Table 70

Hospital Outpatient Procedures, Covered Charges, and Program Payments for Medicare Beneficiaries, by the Leading Principal HCPCS Surgical Procedures: Calendar Year 2001

Principal HCPCS Procedure	HCPCS Code	Number of Procedures
Total All Procedures	---	3,251,380
Total Leading Principal HCPCS Surgical Procedures[1]	---	1,951,220
Extracapsular Cataract Removal with Insertion of Intraocular Lens Prosthesis (One Stage Procedure), Manual or Mechanical Technique	66984	480,020
Colonoscopy, Flexible, Proximal to Splenic Flexure; Diagnostic, with or without Colon Decompression	45378	325,120
Injection, Single, of Diagnostic or Therapeutic Substances, Epidural or Subarachnoid; Lumbar Sacral (Caudal)	62311	215,800
Debridement; Skin, and Subcutaneous Tissue	11042	120,840
Upper Gastrointestinal Endoscopy Including Esophagus, Stomach, and Either the Duodenum and/or Jejunum as Appropriate; Complex Diagnostic	43235	83,580
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	67,180
Debridement; Skin, Partial Thickness	11040	58,000
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	49,120
Debridement; Skin, Full Thickness	11041	47,900
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	45,660
Sigmoidoscopy, Flexible Fiberoptic; Diagnostic	45330	39,320
Destruction by any Method, Including, Laser, with or without Surgical Curettement, all Benign or Premalignant Lesions other than Skin Tags	17000	38,040
Cystourethroscopy (Separate Procedure)	52000	37,660
Injection, Tendon Sheath, Ligament, Trigger Points or Ganglion Cyst	20550	37,280

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 2001

Covered Charges in Thousands	Operating Room Charges in Thousands	Program Payments in Thousands	Average Covered Charge per Procedure	Average Program Payment per Procedure[2]
$5,410,672	$2,241,512	$1,097,852	$1,664	$342
2,853,346	1,195,485	588,773	1,462	305
1,632,556	740,533	349,072	3,401	732
397,240	148,242	68,803	1,222	214
147,573	76,025	24,582	684	115
85,404	31,959	22,595	707	189
104,429	37,061	18,062	1,249	218
24,667	521	8,535	367	128
31,285	9,716	9,031	539	157
81,003	27,738	11,382	1,649	234
23,505	8,714	5,903	491	124
18,638	343	6,027	408	133
22,807	8,096	4,163	580	106
5,873	1,825	2,489	154	68
37,763	23,788	8,078	1,003	216
17,875	8,180	4,731	479	130

Table 70—Continued

Hospital Outpatient Procedures, Covered Charges, and Program Payments for Medicare Beneficiaries, by the Leading Principal HCPCS Surgical Procedures: Calendar Year 2001

Principal HCPCS Procedure	HCPCS Code	Number of Procedures
Strapping; Unna Boot	29580	37,180
Arthrocentesis, Aspiration and/or Injection; Major Joint or Bursa	20610	34,080
Debridement of Nails by any Method(s); Six or More	11721	32,800
Neuroplasty and/or Transposition; Median Nerve at Carpal Tunnel	64721	28,420
Control Nasal Hemorrhage, Anterior, Simple (Limited Cautery and/or Packing) any Method	30901	26,640
Simple Repair of Superficial Wounds of Face, Ears, Eyelids, Nose, Lips and/or Mucous Membranes; 2.5 cm or Less	12011	26,120
Colonoscopy, Fiberoptic, Beyond Splenic Flexure; with Removal of Polypoid Lesion(s)	45385	25,420
Arterial Puncture, Withdrawal of Blood for Diagnoses	36600	24,960
Change of Gastrostomy Tube	43760	24,340
Catheterization, Urethra; Simple	53670	23,140
Injection, Single, of Diagnostic or Therapeutic Substances, Epidural or Subarachnoid; Cervical or Thoracic	62310	22,600
Total All Other Procedures	---	1,300,160

[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. The Current Procedural Terminology (CPT) codes, descriptions and other data only are Copyright 2001 American Medical Association All Rights Reserved (or such other data of publication of CPT). CPT is a trademark of the American Medical Association (AMA). For fuller description of each procedure, refer to the previously mentioned publication. Medicare program payments represent fee-for-service only and 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 2001

Covered Charges in Thousands	Operating Room Charges in Thousands	Program Payments in Thousands	Average Covered Charge per Procedure	Average Program Payment per Procedure[2]
$15,281	$1,433	$4,389	$411	$119
15,607	4,855	4,755	458	142
3,303	724	1,252	101	41
62,005	39,385	11,025	2,182	394
9,131	296	3,308	343	125
11,030	316	3,527	422	136
41,515	13,983	5,599	1,633	223
26,557	768	4,543	1,064	187
11,843	1,954	2,584	487	107
9,646	465	1,791	417	79
16,812	8,564	2,545	744	114
2,557,327	1,046,027	509,079	1,967	397