Table 55

Medicare Supplementary Medical Insurance Disbursements for Benefits, by Type of Provider: Selected Calendar Years 1970-2001

Type of Provider	1970	1975	1980	1985	1990
			Dollars in Millions		
Total, Old Format[1]	$1,975	$4,273	$10,635	$22,947	$42,468
Physicians and Suppliers[2]	1,790	3,416	8,187	17,312	29,609
Outpatient Facilities[3]	114	643	1,897	4,319	8,482
Managed Care[4]	26	80	203	720	2,827
Home Health Agencies[5]	34	95	234	38	74
Independent Laboratories	11	39	114	558	1,476
Total, New Format[1,6]	---	---	---	---	---
Physician Fee Schedule	---	---	---	---	---
Durable Medical Equipment	---	---	---	---	---
Carrier Laboratories	---	---	---	---	---
Other Carrier	---	---	---	---	---
Hospital	---	---	---	---	---
Home Health Agencies[5]	---	---	---	---	---
Intermediary Laboratories	---	---	---	---	---
Other Intermediary	---	---	---	---	---
Managed Care	---	---	---	---	---
			Percent Distribution		
Total, Old Format[1]	100.0	100.0	100.0	100.0	100.0
Physicians and Suppliers[2]	90.6	79.9	77.0	75.4	69.7
Outpatient Facilities[3]	5.8	15.0	17.8	18.8	20.0
Managed Care[4]	1.3	1.9	1.9	3.1	6.7
Home Health Agencies[5]	1.7	2.2	2.2	0.2	0.2
Independent Laboratories	0.6	0.9	1.1	2.4	3.5
Total, New Format[1, 6]	---	---	---	---	---
Physician Fee Schedule	---	---	---	---	---
Durable Medical Equipment	---	---	---	---	---
Carrier Laboratories	---	---	---	---	---
Other Carrier	---	---	---	---	---
Hospital	---	---	---	---	---
Home Health Agencies[5]	---	---	---	---	---
Intermediary Laboratories	---	---	---	---	---
Other Intermediary	---	---	---	---	---
Managed Care	---	---	---	---	---

[1]Represents disbursements accrued on a cash-flow basis. Excludes disbursements for program administration and the net cost of private health insurance, government public health activities, and research and construction.

[2]Excludes disbursements for health maintenance organizations, competitive medical plans, and other prepaid health plans.

[3]Includes disbursements for hospital outpatient facilities, end stage renal disease freestanding facilities, rural health clinics, and outpatient rehabilitation facilities.

[4]Includes disbursements for health maintenance organizations, competitive medical plans, and other prepaid health plans.

[5]As a result of the Omnibus Budget Reconciliation Act 1980 legislation, most home health agency services were covered under the hospital insurance program beginning in 1981. The Balanced Budget Act of 1997 provided that home health agency services, associated with a hospital or skilled nursing facility stay after the first 100 visits, be transferred from Part A (HI) to Part B (SMI).

[6]Costs for peer review organization activity, from 1991-2001, are excluded from the totals.

NOTES: Numbers may not add to totals because of rounding. --- not available.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, Division of Medicare and Medicaid Cost Estimates; data development by the Office of Research, Development, and Information.

Table 55—Continued

Medicare Supplementary Medical Insurance Disbursements for Benefits, by Type of Provider: Selected Calendar Years 1970-2001

1995	1996	1997	1999	2000	2001
Dollars in Millions					
$64,972	$68,599	$72,757	---	---	---
40,474	41,238	42,411	---	---	---
15,625	16,456	17,416	---	---	---
6,608	8,847	10,980	---	---	---
200	219	228	---	---	---
2,065	1,839	1,722	---	---	---
$64,970	$68,584	$72,710	$81,287	$90,552	$102,709
31,660	31,631	31,898	33,354	36,963	42,028
3,689	3,825	4,236	4,279	4,718	5,447
2,807	2,550	2,385	2,078	2,226	2,434
4,530	5,059	5,586	6,451	7,408	8,904
8,666	8,614	9,358	8,795	8,494	12,839
229	241	208	1,169	4,351	4,386
1,448	1,355	1,503	1,681	1,782	1,947
5,331	5,749	6,575	5,777	6,251	7,164
6,610	9,558	10,962	17,702	18,358	17,560
100.0	100.0	100.0	---	---	---
62.3	60.1	58.3	---	---	---
24.0	24.0	23.9	---	---	---
10.2	12.9	15.1	---	---	---
0.3	0.3	0.3	---	---	---
3.2	2.7	2.4	---	---	---
100.0	100.0	100.0	100.0	100.0	100.0
48.7	46.1	43.9	41.0	40.8	40.9
5.7	5.6	5.8	5.3	5.2	5.3
4.3	3.7	3.3	2.6	2.5	2.4
7.0	7.4	7.7	7.9	8.2	8.7
13.3	12.6	12.9	10.8	9.4	12.5
0.4	0.4	0.3	1.4	4.8	4.3
2.2	2.0	2.1	2.1	2.0	1.9
8.2	8.4	9.0	7.1	6.9	7.0
10.2	13.9	15.1	21.8	20.3	17.1

Table 56

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Demographic Characteristics: Calendar Year 2001

Demographic Characteristic	Persons Served[1]	Services: Number in Thousands	Services: Per Person Served[1]	Submitted Charges: Amount in Thousands	Submitted Charges: Per Person Served[1]
Total	30,688,840	1,340,531	43.7	$147,219,411	$4,797
Sex					
Male	12,652,240	551,979	43.6	64,484,121	5,097
Female	18,036,600	788,552	43.7	82,735,289	4,587
Age					
Under 65 Years	4,027,860	176,419	43.8	20,137,944	5,000
65-74 Years	12,455,180	486,780	39.1	54,630,922	4,386
75-84 Years	10,117,540	486,078	48.0	53,570,048	5,295
85 Years or Over	4,088,260	191,254	46.8	18,880,497	4,618
Race[3]					
White	26,238,560	1,135,890	43.3	124,308,520	4,738
Other	3,434,680	155,433	45.3	17,622,344	5,131
Medicare Status[4]					
Aged	26,491,380	1,143,226	43.2	124,507,658	4,700
Disabled	3,950,280	158,827	40.2	17,665,869	4,472
End Stage Renal Disease	247,180	38,478	155.7	5,045,884	20,414

See footnotes at end of table.

Table 56—Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Demographic Characteristics: Calendar Year 2001

Demographic Characteristic	Allowed Charges				Program Payments		Balance Billing	
	Amount in Thousands	Per Person Served[1]	Assigned in Thousands	Percent of Charges Assigned	Amount in Thousands	Per Person Served[2]	Amount in Thousands	Per Person with Liability
Total	$76,672,497	$2,498	$75,636,818	98.6	$59,113,949	$1,976	$70,241	$25
Sex								
Male	33,266,351	2,629	32,843,504	98.7	25,682,818	2,097	29,183	26
Female	43,406,146	2,407	42,793,314	98.6	33,431,130	1,893	41,058	24
Age								
Under 65 Years	10,457,663	2,596	10,401,353	99.5	7,879,397	2,050	3,541	26
65-74 Years	27,627,147	2,218	27,209,682	98.5	21,253,753	1,758	27,714	24
75-84 Years	28,037,341	2,771	27,618,507	98.5	21,802,769	2,190	28,786	26
85 Years or Over	10,550,345	2,581	10,407,276	98.6	8,178,030	2,033	10,201	26
Race[3]								
White	64,682,710	2,465	63,692,537	98.5	49,825,053	1,946	67,312	25
Other	9,094,190	2,648	9,060,329	99.6	7,037,092	2,122	2,181	20
Medicare Status[4]								
Aged	64,928,682	2,451	63,953,775	98.5	50,211,145	1,939	66,396	25
Disabled	9,274,417	2,348	9,219,235	99.4	6,931,639	1,842	3,457	25
End Stage Renal Disease	2,469,398	9,990	2,463,808	99.8	1,971,165	8,056	388	34

[1]Includes beneficiaries who received covered services but for whom no program payments were reported during the year.

[2]The average program payment per person served does not reflect beneficiaries who received covered services but for whom no program payments were reported.

[3]Excludes unknown race.

[4]Aged = Aged without ESRD (MSC 10); Disabled = Disabled without ESRD (MSC 20); ESRD = Aged with ESRD (MSC 11), Disabled with ESRD (MSC 21), and ESRD only (MSC 31).

NOTE: Medicare charges and program payments represent fee-for-service utilization only.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Research, Development, and Information.

Table 57

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Type of Service: Calendar Year 2001

Type of Service	Persons Served[1]	Services: Number in Thousands	Services: Per Person Served[1]	Submitted Charges: Amount in Thousands	Submitted Charges: Per Person Served[1]
Total	30,688,840	1,340,531	43.7	$147,219,411	$4,797
Medical Care	29,656,360	493,358	16.6	40,414,118	1,363
Surgery	17,402,380	82,207	4.7	34,141,365	1,962
Consultation	11,113,120	27,275	2.5	4,851,617	437
Diagnostic X-Ray	20,121,720	111,111	5.5	13,902,256	691
Diagnostic Laboratory	24,780,440	387,441	15.6	17,952,273	724
Radiation Therapy	1,005,600	10,602	10.5	2,961,949	2,945
Anesthesia	5,377,140	10,308	1.9	5,852,514	1,088
Assistance at Surgery	797,680	1,258	1.6	1,153,979	1,447
Other Medical Services	988,220	10,182	10.3	1,568,984	1,588
Ambulatory Surgical Center	1,878,640	2,926	1.6	4,084,367	2,174
Renal Supplies in the Home	22,440	638	28.4	292,555	13,037
ESRD Capitation Payment	252,060	2,373	9.4	848,006	3,364
Psychological Therapy	2,464,040	16,672	6.8	1,506,901	612
Occupational Therapy	23,120	783	33.9	27,803	1,203
Pneumococcal Vaccine	11,828,820	25,166	2.1	254,340	22
Physical Therapy	586,020	23,492	40.1	772,892	1,319
Durable Medical Equipment [4]	7,027,600	92,286	13.1	10,103,039	1,438
Other[5]	NA	42,453	NA	6,530,453	NA

[1]Includes beneficiaries who received covered services, but for whom no program payments were reported during the year. Numbers do not add to totals because beneficiaries may use more than 1 service during the reporting year

[2]Ratio of assigned allowed charges to total allowed charges.

[3]The average program payment per person served does not reflect beneficiaries who received covered services, but for whom no program payments were reported.

[4]Durable medical equipment (DME) was identified based on selected Berenson-Eggers Type of Service system codes and Healthcare Common Procedure Coding System (HCPCS) codes.

[5]Includes blood, ambulance, enteral/parenteral supplies, immunosuppressive drugs, hearing items and services, kidney donor, lump sum purchase of DME, vision items or services, rental of DME.

[6]Less than $500.

NOTES: Medicare charges and program payments represent fee-for-service utilization only. Numbers may not add to total because of rounding BETOS is Berenson-Eggers Type of Service System for classifying HCPCS. ESRD is end stage renal disease. NA is not applicable.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Research, Development, and Information.

Table 57—Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Type of Service: Calendar Year 2001

Allowed Charges				Program Payments		Balance Billing	
Amount in Thousands	Per Person Served[1]	Assigned in Thousands	Percent of Charges Assigned[2]	Amount in Thousands	Per Person Served[3]	Amount in Thousands	Per Person with Liability
$76,672,497	$2,498	$75,636,818	98.6	$59,113,949	$1,976	$70,241	$25
27,928,057	942	27,464,350	98.3	20,780,578	739	30,915	17
13,262,058	762	13,128,863	99.0	10,378,077	606	10,626	29
3,379,885	304	3,350,074	99.1	2,609,548	237	2,438	16
6,050,333	301	6,004,557	99.2	4,695,843	242	3,812	14
6,904,256	279	6,865,794	99.4	5,909,583	240	3,142	8
1,063,707	1,058	1,058,268	99.5	845,279	844	482	74
1,539,679	286	1,534,933	99.7	1,217,754	227	407	19
201,745	253	200,444	99.4	160,241	201	115	22
903,309	914	901,821	99.8	717,828	730	79	32
1,601,565	853	1,601,557	99.9	1,269,300	676	(6)	0
185,309	8,258	185,307	99.9	147,581	6,594	(6)	5
520,451	2,065	520,269	99.9	408,725	1,626	16	68
1,152,760	468	1,114,349	96.7	537,243	234	2,402	35
20,291	878	20,203	99.6	16,042	699	6	35
147,410	12	145,935	99.0	147,196	12	76	1
581,724	993	575,070	98.9	459,048	788	257	48
6,901,860	982	6,750,387	97.8	5,400,105	779	7,039	14
4,328,098	NA	4,214,637	97.4	3,413,978	NA	8,429	NA

Table 58

Persons Served, Services, Submitted and Allowed Charges, Program Payments for Medicare Physician and Supplier Services, by Place of Service: Calendar Year 2001

Place of Service	Persons Served[1]	Services: Number in Thousands	Services: Per Person Served[1]	Submitted Charges: Amount in Thousands	Submitted Charges: Per Person Served[1]
Total	30,688,840	1,340,531	43.7	$147,219,411	$4,797
Office	28,485,440	656,525	23.0	52,282,685	1,835
Home	7,515,940	106,299	14.1	11,667,881	1,552
Inpatient Hospital	8,050,780	191,916	23.8	37,339,151	4,638
Outpatient Hospital[4]	16,287,300	82,842	5.1	18,821,970	1,156
Emergency Room Hospital[4]	9,377,060	32,315	3.4	4,695,717	501
Ambulatory Surgical Center	2,207,380	7,492	3.4	7,513,524	3,404
Skilled Nursing Care Facility	2,223,220	27,823	12.5	2,027,835	912
Nursing Home	1,668,940	18,078	10.8	887,241	532
Hospice	8,080	21	2.6	1,964	243
Ambulance[5]	3,706,360	25,736	6.9	3,915,321	1,056
Independent Laboratory	14,764,660	164,674	11.2	6,112,948	414
All Other[6]	NA	26,810	NA	1,953,174	NA

See footnotes at end of table.

Table 58—Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments for Medicare Physician and Supplier Services, by Place of Service: Calendar Year 2001

	Allowed Charges					Program Payments		
Place of Service	Amount in Thousands	Percent	Per Person Served[1]	Assigned in Thousands	Percent of Charges Assigned[2]	Amount in Thousands	Percent	Per Person Served[3]
Total	$76,672,497	100.0	$2,498	$75,636,818	98.6	$59,113,949	100.0	$1,976
Office	33,844,895	44.1	1,188	33,201,638	98.1	25,245,505	42.7	919
Home	7,965,165	10.4	1,060	7,786,653	97.8	6,227,444	10.5	841
Inpatient Hospital	15,871,982	20.7	1,971	15,790,826	99.5	12,565,359	21.3	1,570
Outpatient Hospital[4]	6,289,973	8.2	386	6,257,821	99.5	4,892,462	8.3	309
Emergency Room Hospital[4]	2,007,676	2.6	214	2,005,138	99.9	1,550,538	2.6	169
Ambulatory Surgical Center	2,798,087	3.6	1,268	2,788,543	99.7	2,214,552	3.7	1,005
Skilled Nursing Care Facility	1,464,666	1.9	659	1,461,314	99.8	1,094,311	1.9	502
Nursing Home	634,888	0.8	380	633,647	99.8	457,392	0.8	281
Hospice	1,132	(7)	140	1,132	100.0	884	(7)	112
Ambulance[5]	2,527,139	3.3	682	2,450,804	97.0	2,005,395	3.4	541
Independent Laboratory	2,063,918	2.7	140	2,063,298	99.9	1,953,853	3.3	133
All Other[6]	1,202,976	1.6	NA	1,196,004	99.4	906,264	1.5	NA

[1]Includes beneficiaries who received covered services, but for whom no program payments were reported during the year. Numbers do not add to totals because beneficiaries may use more than 1 service during the reporting year.

[2]Ratio of assigned allowed charges to total allowed charges. Includes charges for supplier services.

[3]The average program payment per person served does not reflect beneficiaries who received covered services, but for whom no program payments were reported.

[4]Prior to 1992, emergency room and outpatient hospital data were aggregated.

[5]Excludes air or water services.

[6]Includes custodial care facilities, comprehensive inpatient rehabilitation facilities, State or local public health clinics, end stage renal disease treatment facilities, community mental health centers, inpatient psychiatric facilities, etc.

[7]Less than 0.05 percent.

NOTES: Medicare charges and program payments represent fee-for-service utilization only. NA is not applicable.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Research, Development, and Information.

Table 59

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Physician Specialty: Calendar Year 2001

Physician/Supplier Specialty[1]	Persons Served[2]	Services			Submitted Charges		
		Number in Thousands	Percent	Per Person Served[2]	Amount in Thousands	Percent	Per Person Served[2]
Total, All Specialties	30,688,840	1,340,531	100.0	43.7	$147,219,411	100.0	$4,797
Total, Physicians	29,964,320	913,590	68.2	30.5	108,830,520	73.9	3,632
General Practice	3,050,260	20,558	1.5	6.7	1,342,426	0.9	440
General Surgery	4,126,260	14,231	1.1	3.4	4,784,911	3.3	1,160
Allergy and Immunology	345,040	10,992	0.8	31.9	194,864	0.1	565
Otology, Laryngology, Rhinology	2,679,100	12,241	0.9	4.6	1,290,324	0.9	482
Anesthesiology	4,927,800	12,485	0.9	2.5	5,213,060	3.5	1,058
Cardiology	9,248,720	84,624	6.3	9.1	12,014,233	8.2	1,299
Dermatology	4,673,560	29,872	2.2	6.4	2,052,110	1.4	439
Family Practice	11,498,500	99,785	7.4	8.7	5,361,255	3.6	466
Gastroenterology	3,697,600	14,172	1.1	3.8	3,349,539	2.3	906
Internal Medicine	15,505,740	169,696	12.7	10.9	11,866,301	8.1	765
Manipulative Therapy	77,260	587	(5)	7.6	40,511	(5)	524
Neurology	2,771,060	13,067	1.0	4.7	1,622,414	1.1	585
Neurologiclal Surgery	599,040	1,818	0.1	3.0	1,356,596	0.9	2,265
Obstetrics and Gynecology	2,389,520	6,679	0.5	2.8	911,833	0.6	382
Ophthalmology	10,659,280	34,100	2.5	3.2	8,049,154	5.5	755
Oral Surgery (Dentists Only)	90,280	188	(5)	2.1	36,893	(5)	409
Orthopedic Surgery	4,431,460	25,956	1.9	5.9	6,101,359	4.1	1,377
Pathology	5,516,120	17,076	1.3	3.1	1,794,762	1.2	325
Plastic and Reconstructive Surgery	478,500	1,642	0.1	3.4	604,103	0.4	1,262
Physical Medicine and Rehabilitation	1,066,860	10,612	0.8	9.9	904,239	0.6	848
Psychiatry	1,950,220	15,468	1.2	7.9	1,474,690	1.0	756
Colorectal Surgery (Proctology)	226,220	584	(5)	2.6	203,175	0.1	898
Pulmonary Disease	2,354,740	19,127	1.4	8.1	1,870,960	1.3	795
Diagnostic Radiology	17,864,380	80,114	6.0	4.5	9,844,130	6.7	551
Thoracic Surgery	521,760	1,539	0.1	2.9	1,318,890	0.9	2,528
Urology	3,976,960	25,091	1.9	6.3	4,059,801	2.8	1,021
Chiropractic	1,777,480	16,023	1.2	9.0	576,899	0.4	325
Nuclear Medicine	432,700	1,041	0.1	2.4	193,022	0.1	446
Pediatric Medicine	251,360	1,353	0.1	5.4	87,358	0.1	348
Geriatric Medicine	265,260	1,757	0.1	6.6	120,957	0.1	456
Nephrology	1,034,320	21,319	1.6	20.6	1,898,930	1.3	1,836
Optometrist	4,401,660	8,204	0.6	1.9	574,517	0.4	131
Infectious Disease	582,860	5,638	0.4	9.7	510,768	0.3	876
Endocrinology	812,620	6,062	0.5	7.5	370,529	0.3	456
Podiatry	5,393,320	25,791	1.9	4.8	1,640,535	1.1	304

See footnotes at end of table.

Table 59—Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Physician Specialty: Calendar Year 2001

Allowed Charges					Program Payments			Balance Billing	
Amount in Thousands	Percent	Per Person Served[2]	Assigned in Thousands	Percent of Charges Assigned[3]	Amount in Thousands	Percent	Per Person Served[4]	Amount in Thousands	Per Person with Liability
$76,672,497	100.0	$2,498	$75,636,818	98.6	$59,113,949	100.0	$1,976	$70,241	$25
56,279,551	73.4	1,878	55,502,248	98.6	42,934,050	72.6	1,480	55,106	26
901,208	1.2	295	879,531	97.6	661,987	1.1	228	1,252	16
2,020,603	2.6	490	2,007,377	99.3	1,574,072	2.7	393	1,070	30
149,940	0.2	435	144,561	96.4	112,901	0.2	337	368	28
680,737	0.9	254	673,495	98.9	510,846	0.9	200	567	14
1,455,752	1.9	295	1,449,029	99.5	1,145,223	1.9	234	572	23
5,511,931	7.2	596	5,473,319	99.3	4,276,447	7.2	474	3,092	30
1,517,142	2.0	325	1,474,955	97.2	1,138,169	1.9	255	3,309	17
3,686,948	4.8	321	3,613,983	98.0	2,659,131	4.5	242	5,438	16
1,443,174	1.9	390	1,428,143	99.0	1,117,476	1.9	308	1,217	27
7,707,946	10.1	497	7,553,376	98.0	5,804,825	9.8	386	12,603	22
26,399	(5)	342	24,559	93.0	19,775	(5)	266	93	20
991,763	1.3	358	981,637	99.0	761,263	1.3	282	841	23
417,261	0.5	697	411,665	98.7	326,898	0.6	561	481	57
467,542	0.6	196	454,357	97.2	351,317	0.6	153	981	13
4,305,101	5.6	404	4,250,327	98.7	3,229,080	5.5	322	4,260	19
20,979	(5)	232	18,632	88.8	16,169	(5)	185	137	19
2,628,660	3.4	593	2,608,574	99.2	2,031,264	3.4	475	1,667	39
720,898	0.9	131	716,706	99.4	568,526	1.0	105	366	16
248,176	0.3	519	244,616	98.6	193,962	0.3	419	276	40
546,418	0.7	512	543,678	99.5	428,818	0.7	407	219	26
1,034,856	1.3	531	995,246	96.2	644,660	1.1	342	2,488	42
89,377	0.1	395	88,332	98.8	68,840	0.1	311	87	25
1,209,592	1.6	514	1,203,660	99.5	942,032	1.6	407	501	24
3,874,470	5.1	217	3,844,501	99.2	3,018,478	5.1	174	2,531	27
477,060	0.6	914	474,999	99.6	376,818	0.6	734	181	63
2,495,757	3.3	628	2,478,106	99.3	1,937,146	3.3	495	1,519	31
506,670	0.7	285	413,545	81.6	374,055	0.6	220	3,135	13
85,884	0.1	198	84,560	98.5	67,354	0.1	159	114	18
51,788	0.1	206	51,156	98.8	38,840	0.1	161	35	24
86,097	0.1	325	84,800	98.5	64,378	0.1	250	111	23
1,113,967	1.5	1,077	1,110,060	99.6	872,826	1.5	857	338	29
497,791	0.6	113	484,251	97.3	343,068	0.6	88	214	6
327,236	0.4	561	325,304	99.4	257,316	0.4	447	166	24
248,987	0.3	306	240,873	96.7	192,236	0.3	241	637	19
1,230,101	1.6	228	1,216,912	98.9	913,040	1.5	175	663	12

Table 59—Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Physician Specialty: Calendar Year 2001

Physician/Supplier Specialty[1]	Persons Served[2]	Services			Submitted Charges		
		Number in Thousands	Percent	Per Person Served[2]	Amount in Thousands	Percent	Per Person Served[2]
Rheumatology	1,023,500	10,415	0.8	10.2	$726,606	0.5	$710
Vascular Surgery	840,100	2,302	0.2	2.7	898,906	0.6	1,070
Cardiac Surgery	237,420	686	0.1	2.9	838,205	0.6	3,530
Hematology/Oncology	1,156,720	41,483	3.1	35.9	4,331,328	2.9	3,744
Medical Oncology	503,420	16,810	1.3	33.4	1,942,406	1.3	3,858
Radiation Oncology	671,980	8,803	0.7	13.1	2,323,599	1.6	3,458
Emergency Medicine	6,601,480	15,047	1.1	2.3	2,813,625	1.9	426
All Other Physician[6]	NA	8,551	0.6	NA	1,319,800	0.9	NA
Group Practice	4,379,660	55,820	4.2	12.7	6,442,781	4.4	1,471
Total Non-Physician	7,514,820	51,617	3.9	6.9	8,593,657	5.8	1,144
Total Suppliers	20,192,920	319,503	23.8	15.8	23,352,339	15.9	1,156
Invalid Physician/Supplier Specialty Code	380	1	(5)	2.6	114	(5)	300

[1]Refer to Part B physician or provider specialty code as listed in the data dictionary for the National Claims History, prepared by the Office of Information Services.

[2]Includes beneficiaries who received covered services, but for whom no program payments were reported during the year. Numbers do not add to totals because beneficiaries may use more than 1 service during the reporting year.

[3]Ratio of assigned allowed charges to total allowed charges. Includes charges for supplier services.

[4]The average program payment per person served does not reflect beneficiaries who received covered services, but for whom no program payments were reported.

[5]Less than 0.05 percent.

[6]Includes critical care, addiction to medicine, hand surgery, peripheral vascular disease, preventive medicine, maxillofacial surgery, neuropsychiatry, surgical oncology, interventional radiology, hematology, gynecologist/oncologist, pain management, and unknown physician's specialty.

NOTES: Medicare charges and program payments represent fee-for-service utilization only. Numbers may not add to total because of rounding. NA is not applicable.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Research, Development, and Information.

Table 59—Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Physician Specialty: Calendar Year 2001

Allowed Charges					Program Payments			Balance Billing	
Amount in Thousands	Percent	Per Person Served[2]	Assigned in Thousands	Percent of Charges Assigned[3]	Amount in Thousands	Percent	Per Person Served[4]	Amount in Thousands	Per Person with Liability
$513,102	0.7	$501	$496,660	96.8	$391,947	0.7	$392	$1,362	$24
362,471	0.5	431	361,434	99.7	284,147	0.5	345	86	27
293,238	0.4	1,235	290,283	99.0	232,100	0.4	992	258	159
2,533,347	3.3	2,190	2,528,392	99.8	2,007,922	3.4	1,760	393	41
1,055,739	1.4	2,097	1,053,709	99.8	835,436	1.4	1,689	174	35
863,961	1.1	1,286	859,568	99.5	684,686	1.2	1,051	391	87
1,263,675	1.6	191	1,261,814	99.9	976,188	1.7	151	148	10
615,804	0.8	NA	601,562	97.7	482,389	0.8	NA	765	NA
3,172,429	4.1	724	3,168,776	99.9	2,440,958	4.1	573	296	27
3,836,872	5.0	511	3,814,155	99.4	2,859,749	4.8	389	1,101	10
13,383,576	17.5	663	13,151,570	98.3	10,879,145	18.4	541	13,737	20
69	(5)	182	69	100.0	46	(5)	155	0	0

Table 60

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Area of Residence: Calendar Year 2001

Area of Residence	Persons Served[1] Number	Persons Served[1] Per 1,000 Enrollees[2]	Services Number in Thousands	Services Per Person Served[1]	Submitted Charges Amount in Thousands	Submitted Charges Per Person Served[1]
All Areas[5]	30,688,840	974	1,340,531	43.7	$147,219,411	$4,797
United States[6]	30,275,180	975	1,321,153	43.6	145,887,044	4,819
Northeast	5,975,540	970	275,308	46.1	30,356,014	5,080
Midwest	7,884,320	987	310,451	39.4	33,579,511	4,259
South	11,785,400	975	536,893	45.6	60,128,999	5,102
West	4,629,920	965	198,502	42.9	21,822,520	4,713
New England	1,591,140	973	64,603	40.6	7,338,248	4,612
Connecticut	409,240	984	17,957	43.9	2,106,927	5,148
Maine	199,400	958	6,957	34.9	776,807	3,896
Massachusetts	649,940	975	27,381	42.1	3,090,727	4,755
New Hampshire	151,080	956	5,247	34.7	577,467	3,822
Rhode Island	99,000	990	4,671	47.2	479,174	4,840
Vermont	82,480	959	2,390	29.0	307,146	3,724
Middle Atlantic	4,384,400	968	210,704	48.1	23,017,765	5,250
New Jersey	962,560	967	49,822	51.8	5,590,473	5,808
New York	1,991,580	966	99,232	49.8	10,269,782	5,157
Pennsylvania	1,430,260	973	61,650	43.1	7,157,511	5,004
East North Central	5,422,180	983	218,045	40.2	24,376,039	4,496
Illinois	1,339,580	965	54,355	40.6	6,215,832	4,640
Indiana	775,800	990	29,835	38.5	3,475,710	4,480
Michigan	1,248,780	986	53,796	43.1	5,675,699	4,545
Ohio	1,359,700	986	54,602	40.2	6,206,959	4,565
Wisconsin	698,320	995	25,457	36.5	2,801,839	4,012
West North Central	2,462,140	998	92,406	37.5	9,203,472	3,738
Iowa	444,760	1,010	16,742	37.6	1,523,287	3,425
Kansas	340,340	1,002	13,524	39.7	1,440,783	4,233
Minnesota	554,100	1,016	17,802	32.1	1,823,631	3,291
Missouri	684,780	981	27,726	40.5	2,911,474	4,252
Nebraska	233,060	994	8,944	38.4	859,001	3,686
North Dakota	96,280	991	3,529	36.7	328,840	3,415
South Dakota	108,820	969	4,139	38.0	316,457	2,908
South Atlantic	6,334,260	977	293,867	46.4	33,262,896	5,251
Delaware	105,940	978	4,829	45.6	592,954	5,597
District of Columbia	54,060	884	2,473	45.7	313,244	5,794
Florida	2,066,940	987	114,698	55.5	12,706,665	6,148
Georgia	835,660	973	35,256	42.2	4,138,075	4,952
Maryland	565,400	961	25,522	45.1	3,218,131	5,692
North Carolina	1,048,140	983	43,318	41.3	4,876,097	4,652
South Carolina	548,320	982	23,871	43.5	2,676,063	4,880
Virginia	818,540	969	32,517	39.7	3,471,657	4,241
West Virginia	291,260	962	11,383	39.1	1,270,009	4,360

See footnotes at end of table

Table 60—Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Area of Residence: Calendar Year 2001

Allowed Charges				Program Payments			Balance Billing	
Amount in Thousands	Per- cent	Per Person Served[1]	Percent of Charges Assigned[3]	Amount in Thousands	Per- cent	Per Person Served[4]	Amount in Thousands	Per Person with Liability
$76,672,497	100.0	$2,498	98.6	$59,113,949	100.0	$1,976	$70,241	$25
75,688,499	98.7	2,500	98.6	58,354,466	98.7	1,977	70,142	25
16,389,141	21.4	2,743	98.6	12,654,873	21.4	2,166	13,963	27
17,032,615	22.2	2,160	98.3	13,063,379	22.1	1,703	19,857	26
30,318,101	39.5	2,573	99.1	23,404,143	39.6	2,037	19,695	19
11,948,642	15.6	2,581	98.1	9,232,072	15.6	2,048	16,627	32
3,806,648	5.0	2,392	99.3	2,916,171	4.9	1,878	1,779	23
1,080,236	1.4	2,640	98.6	831,366	1.4	2,072	1,140	32
388,420	0.5	1,948	99.4	296,359	0.5	1,538	138	19
1,640,359	2.1	2,524	99.7	1,255,520	2.1	1,975	209	13
302,023	0.4	1,999	99.0	229,989	0.4	1,568	177	17
248,564	0.3	2,511	99.8	191,761	0.3	1,979	23	11
147,046	0.2	1,783	98.9	111,177	0.2	1,394	92	20
12,582,494	16.4	2,870	98.4	9,738,702	16.5	2,270	12,184	27
3,105,697	4.1	3,226	97.7	2,413,166	4.1	2,556	5,049	27
5,867,963	7.7	2,946	98.2	4,539,610	7.7	2,325	6,459	30
3,608,834	4.7	2,523	99.5	2,785,926	4.7	1,999	676	15
12,287,879	16.0	2,266	98.7	9,438,285	16.0	1,787	10,467	24
3,082,634	4.0	2,301	97.7	2,367,939	4.0	1,813	4,655	26
1,639,686	2.1	2,114	98.3	1,251,375	2.1	1,665	1,649	20
3,186,396	4.2	2,552	99.2	2,459,431	4.2	2,014	1,643	26
3,092,063	4.0	2,274	99.5	2,375,456	4.0	1,795	543	13
1,287,101	1.7	1,843	97.8	984,084	1.7	1,447	1,978	26
4,744,736	6.2	1,927	97.2	3,625,094	6.1	1,518	9,390	30
808,453	1.1	1,818	96.3	614,742	1.0	1,428	2,111	38
723,636	0.9	2,126	98.7	554,764	0.9	1,675	559	21
922,745	1.2	1,665	97.4	700,601	1.2	1,306	1,665	31
1,473,777	1.9	2,152	98.5	1,131,848	1.9	1,703	1,395	19
451,213	0.6	1,936	95.3	344,350	0.6	1,522	1,644	33
173,627	0.2	1,803	95.7	132,945	0.2	1,421	605	42
191,286	0.2	1,758	90.8	145,846	0.2	1,383	1,412	36
16,970,780	22.1	2,679	99.0	13,114,020	22.2	2,117	11,514	20
290,184	0.4	2,739	98.9	224,420	0.4	2,162	206	16
153,638	0.2	2,842	98.1	118,832	0.2	2,257	219	37
7,046,375	9.2	3,409	99.2	5,494,522	9.3	2,704	3,823	22
1,993,932	2.6	2,386	99.0	1,532,980	2.6	1,882	1,408	20
1,592,640	2.1	2,817	98.8	1,230,937	2.1	2,221	1,413	24
2,275,267	3.0	2,171	98.5	1,740,245	2.9	1,703	2,430	18
1,292,531	1.7	2,357	99.1	991,609	1.7	1,855	750	14
1,732,952	2.3	2,117	99.0	1,325,567	2.2	1,662	1,081	20
593,259	0.8	2,037	99.5	454,909	0.8	1,610	184	16

Table 60—Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Area of Residence: Calendar Year 2001

	Persons Served[1]		Services		Submitted Charges	
Area of Residence	Number	Per 1,000 Enrollees[2]	Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
East South Central	2,299,360	979	99,497	43.3	$10,810,060	$4,701
Alabama	600,700	982	25,848	43.0	2,756,548	4,589
Kentucky	558,280	976	24,240	43.4	2,500,470	4,479
Mississippi	390,860	977	15,917	40.7	1,814,591	4,643
Tennessee	749,520	979	33,492	44.7	3,738,451	4,988
West South Central	3,151,780	966	143,529	45.5	16,056,043	5,094
Arkansas	388,780	978	16,762	43.1	1,678,960	4,319
Louisiana	474,740	975	21,301	44.9	2,367,062	4,986
Oklahoma	426,760	976	17,197	40.3	1,752,019	4,105
Texas	1,861,500	960	88,268	47.4	10,258,002	5,511
Mountain	1,561,740	976	58,060	37.2	6,446,466	4,128
Arizona	408,600	961	17,688	43.3	1,868,939	4,574
Colorado	298,660	1,001	10,728	35.9	1,172,130	3,925
Idaho	150,100	1,023	4,697	31.3	448,386	2,987
Montana	127,660	968	4,225	33.1	444,394	3,481
Nevada	146,300	938	6,863	46.9	920,943	6,295
New Mexico	178,900	947	5,716	31.9	689,967	3,857
Utah	190,400	993	6,089	32.0	682,598	3,585
Wyoming	61,120	980	2,055	33.6	219,110	3,585
Pacific	3,068,180	960	140,442	45.8	15,376,054	5,011
Alaska	34,660	857	1,080	31.2	157,663	4,549
California	2,082,940	946	106,293	51.0	11,733,515	5,633
Hawaii	109,320	1,077	3,741	34.2	373,445	3,416
Oregon	308,340	1,029	9,704	31.5	1,030,785	3,343
Washington	532,920	961	19,623	36.8	2,080,647	3,904
Outlying Areas[7]	413,660	872	19,378	46.8	1,332,367	3,221

[1]Includes beneficiaries who received covered services, but for whom no program payments were reported during the year.

[2]The numerator is a count of enrollees who received a service at any time during the year regardless of how long or when they were actually enrolled. The denominator is the count of SMI enrollees as of July 1.

[3]Ratio of assigned allowed charges to total allowed charges. Includes charges for supplier services.

[4]The average program payment per person served does not reflect beneficiaries who received covered services, but for whom no program payments were reported.

[5]Consists of United States and outlying areas.

[6]Includes 50 States and District of Columbia.

[7]Includes Puerto Rico, Guam, Virgin Islands, residence unknown, and all other outlying areas.

NOTES: Medicare charges and program payments represent fee-for-service utilization only. Numbers may not add to total because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Research, Development, and Information.

Table 60—Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Area of Residence: Calendar Year 2001

Allowed Charges				Program Payments			Balance Billing	
Amount in Thousands	Per-cent	Per Person Served[1]	Percent of Charges Assigned[3]	Amount in Thousands	Per-cent	Per Person Served[4]	Amount in Thousands	Per Person with Liability
$5,336,173	7.0	$2,321	99.3	$4,094,008	6.9	$1,833	$2,357	$16
1,430,292	1.9	2,381	99.5	1,099,923	1.9	1,885	416	16
1,234,382	1.6	2,211	99.1	946,732	1.6	1,750	646	16
878,450	1.1	2,247	99.3	675,265	1.1	1,785	423	13
1,793,048	2.3	2,392	99.2	1,372,087	2.3	1,878	872	18
8,011,149	10.4	2,542	99.0	6,196,115	10.5	2,023	5,824	19
871,590	1.1	2,242	99.4	670,019	1.1	1,782	349	20
1,206,565	1.6	2,542	99.4	933,432	1.6	2,027	482	13
976,429	1.3	2,288	98.8	751,578	1.3	1,811	848	20
4,956,566	6.5	2,663	98.9	3,841,085	6.5	2,121	4,145	20
3,460,438	4.5	2,216	97.0	2,656,794	4.5	1,753	8,042	35
1,048,458	1.4	2,566	95.8	813,244	1.4	2,034	3,556	58
624,088	0.8	2,090	97.6	478,507	0.8	1,654	1,119	27
264,709	0.3	1,764	93.3	201,475	0.3	1,385	1,405	28
250,350	0.3	1,961	97.2	191,030	0.3	1,551	481	27
437,515	0.6	2,991	99.3	335,831	0.6	2,365	212	30
340,781	0.4	1,905	97.8	261,194	0.4	1,524	514	25
372,259	0.5	1,955	99.0	281,865	0.5	1,521	241	21
122,279	0.2	2,001	94.6	93,650	0.2	1,591	513	28
8,488,203	11.1	2,767	98.6	6,575,277	11.1	2,198	8,585	30
72,887	0.1	2,103	97.9	55,824	0.1	1,674	118	22
6,483,101	8.5	3,112	98.9	5,043,582	8.5	2,479	5,367	32
192,162	0.3	1,758	98.7	143,896	0.2	1,355	155	22
575,166	0.8	1,865	96.7	439,721	0.7	1,471	1,453	31
1,164,886	1.5	2,186	98.2	892,254	1.5	1,718	1,492	25
983,998	1.3	2,379	99.7	759,483	1.3	1,900	99	15

Table 61

Medicare Assignment Rates and Ratio of Submitted Charges to Allowed Charges for Physician Services, by Area of Residence: Calendar Years 1983, 1988, and 2001

Area of Residence	Assignment Rate[1]			Ratio of Submitted Charges to Allowed Charges		
	1983	1988	2001	1983	1988	2001
United States	0.51	0.77	0.99	1.31	1.78	1.93
Alabama	0.56	0.84	0.99	1.35	1.92	1.93
Alaska	0.46	0.71	0.98	1.33	1.82	2.16
Arizona	0.34	0.70	0.96	1.30	1.58	1.78
Arkansas	0.58	0.82	0.99	1.32	1.85	1.93
California	0.53	0.79	0.99	1.28	1.74	1.81
Colorado	0.42	0.66	0.98	1.37	1.67	1.88
Connecticut	0.44	0.74	0.99	1.31	1.86	1.95
Delaware	0.75	0.80	0.99	1.28	2.05	2.04
District of Columbia	0.76	0.86	0.98	1.33	2.07	2.04
Florida	0.34	0.76	0.99	1.29	1.72	1.80
Georgia	0.55	0.75	0.99	1.30	1.89	2.08
Hawaii	0.42	0.75	0.99	1.34	2.02	1.94
Idaho	0.22	0.40	0.93	1.32	1.43	1.69
Illinois	0.36	0.67	0.98	1.29	1.65	2.02
Indiana	0.28	0.87	0.98	1.33	1.85	2.12
Iowa	0.33	0.63	0.96	1.34	1.66	1.88
Kansas	0.48	0.82	0.99	1.30	1.82	1.99
Kentucky	0.39	0.89	0.99	1.29	1.84	2.03
Louisiana	0.37	0.79	0.99	1.37	1.80	1.96
Maine	0.73	0.84	0.99	1.28	1.90	2.00
Maryland	0.72	0.87	0.99	1.30	1.98	2.02
Massachusetts	0.85	0.93	0.99	1.28	1.92	1.88
Michigan	0.79	0.93	0.99	1.32	1.77	1.78
Minnesota	0.27	0.53	0.97	1.30	1.66	1.98
Mississippi	0.58	0.72	0.99	1.37	1.85	2.07
Missouri	0.44	0.76	0.99	1.28	1.72	1.98
Montana	0.19	0.53	0.97	1.27	1.42	1.78
Nebraska	0.19	0.54	0.95	1.28	1.59	1.90
Nevada	0.61	0.86	0.99	1.30	1.92	2.10
New Hampshire	0.51	0.69	0.99	1.32	1.86	1.91
New Jersey	0.58	0.70	0.98	1.34	1.67	1.80
New Mexico	0.41	0.70	0.98	1.34	1.68	2.02
New York	0.62	0.89	0.98	1.37	1.71	1.75
North Carolina	0.49	0.75	0.99	1.31	1.95	2.14
North Dakota	0.29	0.47	0.96	1.27	1.80	1.89

See footnotes at end of table.

Table 61—Continued

Medicare Assignment Rates and Ratio of Submitted Charges to Allowed Charges for Physician Services, by Area of Residence: Calendar Years 1983, 1988, and 2001

Area of Residence	Assignment Rate[1]			Ratio of Submitted Charges to Allowed Charges		
	1983	1988	2001	1983	1988	2001
Ohio	0.34	0.73	0.99	1.32	1.82	2.01
Oklahoma	0.30	0.63	0.99	1.37	1.65	1.79
Oregon	0.25	0.57	0.97	1.28	1.55	1.79
Pennsylvania	0.76	0.88	0.99	1.28	1.94	1.98
Rhode Island	0.90	0.90	0.99	1.39	2.05	1.93
South Carolina	0.57	0.76	0.99	1.32	1.89	2.07
South Dakota	0.18	0.46	0.91	1.29	1.46	1.65
Tennessee	0.46	0.75	0.99	1.34	1.85	2.08
Texas	0.53	0.75	0.99	1.37	1.75	2.07
Utah	0.45	0.73	0.99	1.27	1.67	1.83
Vermont	0.58	0.78	0.99	1.31	2.01	2.09
Virginia	0.56	0.73	0.99	1.31	1.91	2.00
Washington	0.30	0.57	0.98	1.27	1.54	1.79
West Virginia	0.51	0.81	0.99	1.39	1.96	2.14
Wisconsin	0.32	0.61	0.98	1.25	1.67	2.18
Wyoming	0.26	0.46	0.95	1.32	1.50	1.79

[1]Assignment rates are calculated based on the ratio of assigned allowed charges to total allowed charges (which reflects both assigned and unassigned allowed charges) for all physician services. Supplier services are excluded from this table.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Research, Development, and Information.

Table 62

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 2001

BETOS Classification	BETOS Codes	Persons Served[1]	Services: Number in Thousands	Services: Percent	Services: Per Person Served[1]
Total, All BETOS Groups	Total	30,688,840	1,345,755	100.0	44
Office Visits - Established	M1B	26,474,140	187,344	13.9	7
Hospital Visit - Subsequent	M2B	6,465,240	87,222	6.5	13
Consultations	M6	11,004,620	26,273	2.0	2
Chemotherapy	O1D	533,500	19,106	1.4	36
Other Drugs	O1E	5,353,140	50,759	3.8	9
Ambulance	O1A	3,713,380	24,945	1.9	7
Eye Procedure - Cataract Removal/Lens Insertion	P4B	1,263,960	7,541	0.6	6
Specialist - Ophthalmology	M5C	11,702,540	24,478	1.8	2
Minor Procedures - Other (MFS)	P6C	5,973,820	50,659	3.8	8
Lab Tests, Other (Non-MFS)	T1H	17,530,500	141,497	10.5	8
Emergency Room Visit	M3	8,763,320	16,344	1.2	2
Anesthesia	P0	5,380,200	10,394	0.8	2
Major Procedure, Cardiovascular-Other	P2F	2,161,360	5,336	0.4	2
Specialist - Psychiatry	M5B	2,086,040	17,992	1.3	9
Minor Procedures - Skin	P6A	7,535,280	20,186	1.5	3
Hospital Visit - Initial	M2A	5,637,520	9,476	0.7	2
Standard Imaging - Nuclear Medicine	I1E	3,436,980	10,566	0.8	3
Echography - Heart	I3C	4,483,580	15,798	1.2	4
Office Visits - New	M1A	9,300,940	12,563	0.9	1
Durable Medical Equipment[3]	D1A-D1F	10,403,140	92,242	6.9	9
All Other BETOS Groups		NA	1,345,755	100.0	NA

[1]Includes beneficiaries who received covered services, but for whom no program payments were reported during the year. Numbers do not add to totals because beneficiaries may use more than one service during the reporting year.

[2]The average program payment per person served does not reflect beneficiaries who received covered services, but for whom no program payments were reported.

[3]Durable medical equipment includes medical and surgical supplies, hospital beds, oxygen and supplies, wheelchairs, other durable medical equipment, and orthotic devices.

NOTES: Numbers may not add to totals because of rounding. BETOS is the Berenson-Eggers Type of Service system for classifying HCPCS (Healthcare Common Procedure Coding System) codes. MFS is the Medicare fee schedule. NA is not applicable. The leading BETOS codes are based on amount of allowed charges for 2001. Medicare program payments represent fee for service only. Due to differences in timing and edits, the physician/supplier claims included in this table will cause the number of services and associated charges and payments to differ slightly from other tables on Medicare physician/supplier utilization.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Research, Development, and Information.

Table 62—Continued

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 2001

Allowed Charges			Program Payments		
Amount in Thousands	Percent	Per Person Served[1]	Amount in Thousands	Percent	Per Person Served[2]
$76,672,496	100.0	$2,498	$59,113,948	100.0	$1,976
9,727,352	12.7	367	6,729,221	11.4	272
4,903,052	6.4	758	3,892,314	6.6	604
3,319,923	4.3	302	2,562,016	4.3	235
2,721,563	3.5	5,101	2,157,678	3.7	4,059
2,683,106	3.5	501	2,120,973	3.6	413
2,584,860	3.4	696	2,051,392	3.5	553
2,004,528	2.6	1,586	1,591,016	2.7	1,260
1,848,736	2.4	158	1,299,263	2.2	121
1,637,244	2.1	274	1,277,395	2.2	220
1,551,844	2.0	89	1,546,767	2.6	88
1,550,175	2.0	177	1,196,902	2.0	140
1,546,335	2.0	287	1,221,175	2.1	227
1,340,754	1.7	620	1,063,508	1.8	494
1,327,224	1.7	636	716,459	1.2	356
1,304,412	1.7	173	972,313	1.6	134
1,265,442	1.7	224	987,714	1.7	176
1,223,321	1.6	356	965,563	1.6	283
1,145,958	1.5	256	900,051	1.5	203
1,138,174	1.5	122	787,418	1.3	92
6,892,860	9.0	663	5,393,106	9.1	NA
76,672,496	100.0	NA	59,113,948	100.0	NA

Table 63

Services, Submitted and Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2001

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Services in Thousands	Submitted Charges in Thousands	Allowed Charges: Amount in Thousands	Allowed Charges: Percent of Charges Assigned	Program Payments in Thousands
Total, All Diagnoses	---	1,340,530	$147,219,410	$76,672,496	98.6	$59,113,948
Leading Diagnoses[2]	---	790,251	79,527,936	42,139,310	98.6	32,456,387
Infectious and Parasitic Diseases (MDC 1)	001-139	18,072	1,343,179	870,002	99.0	662,592
Dermatophytosis	110	7,656	391,353	311,808	99.0	225,298
Neoplasm (MDC 2)	140-239	114,216	18,501,666	9,394,949	99.1	7,406,112
Malignant Neoplasm of Colon	153	8,099	895,387	425,688	99.6	338,246
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	14,048	1,913,877	970,538	99.7	771,168
Other Malignant Neoplasm of Skin	173	6,390	1,386,065	826,048	98.5	644,757
Malignant Neoplasm of Female Breast	174	14,328	1,767,357	875,670	98.0	690,682
Malignant Neoplasm of Prostate	185	14,027	3,040,185	1,825,453	99.5	1,441,571
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	142,497	6,842,652	3,876,877	97.4	3,057,576
Thyroiditis	244	11,294	490,924	234,640	98.3	197,926
Diabetes Mellitus	250	75,399	3,442,084	2,259,110	96.6	1,740,228
Disorders of Lipoid Metabolism	272	36,693	1,395,253	592,223	98.1	487,197
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	6,736	486,611	276,912	99.4	220,415
Diseases of the Blood and Blood-Forming Organs (MDC 4)	280-289	39,190	2,844,133	1,524,119	99.6	1,239,041
Other and Unspecified Anemias	285	19,346	1,564,533	834,619	99.6	679,176
Mental Disorders (MDC 5)	290-319	33,592	3,192,690	2,218,231	98.0	1,370,392
Schizophrenic Disorders	295	5,985	485,404	327,716	99.4	201,671
Affective Psychoses	296	10,032	982,852	700,273	97.1	409,741
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	71,332	14,851,626	7,767,149	98.8	5,874,397
Other Retinal Disorders	362	7,731	1,555,039	1,030,437	99.4	785,466
Glaucoma	365	10,033	1,051,368	715,843	98.5	514,737
Cataract	366	15,833	7,342,687	3,133,782	99.0	2,399,605

See footnotes at end of table.

Table 63—Continued

Services, Submitted and Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2001

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Services in Thousands	Submitted Charges in Thousands	Allowed Charges: Amount in Thousands	Allowed Charges: Percent of Charges Assigned	Program Payments in Thousands
Diseases of the Circulatory System (MDC 7)	390-459	215,936	$26,678,720	$13,045,891	98.8	$10,047,654
Essential Hypertension	401	49,644	2,676,758	1,750,882	97.4	1,246,478
Acute Myocardial Infarction	410	4,570	789,593	351,031	98.8	277,068
Other Acute and Subacute Forms of Ischemic Heart Disease	411	4,358	1,069,755	406,740	99.4	320,049
Angina Pectoris	413	5,321	920,395	418,231	99.3	325,409
Other Forms of Chronic Ischemic Heart Disease	414	30,888	5,779,593	2,486,801	99.1	1,927,218
Other Diseases of Endocardium	424	7,194	1,476,354	600,180	99.0	469,735
Cardiac Dysrhythmias	427	31,108	2,746,829	1,376,500	98.8	1,071,206
Heart Failure	428	25,425	2,541,269	1,435,437	99.3	1,125,594
Ill-Defined Descriptions and Complications of Heart Disease	429	4,955	394,639	183,245	98.6	140,637
Acute, But Ill-Defined, Cerebrovascular Disease	436	9,461	1,145,086	720,353	99.1	564,494
Diseases of the Respiratory System (MDC 8)	460-519	110,182	10,172,201	6,141,197	99.3	4,727,623
Acute Bronchitis and Bronchiolitis	466	4,647	279,210	196,257	97.7	135,035
Allergic Rhinitis	477	16,349	269,319	206,829	97.1	151,510
Pneumonia, Organism Unspecified	486	8,992	824,767	493,892	99.3	386,022
Asthma	493	8,260	580,993	379,236	99.0	287,959
Other Diseases of Lung	518	10,353	1,304,592	724,092	99.6	573,316
Diseases of the Digestive System (MDC 9)	520-579	35,670	7,068,730	3,063,907	99.1	2,384,283
Diseases of the Genitourinary System (MDC 10)	580-629	72,992	7,825,845	3,907,244	99.2	3,056,770
Chronic Renal Failure	585	22,420	2,511,305	1,317,745	99.9	1,045,488
Calculus of Kidney and Ureter	592	1,586	351,317	124,680	99.3	97,391
Other Disorders of Urethra and Urinary Tract	599	16,051	981,320	522,232	99.2	413,218
Hyperplasia of Prostate	600	6,527	622,897	319,466	98.9	247,327
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	45,185	3,118,796	2,074,682	98.2	1,555,489
Other Dermatoses	702	18,646	822,703	600,715	97.3	443,718
Chronic Ulcer of Skin	707	6,150	826,557	475,972	99.5	373,080

See footnotes at end of table.

Table 63—Continued

Services, Submitted and Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2001

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Services in Thousands	Submitted Charges in Thousands	Allowed Charges: Amount in Thousands	Allowed Charges: Percent of Charges Assigned	Program Payments in Thousands
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	136,759	$15,409,746	$7,828,665	97.8	$6,006,736
Rheumatoid Arthritis and Ofher Inflammatory Polyarthrophathies	714	7,699	612,279	402,703	98.2	312,266
Osteoarthrosis and Allied Disorders	715	21,462	3,352,317	1,657,987	98.6	1,277,425
Other and Unspecified Arthropathies	716	3,407	288,032	171,968	98.0	129,457
Other and Unspecified Disorders of Joint	719	19,135	1,360,255	749,460	98.7	573,143
Other and Unspecified Disorders of Back	724	20,577	2,814,901	1,267,730	98.3	977,874
Peripheral Enthesopathies and Allied Syndromes	726	9,093	649,812	389,701	98.7	294,529
Other Disorders of Soft Tissues	729	9,132	738,062	403,216	98.4	305,648
Non-Allopathic Lesions, Not Elsewhere Classified	739	11,535	429,684	374,388	83.4	277,535
Congenital Anomalies (MDC 14)	740-759	2,029	398,676	181,420	98.6	140,398
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	150,015	16,372,039	8,427,895	99.0	6,557,525
General Symptoms	780	31,869	3,273,439	1,768,413	98.8	1,388,884
Symptoms Involving Respiratory System and Other Chest Symptoms	786	45,674	4,973,711	2,511,562	98.8	1,943,319
Symptoms Involving Digestive System	787	10,910	1,280,038	685,768	99.4	536,730
Symptoms Involving Urinary System	788	8,350	620,357	340,033	98.9	262,878
Sudden Death, Cause Unknown	798	15	2,850	1,526	99.2	1,166
Other Ill-Defined and Unknown Causes of Morbidity and Mortality	799	3,191	373,662	224,781	99.3	178,380
Injury and Poisoning (MDC 17)	800-999	46,006	7,415,898	3,554,306	98.7	2,767,704
Fracture of Neck of Femur	820	4,254	1,216,151	531,937	99.4	420,402
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	V01-V82	98,351	4,472,475	2,388,153	97.2	1,932,373
Need for Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	V04	21,642	210,328	121,965	99.0	120,849
Special Investigations and Examinations	V72	5,744	225,803	104,871	98.6	86,040

[1]ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification.* Only the first listed or principal diagnosis has been used.

[2]Specific diagnostic categories were selected for presentation based on amount of allowed charges.

NOTES: Numbers may not add to totals because of rounding. MDCs 11 {Complications of Pregnancy, Childbirth, and the Puerperium (630-676)} and 15 {Certain Conditions Originating in the Perinatal Period (780-799)} were not shown separately (but are included in the totals) because these diagnostic conditions are, for the most part, not applicable to Medicare beneficiaries.
E Codes {Supplementary Classifications of External Causes of Injury and Poisoning (E800-E999)} are also not broken out separately. Medicare program payments represent fee-for-service only.
Due to differences in timing and edits, the physician/supplier claims included in this table will cause the number of services and associated charges and payments to differ slightly from other tables on Medicare physician/supplier utilization.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Research, Development, and Information.