Section 2
Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, Top 20 MS-DRGs by Volume of Discharges to PAC

The following tables include data on Medicare post-acute care (PAC) utilization and payments for the top 20 MS-DRGs for beneficiaries discharged to PAC (by volume of discharges). Utilization and payment data are presented separately for each of the 18 PAC episode definitions included in our analysis (Tables 1 -18). See Introduction, Table 1 for a complete list of episode definitions.

Data shown here include percent of beneficiaries discharged to PAC, number of PAC users, percent of PAC users, and cumulative percent of PAC users overall and for the top 20 MS-DRGs. Mean PAC episode and total episode payment and length of stay are calculated per beneficiary for beneficiaries using PAC services (per PAC user), for each of the top 20 MS-DRGs, and for each episode definition. Utilization and payments are also presented for the index acute hospital stay and for physician services during the index acute hospital stay. Utilization for physician services during index acute hospital stay was calculated based on the units of services on physician claims.

Key findings

- As in Section 1, these tables show that 35.2 percent of beneficiaries with index acute hospital stays are discharged to PAC. MS-DRG 470 Major joint replacement or reattachment of lower extremity w/o MCC is the most common MS-DRG among PAC user, representing 13.2 percent of all PAC users. The second most frequently occurring MS-DRG among PAC users is MS-DRG 194 Simple pneumonia & pleurisy w CC which represents 2.4 percent of all PAC users. The cumulative percent of PAC users in MS-DRG 470 and MS-DRG 194 is 15.7 percent.

- These tables allow us to compare mean payments and length of stay across episode definitions by MS-DRG. In Episode Definition A (30 Day Fixed), we see that mean PAC payment per PAC user across all MS-DRGs is $9,907 and mean length of stay across all MS-DRGs is 37.6 days. Mean PAC payment per PAC user across all MS-DRGs in Episode Definition B (30 Day Fixed Excluding Readmissions) decreases to $7,591 and 35.6 days due to the exclusion of readmissions. Similarly, we see that mean total episode payment and mean episode length of stay across all MS-DRGs decreases from Episode Definition A ($21,735 and 45.5 days) to Episode Definition B ($19,419 and 43.5 days) when readmissions are excluded. Note that the difference between total episode payments and PAC payments is the index acute hospital stay and physicians services during the index acute hospital stay.

- In comparing mean PAC payment and mean length of stay per PAC user for Episode Definition A (30 Day Fixed) to Episode Definition C (30 Day Fixed-pro

rated), we see that mean PAC payment and length of stay decreases when we pro rate the last claim in an episode rather than allowing any claim initiating during a fixed time period to be included in an episode ($9,907 and 37.6 days in Episode Definition A versus $7,567 and 24.3 days in Episode Definition C).

- At the MS-DRG level, mean PAC payment per PAC user for MS-DRG 470 is $7,951 as compared to a mean PAC payment of $7,721 for MS-DRG 194 for Episode Definition A (30 Day Fixed). In Episode Definition B (30 Day Fixed Excluding Readmissions), mean PAC payments per PAC user for MS-DRG 470 are $7,065 and mean PAC payments for MS-DRG 194 are $5,631. The effect of excluding readmissions in Episode Definition B has a greater impact in MS-DRG 194 due to the fact that beneficiaries in MS-DRG 194 are more likely to have acute hospital readmissions compared to beneficiaries in MS-DRG 470.

- Mean total episode payment for MS-DRG 470 is $19,955 as compared to a mean total episode payment of $13,570 for MS-DRG 194 in Episode Definition A (30 Day Fixed). Much of the difference in total episode payment is driven by differences in the mean index acute hospital payment for these two MS-DRGs where surgical procedures corresponding to MS-DRG 470 account for higher inpatient payments.

- Results examining Episode Definitions D through R are also included in this section allowing for comparison of results across each of the fixed and variable length episode definitions included in our analyses. In general, we see that longer episode definitions (60 day fixed, 90 day fixed, 30 day variable length, 45 day variable length, and 60 day variable length are associated with higher PAC payments per acute hospital discharge and per PAC user and that similar patterns hold across MS-DRGs.

Section 2 - Table 1

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC

Episode Definition A: 30 Day Fixed: Any Claim Starting Within 30 Days After Hospital Discharge

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$9,907**	**37.6**	**$21,735**	**45.5**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$7,951	34.9	$19,955	39.8
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$7,721	35.2	$13,570	42.6
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$17,685	45.4	$25,006	51.6
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$16,448	51.0	$27,873	57.0
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$9,105	39.5	$13,702	45.5
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$13,075	40.5	$19,887	46.1
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$9,033	38.9	$13,337	45.0
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$8,228	38.9	$14,384	46.1
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$11,062	38.3	$21,962	48.3
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$15,323	48.8	$25,180	53.9
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$6,328	33.4	$11,372	39.7
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$10,052	39.2	$14,558	45.2
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$7,018	36.9	$11,536	43.5
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$10,095	39.2	$17,235	48.2
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$7,243	36.6	$11,636	42.4
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$6,706	34.5	$11,259	40.9
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$6,638	37.6	$12,249	43.6
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$5,774	34.3	$10,653	40.7
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$9,527	38.7	$17,155	46.4
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$12,737	44.3	$16,778	48.9

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 2

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition B: 30 Day Fixed: Any Claim Starting Within 30 Days After Hospital Discharge Excluding Acute Hospital Readmissions.

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$7,591**	**35.6**	**$19,419**	**43.5**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$7,065	33.9	$19,069	38.9
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$5,631	33.2	$11,481	40.5
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$15,281	42.2	$22,602	48.5
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$14,188	47.0	$25,612	52.9
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$7,111	36.8	$11,708	42.8
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$11,011	38.7	$17,824	44.3
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$6,701	36.2	$11,005	42.3
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$5,402	37.8	$11,558	45.0
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$7,891	34.9	$18,791	44.9
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$13,661	45.9	$23,518	51.0
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$4,973	32.1	$10,017	38.4
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$7,545	35.8	$12,051	41.8
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$5,174	35.0	$9,692	41.6
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$6,609	37.0	$13,749	46.0
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$5,927	35.7	$10,320	41.5
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$4,919	33.1	$9,472	39.6
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$4,283	37.3	$9,894	43.4
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$4,104	33.6	$8,983	40.1
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$6,647	36.2	$14,275	43.9
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$10,559	41.0	$14,600	45.7

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y221).

Section 2-Table 3
Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006
Episode Definition C: 30 Day Fixed Following Hospital Discharge (pro rated)

						Per PAC User							
						Index Acute Hospital		Physician Services During Index Acute Hospital Stay		Post-Acute Care		Total Episode	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$7,576**	**24.3**	**$19,404**	**32.3**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	19.6	$6,835	25.5	$18,838	30.4
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	30.2	$5,806	23.1	$11,655	30.4
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	223.0	$13,372	26.3	$20,693	32.6
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	126.0	$11,559	28.2	$22,984	34.2
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	322.0	$6,521	24.2	$11,118	30.1
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	335.0	$10,317	25.2	$17,130	30.8
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	26.5	$6,444	24.2	$10,748	30.2
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	72.6	$5,908	24.4	$12,063	31.6
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	334.8	$8,057	23.7	$18,956	33.7
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	23.9	$11,273	27.9	$21,130	33.1
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	24.6	$4,801	22.1	$9,845	28.4
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	175.5	$7,622	25.1	$12,128	31.1
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	23.4	$4,952	23.4	$9,470	30.0
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	46.8	$7,671	24.7	$14,811	33.7
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	47.1	$5,493	23.8	$9,886	29.6
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	84.4	$5,084	22.4	$9,636	28.9
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	79.7	$5,030	23.8	$10,641	29.9
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	99.1	$4,440	22.3	$9,319	28.8
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	91.5	$6,773	24.1	$14,402	31.8
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	23.5	$9,643	27.5	$13,684	32.1

NOTES:
1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization. An index acute hospitalization is defined as a hospital admission following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.
SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 4

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition D: 30 Day Fixed Following Hospital Discharge (pro rated) Excluding Acute Hospital Readmissions

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$5,819**	**22.2**	**$17,647**	**30.1**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$6,115	24.6	$18,119	29.5
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$4,214	20.8	$10,064	28.1
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$11,720	24.3	$19,041	30.6
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$10,050	26.2	$21,474	32.1
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$5,027	22.0	$9,624	27.9
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$8,772	23.5	$15,585	29.1
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$4,763	21.9	$9,067	28.0
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$3,872	21.8	$10,028	29.0
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$5,642	20.9	$16,541	30.9
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$10,038	26.3	$19,895	31.5
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$3,716	20.5	$8,760	26.7
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$5,796	22.6	$10,302	28.6
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$3,650	21.6	$8,168	28.1
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$4,877	21.4	$12,016	30.4
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$4,434	22.4	$8,827	28.2
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$3,683	20.5	$8,236	27.0
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$3,060	21.6	$8,671	27.7
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$3,058	20.2	$7,936	26.7
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$4,722	21.3	$12,351	29.0
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$8,052	25.6	$12,093	30.3

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 5

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition E: 60 Day Fixed: Any Claim Starting Within 60 Days After Hospital Discharge

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$11,827**	**45.6**	**$23,655**	**53.5**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$8,735	43.2	$20,739	48.2
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$9,277	41.5	$15,126	48.8
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$20,257	56.8	$27,578	63.1
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$18,580	62.0	$30,004	67.9
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$10,989	46.9	$15,586	52.8
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$14,838	49.0	$21,650	54.5
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$10,935	46.3	$15,239	52.3
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$10,380	45.6	$16,535	52.8
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$13,499	45.9	$24,398	55.9
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$16,990	58.2	$26,847	63.3
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$7,747	39.5	$12,791	45.8
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$11,977	48.5	$16,483	54.6
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$8,619	42.8	$13,137	49.4
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$12,561	45.9	$19,701	54.9
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$8,973	44.0	$13,366	49.8
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$8,600	41.4	$13,152	47.9
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$8,629	43.4	$14,239	49.5
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$7,404	39.5	$12,283	45.9
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$11,967	47.1	$19,595	54.8
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$14,576	54.4	$18,617	59.0

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 6

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition F: 60 Day Fixed: Any Claim Starting Within 60 Days After Hospital Discharge Excluding Acute Hospital Readmissions.

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$7,885**	**39.9**	**$19,713**	**47.8**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$7,299	40.8	$19,303	45.8
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$5,780	35.6	$11,629	42.9
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$16,032	49.6	$23,353	55.9
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$14,876	54.2	$26,301	60.1
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$7,338	40.1	$11,935	46.1
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$11,464	44.1	$18,276	49.7
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$6,965	39.6	$11,269	45.7
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$5,585	40.1	$11,740	47.3
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$8,122	38.1	$19,022	48.1
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$14,246	52.8	$24,103	57.9
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$5,113	34.7	$10,157	41.0
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$7,851	40.8	$12,357	46.8
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$5,341	37.8	$9,859	44.4
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$6,768	38.9	$13,907	47.9
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$6,250	39.7	$10,644	45.4
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$5,086	36.1	$9,638	42.6
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$4,380	39.0	$9,991	45.1
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$4,186	35.4	$9,065	41.9
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$6,844	39.1	$14,472	46.8
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$11,126	48.0	$15,167	52.7

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dischcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 7

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC

Episode Definition G: 60 Day Fixed Following Hospital Discharge (pro rated)

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$10,703**	**39.7**	**$22,531**	**47.6**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$8,339	39.6	$20,343	44.6
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$8,427	36.8	$14,276	44.1
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$17,995	45.7	$25,316	52.0
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$16,405	49.6	$27,829	55.5
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$9,652	39.8	$14,249	45.7
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$13,524	42.0	$20,336	47.6
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$9,689	39.8	$13,993	45.9
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$9,224	40.3	$15,379	47.5
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$11,746	38.6	$22,645	48.6
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$15,280	48.1	$25,138	53.3
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$7,013	35.2	$12,057	41.4
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$10,800	41.7	$15,306	47.8
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$7,623	37.4	$12,141	44.0
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$11,522	40.6	$18,661	49.6
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$8,075	38.6	$12,468	44.4
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$7,783	36.8	$12,335	43.3
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$7,913	39.2	$13,524	45.2
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$6,707	35.8	$11,586	42.3
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$10,686	40.2	$18,314	47.9
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$13,351	46.5	$17,392	51.2

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 8

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC

Episode Definition H: 60 Day Fixed Following Hospital Discharge (pro rated) Excluding Acute Hospital Readmissions

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$7,216**	**33.6**	**$19,043**	**41.5**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$7,017	37.1	$19,020	42.0
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$5,280	30.4	$11,129	37.7
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$14,428	39.7	$21,749	46.0
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$13,311	43.8	$24,736	49.7
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$6,613	33.2	$11,210	39.1
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$10,556	37.1	$17,369	42.6
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$6,250	33.3	$10,554	39.3
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$4,972	32.7	$11,128	39.9
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$7,273	31.4	$18,172	41.4
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$12,878	43.6	$22,736	48.7
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$4,704	30.0	$9,749	36.3
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$7,252	34.6	$11,758	40.6
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$4,774	32.2	$9,292	38.8
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$6,178	31.9	$13,318	40.9
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$5,702	33.9	$10,095	39.7
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$4,730	31.0	$9,283	37.5
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$3,949	32.6	$9,560	38.6
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$3,800	29.6	$8,679	36.1
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$6,143	31.8	$13,771	39.5
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$10,353	40.9	$14,394	45.5

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 9

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC

Episode Definition I: 90 Day Fixed: Any Claim Starting Within 90 Days After Hospital Discharge

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$13,300**	**55.6**	**$25,128**	**63.5**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$9,304	49.4	$21,307	54.3
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$10,669	51.3	$16,518	58.6
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$21,971	67.9	$29,292	74.1
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$20,027	72.0	$31,452	77.9
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$12,426	56.8	$17,023	62.7
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$16,161	59.4	$22,974	65.0
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$12,401	56.2	$16,705	62.3
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$12,114	59.1	$18,269	66.3
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$15,346	55.2	$26,245	65.2
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$17,967	67.3	$27,825	72.4
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$8,818	48.3	$13,862	54.6
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$13,965	59.2	$18,471	65.2
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$10,214	54.4	$14,732	61.0
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$14,832	58.2	$21,972	67.3
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$10,291	53.9	$14,684	59.7
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$10,093	52.7	$14,645	59.2
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$10,691	57.5	$16,302	63.5
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$9,179	52.2	$14,058	58.6
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$13,941	59.9	$21,569	67.6
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$15,916	63.1	$19,957	67.7

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 10

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition J: 90 Day Fixed: Any Claim Starting Within 90 Days After Hospital Discharge Excluding Acute Hospital Readmissions

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$8,092**	**44.6**	**$19,920**	**52.5**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$7,407	44.7	$19,411	49.7
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$5,965	40.2	$11,815	47.5
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$16,390	55.8	$23,711	62.1
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$15,270	60.4	$26,695	66.3
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$7,527	44.4	$12,124	50.4
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$11,715	50.1	$18,527	55.6
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$7,153	44.0	$11,457	50.1
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$5,820	45.3	$11,976	52.4
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$8,295	41.9	$19,195	52.0
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$14,558	59.0	$24,415	64.1
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$5,257	39.0	$10,301	45.3
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$8,017	44.7	$12,523	50.7
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$5,542	43.7	$10,060	50.3
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$6,979	43.3	$14,119	52.3
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$6,440	44.4	$10,833	50.2
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$5,313	41.4	$9,865	47.9
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$4,641	45.5	$10,252	51.6
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$4,360	40.1	$9,239	46.6
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$7,078	44.1	$14,706	51.8
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$11,408	53.2	$15,449	57.8

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.

2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.

3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.

4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.

5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.

6. Units of service as reported on the Part B physician claim.

7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 11

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC

Episode Definition K: 90 Day Fixed Following Hospital Discharge (pro rated)

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$12,661**	**51.0**	**$24,489**	**58.9**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$9,122	47.3	$21,125	52.3
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$10,104	47.2	$15,953	54.5
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$20,873	60.6	$28,194	66.9
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$19,195	65.0	$30,620	70.9
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$11,839	51.7	$16,436	57.6
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$15,497	54.2	$22,309	59.8
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$11,715	51.3	$16,019	57.3
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$11,453	53.4	$17,609	60.6
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$14,271	50.0	$25,170	60.0
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$17,382	61.9	$27,240	67.1
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$8,420	44.8	$13,465	51.1
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$13,176	54.2	$17,682	60.3
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$9,557	49.7	$14,075	56.3
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$14,100	53.4	$21,240	62.5
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$9,776	49.7	$14,170	55.5
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$9,440	47.7	$13,992	54.1
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$10,062	51.9	$15,673	57.9
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$8,606	47.7	$13,485	54.1
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$13,097	53.9	$20,725	61.6
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$15,294	58.6	$19,335	63.2

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 12

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC

Episode Definition L: 90 Day Fixed Following Hospital Discharge (pro rated) Excluding Acute Hospital Readmissions

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$7,774**	**39.6**	**$19,602**	**47.5**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$7,284	42.6	$19,287	47.5
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$5,712	35.5	$11,561	42.8
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$15,767	49.4	$23,088	55.7
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$14,776	54.6	$26,201	60.5
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$7,257	39.3	$11,854	45.3
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$11,321	44.9	$18,133	50.4
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$6,882	39.1	$11,187	45.2
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$5,488	38.2	$11,644	45.4
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$7,949	37.3	$18,848	47.3
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$14,134	53.9	$23,991	59.1
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$5,072	35.0	$10,116	41.3
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$7,778	40.3	$12,283	46.3
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$5,273	38.4	$9,791	45.0
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$6,650	36.5	$13,790	45.5
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$6,192	39.8	$10,585	45.6
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$5,077	36.0	$9,629	42.5
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$4,307	37.9	$9,918	43.9
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$4,112	34.2	$8,991	40.7
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$6,771	38.1	$14,399	45.8
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$11,135	48.5	$15,176	53.2

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.

2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.

3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.

4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.

5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.

6. Units of service as reported on the Part B physician claim.

7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 13
Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition M: 30 Day Variable Length

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$14,348**	**61.4**	**$26,175**	**69.3**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$9,622	52.0	$21,625	56.9
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$11,143	54.5	$16,992	61.8
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$24,162	85.4	$31,483	91.7
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$21,444	82.8	$32,869	88.8
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$13,286	61.3	$17,883	67.2
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$17,231	69.4	$24,044	74.9
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$13,972	63.0	$18,277	69.0
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$14,029	67.2	$20,184	74.4
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$16,539	59.4	$27,438	69.4
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$18,857	73.6	$28,714	78.8
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$9,093	49.8	$14,138	56.1
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$14,894	64.2	$19,400	70.2
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$11,606	62.0	$16,124	68.5
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$16,254	63.2	$23,394	72.2
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$11,006	56.8	$15,399	62.6
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$11,122	58.8	$15,675	65.3
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$12,258	65.5	$17,869	71.6
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$9,799	55.7	$14,678	62.2
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$15,406	65.2	$23,035	72.9
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$16,610	68.8	$20,651	73.4

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 14

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition N: 30 Day Variable Length Excluding Acute Hospital Readmission

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$8,256**	**47.6**	**$20,084**	**55.5**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$7,479	46.2	$19,483	51.1
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$6,039	41.3	$11,888	48.6
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$16,855	65.1	$24,176	71.4
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$15,524	65.5	$26,949	71.4
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$7,705	47.8	$12,302	53.8
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$11,979	56.3	$18,791	61.9
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$7,349	47.7	$11,653	53.8
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$5,997	48.9	$12,153	56.1
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$8,481	44.2	$19,380	54.2
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$14,707	61.7	$24,564	66.9
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$5,334	40.0	$10,378	46.3
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$8,139	47.5	$12,645	53.5
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$5,732	48.3	$10,250	54.9
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$7,094	45.4	$14,233	54.5
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$6,656	45.9	$11,049	51.7
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$5,434	44.6	$9,986	51.1
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$4,884	49.9	$10,494	55.9
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$4,553	43.4	$9,432	49.9
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$7,247	46.7	$14,875	54.3
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$11,616	56.9	$15,657	61.5

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 15

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC

Episode Definition O: 45 Day Variable Length

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$15,269**	**68.2**	**$27,097**	**76.1**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$9,958	55.2	$21,962	60.1
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$12,010	61.0	$17,860	68.4
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$24,930	93.2	$32,251	99.5
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$21,997	87.9	$33,422	93.9
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$14,154	68.6	$18,751	74.5
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$17,898	74.8	$24,711	80.4
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$14,669	69.5	$18,973	75.6
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$15,631	76.9	$21,787	84.1
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$17,792	67.2	$28,691	77.2
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$19,304	78.7	$29,161	83.8
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$9,855	56.4	$14,899	62.6
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$16,110	72.1	$20,615	78.2
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$12,555	69.4	$17,073	76.0
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$17,818	72.4	$24,958	81.4
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$11,905	63.4	$16,298	69.2
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$11,953	66.0	$16,506	72.5
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$13,798	75.4	$19,409	81.4
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$11,530	66.0	$16,409	72.5
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$16,467	74.3	$24,096	82.0
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$17,133	74.2	$21,174	78.8

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 16

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC

Episode Definition P: 45 Day Variable Length Excluding Acute Hospital Readmission

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$8,301**	**49.3**	**$20,129**	**57.2**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$7,499	47.5	$19,503	52.4
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$6,094	43.1	$11,944	50.4
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$16,936	68.1	$24,256	74.4
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$15,594	67.1	$27,019	73.1
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$7,768	49.5	$12,365	55.5
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$12,013	57.8	$18,826	63.3
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$7,399	49.1	$11,703	55.1
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$6,035	50.1	$12,190	57.3
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$8,566	46.2	$19,465	56.2
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$14,764	63.8	$24,621	68.9
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$5,379	42.0	$10,423	48.3
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$8,209	49.2	$12,715	55.2
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$5,780	50.2	$10,298	56.8
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$7,122	46.6	$14,261	55.6
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$6,708	47.3	$11,101	53.1
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$5,501	46.2	$10,054	52.7
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$4,922	51.2	$10,533	57.2
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$4,579	44.2	$9,458	50.7
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$7,298	48.3	$14,926	56.0
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$11,673	58.9	$15,714	63.6

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dischcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 17

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC

Episode Definition Q: 60 Day Variable Length

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$16,058**	**74.7**	**$27,886**	**82.6**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$10,291	58.4	$22,295	63.4
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$12,893	67.6	$18,743	74.9
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$25,421	99.0	$32,742	105.3
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$22,541	94.3	$33,966	100.2
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$14,919	74.9	$19,516	80.9
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$18,581	81.7	$25,394	87.3
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$15,325	75.5	$19,629	81.6
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$17,111	87.0	$23,267	94.2
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$18,647	72.9	$29,547	82.9
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$19,642	83.2	$29,499	88.3
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$10,339	61.3	$15,383	67.6
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$17,116	80.1	$21,622	86.1
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$13,466	78.2	$17,984	84.8
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$19,457	82.9	$26,596	91.9
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$13,089	73.4	$17,482	79.1
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$12,762	73.0	$17,315	79.4
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$15,108	84.6	$20,719	90.6
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$12,291	73.1	$17,170	79.6
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$17,512	83.6	$25,140	91.3
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$17,889	79.8	$21,930	84.4

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.

2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.

3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.

4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.

5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.

6. Units of service as reported on the Part B physician claim.

7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).

Section 2 - Table 18

Medicare Post-Acute Care Episode Payments and Utilization for PAC Users, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC

Episode Definition R: 60 Day Variable Length Excluding Acute Hospital Readmission

						Per PAC User[1]							
						Index Acute Hospital[2]		Physician Services During Index Acute Hospital Stay[3]		Post-Acute Care[4]		Total Episode[5]	
MS-DRG	Descriptor	Percent of Beneficiaries Discharged to PAC (PAC Users)	Number of PAC Users	Percent of PAC Users	Cumulative Percent of PAC Users	Mean Payment	Mean Length of Stay (days)	Mean Payment	Mean Units of Service[6]	Mean Payment	Mean Length of Stay[7] (days)	Mean Payment	Mean Length of Stay (days)
	All MS-DRGs	**35.2**	**109,236**	**100**	**-**	**$10,297**	**6.8**	**$1,531**	**61.5**	**$8,337**	**50.8**	**$20,165**	**58.7**
470	Major joint replacement or reattachment of lower extremity w/o MCC	87.7	14,447	13.2	13.2	$10,463	4.0	$1,540	83.8	$7,515	48.7	$19,518	53.6
194	Simple pneumonia & pleurisy w CC	34.2	2,661	2.4	15.7	$5,107	6.1	$742	17.0	$6,141	45.0	$11,991	52.4
65	Intracranial hemorrhage or cerebral infarction w CC	69.3	2,311	2.1	17.8	$6,307	5.6	$1,014	20.8	$16,977	69.8	$24,297	76.1
481	Hip & femur procedures except major joint w CC	89.1	2,135	2.0	19.7	$9,698	5.7	$1,727	78.8	$15,661	69.4	$27,085	75.3
690	Kidney & urinary tract infections w/o MCC	38.8	2,125	1.9	21.7	$4,025	4.8	$572	12.5	$7,796	50.9	$12,393	56.9
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	56.6	1,760	1.6	23.3	$5,985	4.4	$828	16.5	$12,060	59.7	$18,872	65.3
641	Nutritional & misc metabolic disorders w/o MCC	33.0	1,647	1.5	24.8	$3,700	4.9	$604	13.0	$7,429	50.2	$11,733	56.2
292	Heart failure & shock w CC	37.0	1,622	1.5	26.3	$5,299	5.9	$856	20.1	$6,114	51.8	$12,270	58.9
871	Septicemia w/o MV 96+ hours w MCC	51.8	1,556	1.4	27.7	$9,475	9.3	$1,424	31.6	$8,592	47.4	$19,492	57.4
482	Hip & femur procedures except major joint w/o CC/MCC	87.3	1,526	1.4	29.1	$8,304	4.8	$1,553	71.5	$14,804	65.5	$24,661	70.7
195	Simple pneumonia & pleurisy w/o CC/MCC	28.8	1,510	1.4	30.5	$4,512	5.0	$533	11.9	$5,401	43.4	$10,446	49.7
552	Medical back problems w/o MCC	51.1	1,433	1.3	31.8	$3,827	4.9	$678	14.5	$8,247	50.7	$12,753	56.7
603	Cellulitis w/o MCC	33.5	1,277	1.2	33.0	$3,905	5.3	$613	14.7	$5,821	52.5	$10,339	59.1
291	Heart failure & shock w MCC	42.3	1,252	1.1	34.1	$5,884	8.0	$1,256	27.8	$7,157	47.8	$14,297	56.8
312	Syncope & collapse	23.9	1,245	1.1	35.3	$3,595	4.2	$798	17.7	$6,743	49.2	$11,136	55.0
392	Esophagitis, gastroent & misc digest disorders w/o MCC	13.5	1,232	1.1	36.4	$3,849	4.7	$704	15.2	$5,553	48.2	$10,106	54.7
293	Heart failure & shock w/o CC/MCC	27.2	1,215	1.1	37.5	$4,987	4.4	$624	14.5	$4,958	52.5	$10,569	58.6
192	Chronic obstructive pulmonary disease w/o CC/MCC	20.4	1,098	1.0	38.5	$4,288	4.8	$591	12.5	$4,599	45.5	$9,478	52.0
683	Renal failure w CC	38.4	1,082	1.0	39.5	$6,590	6.6	$1,038	22.7	$7,348	50.8	$14,977	58.5
536	Fractures of hip & pelvis w/o MCC	84.8	924	0.8	40.3	$3,416	4.1	$625	11.8	$11,696	60.3	$15,738	64.9

NOTES:

1. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from an index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from an index acute hospitalization.
2. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use.
3. Physician services defined as separately billable Part B physician services rendered during the acute hospital stay.
4. Post-acute care includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy. Note that acute hospital readmissions are also included in PAC payments.
5. Total episode payment and length of stay include index acute hospital, physician services during the index acute hospital stay, and post-acute care.
6. Units of service as reported on the Part B physician claim.
7. Post-acute care length of stay is defined as the difference between the admission date on the first PAC episode claim and the dishcarge date on the last PAC episode claim. Note that for some beneficiaries there may be a gap in service use between the discharge date on the index acute hospital claim and the admission date on the first PAC episode claim.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y234).