar Year 1999

	Covered Charges in Thousands	Operating Room Charges in Thousands	Program Payments in Thousands	Average Covered Charge per Procedure	Average Program Payment per Procedure[2]
	$4,865,938	$1,900,030	$1,051,005	$1,602	$352
	2,828,283	1,151,345	598,427	1,459	314
	1,694,200	686,603	365,131	3,044	662
	289,786	112,629	58,342	1,081	221
	93,305	43,990	17,570	571	110
	77,673	52,127	15,027	627	123
	49,465	18,218	9,440	595	118
	83,068	32,481	16,851	1,048	217
	40,764	18,758	7,881	580	114
	29,281	11,356	6,497	436	99
	25,797	6,141	5,765	456	104
	70,873	23,999	14,852	1,334	284
	11,399	230	2,054	249	47
	34,231	20,718	8,279	815	198
	19,172	5,156	3,983	511	108
	14,800	5,806	2,635	440	81

Table 70—Continued

Hospital Outpatient Procedures, Covered Charges, and Program Payments for Medicare Beneficiaries, by the Leading Principal HCPCS Surgical Procedures: Calendar Year 1999

Principal HCPCS Procedure	HCPCS Code	Number of Procedures
Neuroplasty and/or Transposition; Median Nerve at Carpal Tunnel	64721	28,600
Simple Repair of Superficial Wounds of Scalp, Neck, Axillae, External Genitalia, Trunk and/or Extremities (Including Hands and Feet); 2.6 cm to 7.5 cm	12002	28,440
Colonoscopy, Fiberoptic, Beyond Splenic Flexure; with Removal of Polypoid Lesion(s)	45385	25,540
Transfusion, Blood or Blood Components	36430	23,460
Arthrocentesis, Aspiration and/or Injection; Major Joint or Bursa	20610	23,000
Destruction by any Method, Including, Laser, with or without Surgical Curettement, all Benign or Premalignant Lesions other than Skin Tags	17000	22,880
Repair Inguinal Hernia, Age 5 or Over	49505	22,820
Colonoscopy, Flexible, Proximal to Splenic Flexure; Diagnostic with Collection of Specimen by Brushing or Washing	45380	22,520
Arterial Puncture, Withdraw of Arterial Blood	36600	21,280
Colonoscopy, Flexible, Proximal to Splenic Flexure; Diagnostic, with Removal of Tumor, Polyps, or Other Lesions by Hot Biopsy Forceps or Bipolar Cautery	45384	20,320
Change of Gastrostomy Tube	43760	18,540
Total All Other Procedures	---	1,100,460

[1]Leading surgical HCPCS codes were selected from among the code range 10000-69979 (Surgery Procedures) and based on frequency of occurrence.

[2]Does not reflect procedures for beneficiaries who received covered services but for whom no program payments were reported during the year.

NOTES: HCPCS is Healthcare Common Procedure Coding System. Medicare program payments represent fee-for-service only, that is, program payments exclude amounts paid for managed care services.

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.

Table 70—Continued

Hospital Outpatient Procedures, Covered Charges, and Program Payments for Medicare Beneficiaries, by the Leading Principal HCPCS Surgical Procedures: Calendar Year 1999

	Covered Charges in Thousands	Operating Room Charges in Thousands	Program Payments in Thousands	Average Covered Charge per Procedure	Average Program Payment per Procedure[2]
	$53,775	$30,182	$11,137	$1,880	$396
	7,947	343	1,377	279	50
	35,952	12,151	7,157	1,408	287
	24,492	2,271	6,322	1,044	272
	9,657	2,865	2,453	420	109
	2,810	937	959	123	43
	74,736	40,994	16,651	3,275	741
	31,041	11,659	6,887	1,378	312
	19,202	626	4,260	902	203
	27,094	9,535	5,445	1,333	271
	7,762	1,571	1,472	419	81
	2,037,655	748,685	452,578	1,852	420