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 2008

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	---	6,941,190	198	44,512,570	6.4	$83,399,144	$12,096	$1,874
Leading Procedures [5]	---	2,946,020	84	17,542,445	6.0	32,180,779	10,992	1,834
Operations on the Nervous System (MPC 1)	01-05	163,690	5	1,069,035	6.5	2,197,259	13,492	2,055
Spinal Tap	03.31	36,615	1	262,335	7.2	297,182	8,163	1,133
Operations on the Endocrine System (MPC 2)	06-07	25,540	1	100,165	3.9	238,326	9,388	2,379
Operations on the Eye (MPC 3)	08-16	8,150	(6)	35,205	4.3	63,494	7,853	1,804
Operations on the Ear (MPC 4)	18-20	2,620	(6)	13,525	5.2	25,982	10,032	1,921
Operations on the Nose, Mouth, and Pharynx (MPC 5)	21-29	26,800	1	138,460	5.2	218,612	8,267	1,579
Operations on the Respiratory System (MPC 6)	30-34	272,080	8	2,889,635	10.6	5,181,800	19,146	1,793
Bronchoscopy with or Without Biopsy	33.21-33.24,33.27	63,535	2	589,330	9.3	729,114	11,547	1,237
Operations on the Cardiovascular System (MPC 7)	35-39	1,487,250	43	9,694,535	6.5	21,680,042	14,688	2,236
Removal of Coronary Artery Obstruction	36.0	3,410	(6)	11,270	3.3	47,996	14,242	4,259
Coronary Artery Bypass Graft	36.1	86,625	2	876,110	10.1	2,733,358	31,664	3,120
Cardiac Catheterization	37.21-37.23	226,915	6	935,655	4.1	1,640,845	7,275	1,754
Insertion, Replacement, Removal, and Revision of Pacemaker Leads or Device	37.7-37.8	132,045	4	656,685	5.0	1,969,684	14,977	2,999
Hemodialysis	39.95	235,980	7	1,224,330	5.2	1,902,880	8,200	1,554
Operations on the Hemic and Lymphatic System (MPC 8)	40-41	46,280	1	360,955	7.8	664,304	14,426	1,840

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 2008

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	1,124,640	32	8,303,465	7.4	$12,751,594	$11,401	$1,536
Endoscopy of Small Intestine with or Without Biopsy	45.11-45.14,45.16	302,340	9	1,746,620	5.8	1,873,484	6,232	1,073
Endoscopy of Large Intestine with or Without Biopsy	45.21-45.25	107,655	3	628,705	5.8	657,146	6,132	1,045
Partial Excision of Large Intestine	45.7	90,275	3	1,002,155	11.1	1,969,691	21,871	1,965
Appendectomy, Excluding Incidental	47.0	19,155	1	88,870	4.6	174,765	9,181	1,967
Cholecystectomy	51.2	103,215	3	643,010	6.2	1,210,010	11,780	1,882
Lysis of Peritoneal Adhesions	54.5	30,595	1	317,430	10.4	559,899	18,381	1,764
Operations on the Urinary System (MPC 10)	55-59	201,305	6	1,224,330	6.1	2,075,210	10,364	1,695
Cystoscopy with or Without Biopsy	57.31-57.33	12,805	(6)	94,865	7.4	95,271	7,475	1,004
Operations on the Male Genital Organs (MPC 11)[7]	60-64	75,635	5	247,665	3.3	470,850	6,264	1,901
Prostatectomy	60.2-60.6	66,200	4	194,285	2.9	377,843	5,740	1,945
Operations on the Female Genital Organs (MPC 12)[8]	65-71	91,775	5	310,875	3.4	611,996	6,709	1,969
Unilateral Oophorectomy	65.3-65.6	8,910	(6)	40,600	4.6	73,095	8,255	1,800
Hysterectomy	68.3-68.7,68.9	48,425	3	161,215	3.3	324,503	6,740	2,013
Obstetrical Procedures (MPC 13)	72-75	14,140	1	46,155	3.3	50,957	3,653	1,104
Forceps, Vacuum, and Breech Delivery	72.1,72.21,72.31, 72.71,73.6	520	(6)	1,235	2.4	1,055	2,049	854
Cesarean Section and Removal of Fetus	74.0-74.2, 74.4-74.99	6,240	(6)	26,695	4.3	31,439	5,150	1,178
Repair of Current Obstetric Laceration	75.5-75.6	1,350	(6)	3,205	2.4	3,050	2,268	952
Operations on the Musculoskeletal System (MPC 14)	76-84	1,089,765	31	5,672,650	5.2	13,691,872	12,610	2,414
Partial Excision of Bone	76.2-76.3,77.6-77.8	15,050	(6)	132,435	8.8	236,932	15,918	1,789
Reduction of Facial Fracture	76.7,79.0-79.3	193,910	6	1,116,385	5.8	2,108,989	10,915	1,889
Open Reduction of Fracture with Internal Fixation	79.3	138,655	4	796,660	5.7	1,531,861	11,091	1,923
Excision or Destruction of Intervertebral Disc	80.5	25,065	1	69,020	2.8	172,470	6,908	2,499
Total Hip Replacement	81.51	114,730	3	448,835	3.9	1,322,659	11,551	2,947
Total Knee Replacement	81.54	265,845	8	956,235	3.6	2,981,910	11,242	3,118

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 2008

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	236,825	7	1,834,800	7.7	$2,555,415	$10,880	$1,393
Excision of Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	86.22-86.28	73,960	2	763,765	10.3	1,180,021	16,100	1,545
Miscellaneous Diagnostic and Therapeutic Procedures (MPC 16)	87-99	1,690,120	48	11,178,530	6.6	15,204,352	9,076	1,360
Computerized Axial Tomography	87.03,87.41,87.71, 88.01,88.38	98,415	3	468,865	4.8	637,386	6,514	1,359
Arteriography and Angiocardiography Using Contrast Material	88.4-88.5	48,580	1	233,080	4.8	321,831	6,674	1,381
Diagnostic Ultrasound	88.7	150,430	4	785,665	5.2	976,729	6,524	1,243
Respiratory Therapy	93.9,96.7	298,930	9	2,548,205	8.5	4,675,724	15,788	1,835
Nonoperative Intubation of Gastrointestinal and Respiratory Tracts Insertion of Endotracheal Tube	96.04	40,010	1	292,160	7.3	506,237	12,744	1,733
Injection of Infusion of Cancer Chemotherapeutic Substance	99.25	37,985	1	222,565	5.9	386,891	10,257	1,738

[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 Medicare Data Extract System; data development by the Office of Research, Development, and Information.