

### Table 28

Principal ICD-9-CM Procedure <sup>1</sup> Within MPC	ICD-9-CM Code	Discharges <sup>2</sup>		Total Days of Care		Program Payments		
		Number	Per 1,000 HI Enrollees <sup>3</sup>	Number	Per Discharge	Amount in Thousands	Per Discharge <sup>4</sup>	Per Day
Total All Procedures	---	7,268,890	205	48,943,660	6.7	\$73,206,129	\$10,117	\$1,496
Leading Procedures <sup>5</sup>	---	3,580,035	101	21,256,530	5.9	33,582,579	9,419	1,580
Operations on the Nervous System (MPC 1)	01-05	185,635	5	1,201,365	6.5	1,796,050	9,710	1,495
Spinal Tap	03.31	40,115	1	300,685	7.5	267,962	6,712	891
Operations on the Endocrine System (MPC 2)	06-07	24,980	1	88,950	3.6	167,399	6,730	1,882
Operations on the Eye (MPC 3)	08-16	12,310	(6)	47,650	3.9	73,864	6,057	1,550
Operations on the Ear (MPC 4)	18-20	3,000	(6)	14,975	5.0	23,508	7,836	1,570
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	32,275	1	156,535	4.9	206,966	6,458	1,322
Operations on the Respiratory System (MPC 6)	30-34	294,180	8	3,836,225	13.0	6,711,691	22,896	1,750
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	71,480	2	687,275	9.6	678,888	9,528	988
Operations on the Cardiovascular System (MPC 7)	35-39	1,938,515	55	11,549,955	6.0	24,008,816	12,446	2,079
Removal of Coronary Artery Obstruction	36.0	354,925	10	1,090,865	3.1	4,338,383	12,264	3,977
Coronary Artery Bypass Graft	36.1	136,810	4	1,338,295	9.8	3,682,443	26,981	2,752
Cardiac Catheterization	37.21-37.23	313,460	9	1,337,795	4.3	2,097,039	6,720	1,568
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	157,285	4	792,695	5.0	1,917,801	12,216	2,419
Hemodialysis	39.95	194,415	5	1,053,285	5.4	1,147,966	5,978	1,090
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	46,020	1	408,840	8.9	565,993	12,342	1,384

**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 2003**

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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 2003**

Principal ICD-9-CM Procedure <sup>1</sup> Within MPC	ICD-9-CM Code	Discharges <sup>2</sup>		Total Days of Care		Program Payments		
		Number	Per 1,000 HI Enrollees <sup>3</sup>	Number	Per Discharge	Amount in Thousands	Per Discharge <sup>4</sup>	Per Day
Operations on the Integumentary System (MPC 15)	85-86	282,675	8	2,327,660	8.2	\$2,534,824	\$9,021	\$1,089
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	101,020	3	1,119,270	11.1	1,353,860	13,476	1,210
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,620,430	46	11,157,455	6.9	11,904,919	7,393	1,067
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	113,640	3	587,640	5.2	613,267	5,420	1,044
Arteriography and Angiocardiology Using Contrast Material	88.4-88.5	54,795	2	294,210	5.4	308,175	5,644	1,047
Diagnostic Ultrasound	88.7	138,980	4	769,340	5.5	756,639	5,473	983
Respiratory Therapy	93.9,96.7	239,130	7	2,090,705	8.7	3,113,942	13,130	1,489
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	49,840	1	386,465	7.8	520,418	10,495	1,347
Injection of Infusion of Cancer Chemotherapeutic Substance	99.25	39,675	1	241,475	6.1	342,722	8,681	1,419

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

<sup>2</sup>Excludes discharges for managed care enrollees that were paid by the managed care plan.

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

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

<sup>5</sup>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.

<sup>6</sup>Less than 1 discharge per 1,000 enrollees.

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

<sup>8</sup>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 Medicare Data Extract System; data development by the Office of Research, Development, and Information.