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 2009

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Total All Procedures	---	6,836,430	195	42,674,190	6.2	$87,320,088	$12,858	$2,046
Leading Procedures [5]	---	2,874,300	82	16,557,645	5.8	33,272,589	11,645	2,010
Operations on the Nervous System (MPC 1)	01-05	159,700	5	1,012,030	6.3	2,330,269	14,675	2,303
Spinal Tap	03.31	34,695	1	232,880	6.7	302,378	8,771	1,298
Operations on the Endocrine System (MPC 2)	06-07	24,510	1	89,600	3.7	230,160	9,435	2,569
Operations on the Eye (MPC 3)	08-16	7,300	(6)	33,370	4.6	63,217	8,756	1,894
Operations on the Ear (MPC 4)	18-20	2,305	(6)	12,835	5.6	22,667	9,985	1,766
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	26,700	1	130,635	4.9	222,500	8,431	1,703
Operations on the Respiratory System (MPC 6)	30-34	266,840	8	2,709,815	10.2	5,213,241	19,634	1,924
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	60,845	2	541,930	8.9	738,146	12,194	1,362
Operations on the Cardiovascular System (MPC 7)	35-39	1,467,755	42	9,332,025	6.4	22,728,949	15,608	2,436
Removal of Coronary Artery Obstruction	36.0	2,215	(6)	8,235	3.7	31,913	14,843	3,875
Coronary Artery Bypass Graft	36.1	82,065	2	814,585	9.9	2,700,272	33,003	3,315
Cardiac Catheterization	37.21-37.23	218,225	6	885,335	4.1	1,631,665	7,515	1,843
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	123,290	4	620,085	5.0	1,974,396	16,077	3,184
Hemodialysis	39.95	246,685	7	1,224,530	5.0	2,246,332	9,272	1,834
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	46,970	1	363,365	7.7	754,284	16,134	2,076

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 2009

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Operations on the Digestive System (MPC 9)	42-54	1,067,680	30	7,632,620	7.1	$12,720,948	$11,977	$1,667
Endoscopy of Small Intestine with or Without Biopsy	45.11-45.14,45.16	290,815	8	1,617,725	5.6	1,948,419	6,733	1,204
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	99,460	3	569,120	5.7	648,432	6,546	1,139
Partial Excision of Large Intestine	45.7	66,315	2	788,785	11.9	1,630,931	24,670	2,068
Appendectomy, Excluding Incidental	47.0	18,825	1	87,575	4.7	184,692	9,853	2,109
Cholecystectomy	51.2	98,465	3	594,925	6.0	1,209,287	12,323	2,033
Lysis of Peritoneal Adhesions	54.5	30,690	1	313,440	10.2	574,678	18,833	1,833
Operations on the Urinary System (MPC 10)	55-59	197,380	6	1,179,545	6.0	2,221,651	11,314	1,883
Cystoscopy with or Without Biopsy	57.31-57.33	11,745	(6)	83,075	7.1	95,688	8,182	1,152
Operations on the Male Genital Organs (MPC 11)[7]	60-64	70,005	4	223,270	3.2	464,719	6,680	2,081
Prostatectomy	60.2-60.6	61,425	4	176,905	2.9	376,017	6,153	2,126
Operations on the Female Genital Organs (MPC 12)[8]	65-71	87,025	5	287,755	3.3	624,936	7,216	2,172
Unilateral Oophorectomy	65.3-65.6	7,975	(6)	34,740	4.4	69,234	8,709	1,993
Hysterectomy	68.3-68.7,68.9	46,955	2	152,655	3.3	342,435	7,313	2,243
Obstetrical Procedures (MPC 13)[8]	72-75	14,650	1	46,220	3.2	58,339	4,018	1,262
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31, 72.71,73.6	450	(6)	1,070	2.4	1,037	2,306	970
Cesarean Section and Removal of Fetus	74.0-74.2, 74.4-74.99	6,340	(6)	24,715	3.9	34,430	5,491	1,393
Repair of Current Obstetric Laceration	75.5-75.6	1,465	(6)	3,660	2.5	3,883	2,668	1,061
Operations on the Musculoskeletal System (MPC 14)	76-84	1,098,885	31	5,520,795	5.0	14,863,779	13,573	2,692
Partial Excision of Bone	76.2-76.3,77.6-77.8	16,355	(6)	133,485	8.2	264,063	16,300	1,978
Reduction of Facial Fracture	76.7,79.0-79.3	190,165	5	1,066,415	5.6	2,218,528	11,703	2,080
Open Reduction of Fracture with Internal Fixation	79.3	133,570	4	750,670	5.6	1,580,319	11,870	2,105
Excision or Destruction of Intervertebral Disc	80.5	22,785	1	62,210	2.7	166,697	7,360	2,680
Total Hip Replacement	81.51	120,750	3	455,735	3.8	1,462,059	12,132	3,208
Total Knee Replacement	81.54	272,660	8	945,260	3.5	3,193,938	11,734	3,379

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 2009

Principal ICD-9-CM Procedure [1] Within MPC	ICD-9-CM Code	Discharges[2] Number	Discharges[2] Per 1,000 HI Enrollees[3]	Total Days of Care Number	Total Days of Care Per Discharge	Program Payments Amount in Thousands	Program Payments Per Discharge[4]	Program Payments Per Day
Operations on the Integumentary System (MPC 15)	85-86	226,165	6	1,671,695	7.4	$2,597,006	$11,584	$1,554
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	67,330	2	651,885	9.7	1,149,170	17,221	1,763
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,700,560	49	10,997,730	6.5	16,448,702	9,750	1,496
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	93,420	3	426,120	4.6	642,596	6,926	1,508
Arteriography and Angiocardiography Using Contrast Materia	88.4-88.5	44,670	1	211,970	4.7	322,736	7,274	1,523
Diagnostic Ultrasound	88.7	148,475	4	743,285	5.0	1,027,452	6,958	1,382
Respiratory Therapy	93.9,96.7	311,545	9	2,581,210	8.3	5,125,284	16,597	1,986
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	43,330	1	301,365	7.0	573,609	13,313	1,903
Injection of Infusion of Cancer Chemotherapeutic Substance	99.25	33,475	1	201,860	6.0	380,956	11,425	1,887

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

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

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

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

[5]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.

[6]Less than 1 discharge per 1,000 enrollees.

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

[8]Only 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 MEDPAR files: Medicare Provider Analysis and Review; data development by the Office of Research, Development, and Information.