Table 55

Medicare Supplementary Medical Insurance Disbursements for Benefits, by Type of Provider: Selected Calendar Years 1970-2002

Type of Provider	1970	1975	1980	1985	1990
			Amount 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 1980 Omnibus Budget Reconciliation Act legislation, most home health agency services were covered under the hospital insurance program beginning in 1981. The 1997 Balanced Budget Act 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 1991-2002, are excluded from the totals.

NOTES: Numbers may not add to totals because of rounding. --- not available. HI is health insurance. SMI is supplemental medical insurance.

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

ledicare Supplementary Medical Insurance Disbursements for Benefits, by Type of Provide
Selected Calendar Years 1970-2002

1995	1997	1999	2000	2001	2002
		Amount in Millions			
$64,972	$72,757	---	---	---	---
40,474	42,411	---	---	---	---
15,625	17,416	---	---	---	---
6,608	10,980	---	---	---	---
200	228	---	---	---	---
2,065	1,722	---	---	---	---
$64,970	$72,740	$81,287	$90,552	$102,709	$112,042
31,660	31,898	33,354	36,963	42,034	44,804
3,689	4,236	4,279	4,718	5,439	6,553
2,807	2,385	2,078	2,226	2,436	2,787
4,530	5,586	6,451	7,408	8,904	10,869
8,666	9,358	8,790	8,490	12,804	13,532
229	239	1,179	4,359	4,450	5,089
1,448	1,503	1,680	1,782	1,941	2,227
5,331	6,575	5,773	6,248	7,141	8,683
6,610	10,962	17,702	18,358	17,560	17,497
100.0	100.0	---	---	---	---
62.3	58.3	---	---	---	---
24.0	23.9	---	---	---	---
10.2	15.1	---	---	---	---
0.3	0.3	---	---	---	---
3.2	2.4	---	---	---	---
100.0	100.0	100.0	100.0	100.0	100.0
48.7	43.9	41.0	40.8	40.9	40.0
5.7	5.8	5.3	5.2	5.3	5.8
4.3	3.3	2.6	2.5	2.4	2.5
7.0	7.7	7.9	8.2	8.7	9.7
13.3	12.9	10.8	9.4	12.5	12.1
0.4	0.3	1.5	4.8	4.3	4.5
2.2	2.1	2.1	2.0	1.9	2.0
8.2	9.0	7.1	6.9	7.0	7.7
10.2	15.1	21.8	20.3	17.1	15.6

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 2002

Demographic Characteristic	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	31,754,480	1,481,154	46.6	$169,663,267	$5,343
Sex					
Male	13,178,460	613,552	46.6	74,494,076	5,653
Female	18,576,020	867,602	46.7	95,169,191	5,123
Age					
Under 65 Years	4,290,340	201,279	46.9	23,884,259	5,567
65-74 Years	12,837,020	533,935	41.6	62,893,451	4,899
75-84 Years	10,429,860	536,118	51.4	61,481,103	5,895
85 Years or Over	4,197,260	209,822	50.0	21,404,454	5,100
Race[3]					
White	27,063,420	1,248,127	46.1	142,808,756	5,277
Other	4,534,460	226,845	50.0	26,149,016	5,767
Medicare Status[4]					
Aged	27,277,660	1,255,998	46.0	142,922,732	5,240
Disabled	4,216,660	180,573	42.8	21,092,898	5,002
ESRD	260,160	44,583	171.4	5,647,637	21,708

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 2002

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	$83,181,299	$2,620	$82,264,252	98.9	$64,253,710	$2,073	$64,359	$24
Sex								
Male	36,216,397	2,748	35,842,961	99.0	28,004,629	2,192	26,646	25
Female	46,964,902	2,528	46,421,291	98.8	36,249,082	1,990	37,713	23
Age								
Under 65 Years	11,656,933	2,717	11,608,158	99.6	8,809,902	2,147	3,190	24
65-74 Years	29,953,095	2,333	29,578,604	98.7	23,083,827	1,850	26,026	23
75-84 Years	30,296,795	2,905	29,923,255	98.8	23,604,510	2,297	26,528	25
85 Years or Over	11,274,475	2,686	11,154,235	98.9	8,755,472	2,117	8,615	25
Race[3]								
White	69,852,939	2,581	68,977,041	98.7	53,899,799	2,038	61,604	24
Other	12,983,332	2,863	12,945,358	99.7	10,088,776	2,294	2,543	20
Medicare Status[4]								
Aged	70,189,833	2,573	69,325,020	98.8	54,381,766	2,036	60,927	24
Disabled	10,409,611	2,469	10,360,728	99.5	7,806,941	1,939	3,189	24
ESRD	2,581,855	9,924	2,578,504	99.9	2,065,004	8,029	243	26

[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).

NOTES: Medicare charges and program payments represent fee-for-service utilization only. ESRD is end stage renal disease. MSC Is Medicare status code.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

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 2002

Type of Service	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	31,754,480	1,481,154	46.6	$169,663,267	$5,343
Medical Care	30,727,800	534,490	17.4	46,515,438	1,514
Surgery	18,301,160	89,108	4.9	37,859,518	2,069
Consultation	11,901,380	29,344	2.5	5,441,957	457
Diagnostic X-Ray	21,092,780	121,438	5.8	16,482,782	781
Diagnostic Laboratory	25,850,160	421,382	16.3	20,725,464	802
Radiation Therapy	1,129,820	11,110	9.8	3,506,494	3,104
Anesthesia	5,746,840	11,033	1.9	6,619,857	1,152
Assistance at Surgery	838,040	1,342	1.6	1,328,165	1,585
Other Medical Services	1,185,220	13,254	11.2	2,079,955	1,755
Ambulatory Surgical Center	2,206,340	3,468	1.6	5,103,978	2,313
Renal Supplies in the Home	20,420	857	42.0	317,494	15,548
ESRD Capitation Payment	268,140	2,275	8.5	921,966	3,438
Psychological Therapy	2,591,380	17,418	6.7	1,619,143	625
Occupational Therapy	25,460	1,033	40.6	37,758	1,483
Pneumococcal Vaccine	12,853,880	27,056	2.1	297,128	23
Physical Therapy	708,000	30,353	42.9	1,048,223	1,481
Durable Medical Equipment[4]	7,496,820	100,455	13.4	12,046,220	1,607
Other[5]	NA	65,738	NA	7,711,727	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]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.

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 Data Extract System; 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 2002

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
$83,181,299	$2,620	$82,264,252	98.9	$64,253,710	$2,073	$64,359	$24
30,354,064	988	29,920,317	98.6	22,640,463	775	30,995	17
13,481,251	737	13,360,629	99.1	10,550,529	586	9,763	28
3,503,493	294	3,475,026	99.2	2,700,881	229	2,349	16
6,544,061	310	6,500,840	99.3	5,088,975	250	3,676	14
7,418,913	287	7,384,157	99.5	6,379,384	249	2,880	8
1,138,670	1,008	1,132,906	99.5	904,354	804	514	79
1,514,482	264	1,510,657	99.7	1,197,989	209	330	18
198,145	236	197,184	99.5	157,238	188	83	20
1,214,584	1,025	1,214,485	99.9	964,933	818	3	4
1,892,856	858	1,892,800	99.9	1,498,513	680	5	84
150,484	7,369	150,469	99.9	119,988	5,893	1	5
546,993	2,040	546,802	99.9	430,871	1,611	17	84
1,176,322	454	1,140,450	97.0	548,165	227	2,407	35
27,396	1,076	27,334	99.8	21,606	855	1	11
168,088	13	167,406	99.6	167,811	13	45	0
752,819	1,063	745,768	99.1	594,159	844	408	67
8,151,991	1,087	8,010,641	98.3	6,386,691	863	6,888	14
4,946,687	NA	4,886,381	98.8	3,901,160	NA	3,994	NA

Table 58

Persons Served, Services, Submitted and Allowed Charges, Program Payments for Medicare Physician and Supplier Services, by Place of Service: Calendar Year 2002

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	31,754,480	1,481,154	46.6	$169,663,267	$5,343
Office	29,559,240	722,651	24.4	62,169,155	2,103
Home	8,205,060	125,405	15.3	13,892,772	1,693
Inpatient Hospital	8,277,020	202,650	24.5	40,697,460	4,917
Outpatient Hospital[4]	17,043,400	89,400	5.2	20,877,726	1,225
Emergency Room Hospital[4]	9,789,240	34,999	3.6	5,511,885	563
Ambulatory Surgical Center	2,538,820	8,894	3.5	9,190,048	3,620
Skilled Nursing Care Facility	2,199,400	26,034	11.8	1,931,728	878
Nursing Home	1,789,020	22,612	12.6	1,187,862	664
Hospice	4,960	11	2.3	1,056	213
Ambulance[5]	3,956,340	40,554	10.3	4,622,029	1,168
Independent Laboratory	15,642,520	180,313	11.5	7,351,976	470
All Other[6]	NA	27,631	NA	2,229,570	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 2002

	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	$83,181,299	100.0	$2,620	$82,264,252	98.9	$64,253,710	100.0	$2,073
Office	37,889,952	45.6	1,282	37,284,440	98.4	28,396,310	44.2	994
Home	9,346,246	11.2	1,139	9,170,932	98.1	7,316,287	11.4	904
Inpatient Hospital	15,607,466	18.8	1,886	15,537,088	99.5	12,356,031	19.2	1,501
Outpatient Hospital[4]	6,350,791	7.6	373	6,321,308	99.5	4,938,280	7.7	297
Emergency Room Hospital[4]	2,048,027	2.5	209	2,045,682	99.9	1,582,900	2.5	165
Ambulatory Surgical Center	3,179,272	3.8	1,252	3,171,637	99.8	2,514,365	3.9	992
Skilled Nursing Care Facility	1,310,729	1.6	596	1,308,348	99.8	979,593	1.5	455
Nursing Home	851,146	1.0	476	849,942	99.9	622,165	1.0	354
Hospice	674	(7)	136	674	100.0	514	(7)	106
Ambulance[5]	2,903,690	3.5	734	2,883,800	99.3	2,302,113	3.6	582
Independent Laboratory	2,388,067	2.9	153	2,387,656	99.9	2,256,993	3.5	145
All Other[6]	1,305,239	1.6	NA	1,302,745	99.8	988,159	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 one 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 Data Extract System; 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 2002

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	31,754,480	1,481,154	100.0	46.6	$169,663,267	100.0	$5,343
Total Physicians	31,268,260	1,020,200	68.9	32.6	127,863,925	75.4	4,089
General Practice	3,214,620	22,298	1.5	6.9	1,528,383	0.9	475
General Surgery	4,362,100	15,132	1.0	3.5	5,256,286	3.1	1,205
Allergy and Immunology	372,340	11,405	0.8	30.6	224,278	0.1	602
Otology, Laryngology, Rhinology	2,830,580	12,911	0.9	4.6	1,478,321	0.9	522
Anesthesiology	5,272,300	13,131	0.9	2.5	5,886,985	3.5	1,117
Cardiology	10,324,800	96,058	6.5	9.3	14,192,620	8.4	1,375
Dermatology	5,011,180	33,232	2.2	6.6	2,391,809	1.4	477
Family Practice	12,745,120	111,107	7.5	8.7	6,314,400	3.7	495
Gastroenterology	4,150,380	15,162	1.0	3.7	3,879,004	2.3	935
Internal Medicine	17,196,000	190,939	12.9	11.1	14,022,665	8.3	815
Manipulative Therapy	92,900	622	(5)	6.7	45,597	(5)	491
Neurology	3,004,020	14,555	1.0	4.8	1,889,216	1.1	629
Neurologiclal Surgery	655,940	2,019	0.1	3.1	1,570,017	0.9	2,394
Obstetrics and Gynecology	2,582,040	7,449	0.5	2.9	1,055,249	0.6	409
Ophthalmology	11,255,620	37,078	2.5	3.3	8,947,554	5.3	795
Oral Surgery (Dentists Only)	94,460	199	(5)	2.1	40,232	(5)	426
Orthopedic Surgery	4,776,100	29,101	2.0	6.1	6,992,826	4.1	1,464
Pathology	5,936,920	19,470	1.3	3.3	2,076,599	1.2	350
Plastic and Reconstructive Surgery	506,440	1,781	0.1	3.5	686,503	0.4	1,356
Physical Medicine and Rehabilitation	1,222,180	11,948	0.8	9.8	1,070,979	0.6	876
Psychiatry	2,107,140	15,997	1.1	7.6	1,571,625	0.9	746
Colorectal Surgery (Proctology)	246,140	640	(5)	2.6	238,598	0.1	969
Pulmonary Disease	2,646,260	21,149	1.4	8.0	2,173,951	1.3	822
Diagnostic Radiology	19,134,860	88,848	6.0	4.6	11,556,017	6.8	604
Thoracic Surgery	535,620	1,625	0.1	3.0	1,421,627	0.8	2,654
Urology	4,189,480	26,704	1.8	6.4	4,636,448	2.7	1,107
Chiropractic	1,929,740	18,212	1.2	9.4	674,107	0.4	349
Nuclear Medicine	502,400	1,255	0.1	2.5	246,736	0.1	491
Pediatric Medicine	278,220	1,579	0.1	5.7	113,924	0.1	409
Geriatric Medicine	315,740	1,985	0.1	6.3	151,224	0.1	479
Nephrology	1,209,580	24,062	1.6	19.9	2,254,890	1.3	1,864
Optometrist	4,764,940	9,103	0.6	1.9	655,616	0.4	138
Infectious Disease	677,440	6,724	0.5	9.9	625,597	0.4	923
Endocrinology	936,880	6,824	0.5	7.3	438,057	0.3	468
Podiatry	5,673,140	28,106	1.9	5.0	1,838,838	1.1	324

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 2002

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
$83,181,299	100.0	$2,620	$82,264,252	98.9	$64,253,710	100.0	$2,073	$64,359	$24
61,704,454	74.2	1,973	60,982,029	98.8	47,218,044	73.5	1,556	53,751	26
962,450	1.2	299	943,940	98.1	713,688	1.1	232	1,134	16
2,081,752	2.5	477	2,070,294	99.4	1,623,923	2.5	382	938	29
161,800	0.2	435	157,839	97.6	121,918	0.2	338	284	23
731,102	0.9	258	724,343	99.1	549,921	0.9	203	553	15
1,458,054	1.8	277	1,452,849	99.6	1,147,256	1.8	219	449	21
5,912,821	7.1	573	5,877,695	99.4	4,590,163	7.1	454	2,874	29
1,716,731	2.1	343	1,675,307	97.6	1,293,505	2.0	269	3,304	18
4,077,845	4.9	320	4,014,273	98.4	2,962,651	4.6	243	4,964	17
1,495,255	1.8	360	1,480,885	99.0	1,157,190	1.8	283	1,177	28
8,531,877	10.3	496	8,392,928	98.4	6,459,529	10.1	386	11,564	22
27,899	(5)	300	26,276	94.2	21,099	(5)	235	101	22
1,073,936	1.3	357	1,063,902	99.1	825,234	1.3	281	848	23
428,967	0.5	654	424,347	98.9	335,939	0.5	525	401	49
516,399	0.6	200	503,736	97.5	390,757	0.6	156	966	14
4,529,514	5.4	402	4,476,160	98.8	3,404,650	5.3	319	4,183	19
22,409	(5)	237	20,013	89.3	17,223	(5)	188	147	19
2,739,498	3.3	574	2,721,843	99.4	2,118,258	3.3	458	1,471	39
780,690	0.9	131	776,685	99.5	616,850	1.0	105	353	15
263,944	0.3	521	260,763	98.8	206,227	0.3	419	253	35
597,996	0.7	489	594,977	99.5	468,891	0.7	389	242	27
1,030,227	1.2	489	992,894	96.4	642,967	1.0	316	2,501	41
99,225	0.1	403	97,896	98.7	76,622	0.1	317	112	34
1,293,939	1.6	489	1,288,247	99.6	1,008,851	1.6	388	484	24
4,185,085	5.0	219	4,155,231	99.3	3,266,617	5.1	176	2,558	28
445,500	0.5	832	443,882	99.6	351,888	0.5	667	137	58
2,733,171	3.3	652	2,720,411	99.5	2,126,058	3.3	515	1,100	25
559,846	0.7	290	461,848	82.5	412,888	0.6	224	5,093	15
101,233	0.1	201	99,059	97.9	79,595	0.1	161	193	28
65,926	0.1	237	65,471	99.3	49,972	0.1	186	26	16
101,091	0.1	320	99,321	98.2	76,172	0.1	247	156	30
1,255,415	1.5	1,038	1,251,992	99.7	986,366	1.5	825	305	26
555,137	0.7	117	541,217	97.5	384,348	0.6	90	249	6
366,278	0.4	541	364,573	99.5	288,356	0.4	430	147	22
275,325	0.3	294	267,540	97.2	213,445	0.3	232	644	18
1,304,930	1.6	230	1,293,615	99.1	973,701	1.5	177	609	11

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 2002

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	1,155,200	11,888	0.8	10.3	$999,058	0.6	$865
Vascular Surgery	986,220	2,798	0.2	2.8	1,090,494	0.6	1,106
Cardiac Surgery	279,880	824	0.1	2.9	995,960	0.6	3,559
Hematology/Oncology	1,342,580	48,361	3.3	36.0	5,702,801	3.4	4,248
Medical Oncology	593,240	19,930	1.3	33.6	2,556,698	1.5	4,310
Radiation Oncology	819,100	9,792	0.7	12.0	2,924,591	1.7	3,570
Emergency Medicine	7,560,260	17,538	1.2	2.3	3,602,485	2.1	477
All Other Physician [6]	NA	10,663	0.7	NA	1,845,062	1.1	NA
Group Practice	3,291,040	24,987	1.7	7.6	2,958,754	1.7	899
Total Non-Physician	8,862,940	65,443	4.4	7.4	10,866,321	6.4	1,226
Total Suppliers	21,330,560	370,523	25.0	17.4	27,974,123	16.5	1,311
Invalid Physician/Supplier Specialty Code	420	2	(5)	4.8	145	(5)	344

[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 one 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 Data Extract System; 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 2002

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
$663,998	0.8	$575	$650,071	97.9	$510,044	0.8	$451	$1,191	$22
398,655	0.5	404	397,924	99.8	312,421	0.5	323	65	36
304,411	0.4	1,088	300,854	98.8	241,280	0.4	873	317	154
3,261,309	3.9	2,429	3,257,809	99.9	2,587,747	4.0	1,951	298	35
1,374,139	1.7	2,316	1,373,051	99.9	1,085,581	1.7	1,856	97	24
987,581	1.2	1,206	983,311	99.6	782,234	1.2	983	382	87
1,414,729	1.7	187	1,412,868	99.9	1,095,247	1.7	148	153	10
816,367	1.0	NA	803,889	98.5	640,774	1.0	NA	729	NA
1,340,028	1.6	407	1,338,414	99.9	970,290	1.5	326	134	18
4,565,003	5.5	515	4,541,660	99.5	3,414,846	5.3	394	1,317	11
15,571,736	18.7	730	15,402,071	98.9	12,650,472	19.7	595	9,157	16
77	(5)	183	77	100.0	58	(5)	146	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 2002

Area of Residence	Persons Served[1]		Services		Submitted Charges	
	Number	Per 1,000 Enrollees[2]	Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
All Areas[5]	31,754,480	975	1,481,154	47	$169,663,267	$5,343
United States[6]	31,330,520	977	1,459,826	47	168,271,355	5,371
Northeast	6,123,620	973	301,450	49	34,204,179	5,586
Midwest	8,095,300	990	339,388	42	38,643,245	4,774
South	12,215,340	977	592,314	49	69,522,885	5,691
West	4,896,260	959	226,674	46	25,901,047	5,290
New England	1,650,580	974	71,364	43	8,317,662	5,039
Connecticut	450,580	985	21,035	47	2,564,783	5,692
Maine	202,020	957	7,483	37	841,496	4,165
Massachusetts	660,540	976	29,769	45	3,430,607	5,194
New Hampshire	155,100	958	5,625	36	639,807	4,125
Rhode Island	98,240	981	4,888	50	509,422	5,185
Vermont	84,100	965	2,563	31	331,546	3,942
Middle Atlantic	4,473,040	972	230,086	51	25,886,517	5,787
New Jersey	1,011,040	970	55,796	55	6,429,167	6,359
New York	2,011,940	969	107,242	53	11,447,357	5,690
Pennsylvania	1,450,060	979	67,047	46	8,009,993	5,524
East North Central	5,601,420	985	240,678	43	28,264,744	5,046
Illinois	1,403,080	969	60,939	43	7,302,881	5,205
Indiana	788,500	992	31,745	40	3,918,330	4,969
Michigan	1,304,220	985	59,934	46	6,517,281	4,997
Ohio	1,382,140	992	60,012	43	7,069,594	5,115
Wisconsin	723,480	993	28,048	39	3,456,658	4,778
West North Central	2,493,880	1,001	98,711	40	10,378,501	4,162
Iowa	446,340	1,010	17,221	39	1,708,111	3,827
Kansas	348,620	1,003	14,903	43	1,675,897	4,807
Minnesota	558,520	1,019	19,253	35	2,058,651	3,686
Missouri	698,220	987	29,859	43	3,284,210	4,704
Nebraska	235,540	998	9,372	40	944,402	4,010
North Dakota	96,700	994	3,710	38	366,531	3,790
South Dakota	109,940	983	4,393	40	340,698	3,099
South Atlantic	6,548,520	979	322,326	49	38,026,130	5,807
Delaware	109,580	969	5,314	49	665,715	6,075
District of Columbia	54,300	907	2,584	48	327,758	6,036
Florida	2,181,160	984	127,902	59	14,914,541	6,838
Georgia	858,940	977	38,162	44	4,679,460	5,448
Maryland	575,920	966	27,690	48	3,582,055	6,220
North Carolina	1,075,260	989	47,526	44	5,503,768	5,119
South Carolina	559,500	984	25,585	46	3,060,258	5,470
Virginia	838,220	975	35,326	42	3,891,308	4,642
West Virginia	295,640	969	12,237	41	1,401,266	4,740

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 2002

Allowed Charges				Program Payments			Balance Billing	
Amount in Thousands	Percent	Per Person Served[1]	Percent of Charges Assigned[3]	Amount in Thousands	Percent	Per Person Served[4]	Amount in Thousands	Per Person With Liability
$83,181,299	100.0	$2,620	98.9	$64,253,710	100.0	$2,073	$64,359	$24
82,158,751	98.8	2,622	98.9	63,462,760	98.8	2,075	64,271	24
17,412,551	20.9	2,844	98.8	13,467,342	21.0	2,247	13,179	26
18,243,209	21.9	2,254	98.6	14,018,692	21.8	1,777	17,277	24
33,143,109	39.8	2,713	99.2	25,636,707	39.9	2,150	18,531	19
13,359,883	16.1	2,729	98.5	10,340,021	16.1	2,165	15,285	31
4,052,852	4.9	2,455	99.4	3,108,716	4.8	1,925	1,654	22
1,229,193	1.5	2,728	98.8	947,456	1.5	2,138	1,066	30
403,824	0.5	1,999	99.6	308,159	0.5	1,572	113	19
1,709,442	2.1	2,588	99.7	1,310,075	2.0	2,022	198	13
311,665	0.4	2,009	99.1	237,442	0.4	1,577	177	16
248,844	0.3	2,533	99.8	192,201	0.3	2,000	17	10
149,884	0.2	1,782	99.1	113,384	0.2	1,392	83	19
13,359,699	16.1	2,987	98.6	10,358,626	16.1	2,365	11,525	26
3,346,457	4.0	3,310	98.0	2,604,460	4.1	2,621	4,793	26
6,187,654	7.4	3,075	98.4	4,795,437	7.5	2,429	6,038	30
3,825,588	4.6	2,638	99.5	2,958,729	4.6	2,096	693	14
13,243,778	15.9	2,364	98.9	10,190,649	15.9	1,866	9,568	22
3,376,883	4.1	2,407	98.2	2,600,240	4.0	1,900	4,237	26
1,744,495	2.1	2,212	98.7	1,333,976	2.1	1,742	1,389	17
3,431,482	4.1	2,631	99.4	2,651,781	4.1	2,078	1,445	23
3,302,989	4.0	2,390	99.5	2,541,517	4.0	1,887	661	14
1,387,928	1.7	1,918	98.1	1,063,135	1.7	1,508	1,837	24
4,999,431	6.0	2,005	97.9	3,828,043	6.0	1,579	7,708	27
838,571	1.0	1,879	96.8	639,037	1.0	1,473	1,957	37
794,361	1.0	2,279	99.0	611,832	1.0	1,797	507	19
969,979	1.2	1,737	98.5	738,653	1.1	1,363	934	23
1,544,761	1.9	2,212	98.7	1,187,516	1.8	1,748	1,301	19
473,090	0.6	2,009	96.5	361,779	0.6	1,585	1,332	28
178,928	0.2	1,850	97.0	136,917	0.2	1,450	439	40
199,741	0.2	1,817	92.5	152,309	0.2	1,432	1,238	36
18,380,333	22.1	2,807	99.2	14,232,682	22.2	2,221	10,971	20
308,944	0.4	2,819	99.1	239,363	0.4	2,232	185	17
152,803	0.2	2,814	98.1	118,490	0.2	2,224	242	43
7,817,436	9.4	3,584	99.3	6,109,786	9.5	2,849	3,623	21
2,133,483	2.6	2,484	99.2	1,642,027	2.6	1,960	1,296	19
1,688,814	2.0	2,932	98.9	1,306,657	2.0	2,314	1,368	24
2,429,683	2.9	2,260	98.8	1,862,418	2.9	1,771	2,270	19
1,378,267	1.7	2,463	99.2	1,059,633	1.6	1,937	763	15
1,849,058	2.2	2,206	99.1	1,417,101	2.2	1,734	1,037	20
621,845	0.7	2,103	99.5	477,207	0.7	1,667	187	17

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 2002

	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	2,359,700	984	109,102	46	$12,396,123	$5,253
Alabama	621,760	988	28,194	45	3,123,135	5,023
Kentucky	578,000	981	26,304	46	2,836,918	4,908
Mississippi	399,780	978	17,897	45	2,096,114	5,243
Tennessee	760,160	988	36,707	48	4,339,956	5,709
West South Central	3,307,120	968	160,886	49	19,100,633	5,776
Arkansas	408,280	977	18,868	46	1,941,345	4,755
Louisiana	492,460	972	23,403	48	2,781,822	5,649
Oklahoma	440,600	975	18,501	42	2,028,321	4,604
Texas	1,965,780	963	100,114	51	12,349,145	6,282
Mountain	1,632,840	971	65,631	40	7,669,423	4,697
Arizona	440,420	959	20,621	47	2,312,373	5,250
Colorado	314,780	987	12,353	39	1,434,400	4,557
Idaho	153,280	1,016	5,075	33	510,801	3,332
Montana	130,220	973	4,524	35	474,849	3,647
Nevada	156,860	935	8,054	51	1,143,335	7,289
New Mexico	179,220	935	6,360	36	802,738	4,479
Utah	195,380	998	6,457	33	747,270	3,825
Wyoming	62,680	978	2,188	35	243,656	3,887
Pacific	3,263,420	954	161,044	49	18,231,624	5,587
Alaska	37,180	884	1,143	31	180,968	4,867
California	2,238,500	940	123,045	55	13,972,499	6,242
Hawaii	110,720	1,073	4,087	37	429,506	3,879
Oregon	319,020	1,024	10,694	34	1,179,592	3,698
Washington	558,000	954	22,074	40	2,469,058	4,425
Outlying Areas[7]	423,960	879	21,328	50	1,391,912	3,283

[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. SMI is supplemental medical insurance.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

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 2002

Allowed Charges				Program Payments			Balance Billing	
Amount in Thousands	Percent	Per Person Served[1]	Percent of Charges Assigned[3]	Amount in Thousands	Percent	Per Person Served[4]	Amount in Thousands	Per Person With Liability
$5,792,259	7.0	$2,455	99.4	$4,453,529	6.9	$1,938	$2,297	$16
1,551,802	1.9	2,496	99.6	1,195,719	1.9	1,975	430	16
1,339,442	1.6	2,317	99.2	1,029,893	1.6	1,835	659	17
949,560	1.1	2,375	99.5	731,254	1.1	1,884	381	13
1,951,454	2.3	2,567	99.4	1,496,663	2.3	2,013	827	18
8,970,517	10.8	2,712	99.2	6,950,496	10.8	2,159	5,263	18
958,452	1.2	2,348	99.5	737,579	1.1	1,863	303	19
1,338,153	1.6	2,717	99.4	1,035,771	1.6	2,171	530	15
1,051,680	1.3	2,387	99.0	809,925	1.3	1,891	738	19
5,622,231	6.8	2,860	99.1	4,367,221	6.8	2,278	3,692	19
3,892,383	4.7	2,384	97.6	2,994,011	4.7	1,888	7,420	34
1,219,049	1.5	2,768	96.5	947,443	1.5	2,201	3,492	54
718,822	0.9	2,284	97.9	552,644	0.9	1,807	1,173	29
284,340	0.3	1,855	95.1	217,218	0.3	1,461	1,109	24
260,588	0.3	2,001	98.1	198,831	0.3	1,584	330	22
516,324	0.6	3,292	99.5	397,461	0.6	2,609	196	27
371,722	0.4	2,074	98.3	284,360	0.4	1,648	456	24
393,530	0.5	2,014	99.2	298,178	0.5	1,566	181	19
128,007	0.2	2,042	95.2	97,877	0.2	1,636	482	29
9,467,499	11.4	2,901	98.9	7,346,009	11.4	2,303	7,866	29
74,410	0.1	2,001	97.7	56,509	0.1	1,571	140	27
7,276,502	8.7	3,251	99.1	5,669,767	8.8	2,587	5,253	32
207,846	0.2	1,877	98.9	156,830	0.2	1,448	162	25
616,849	0.7	1,934	97.9	471,672	0.7	1,519	965	24
1,291,892	1.6	2,315	98.6	991,232	1.5	1,822	1,346	25
1,022,547	1.2	2,412	99.7	790,950	1.2	1,936	87	13

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 2002

Area of Residence	Assignment Rate[1]			Ratio of Submitted Charges to Allowed Charges		
	1983	1988	2002	1983	1988	2002
United States	0.51	0.77	0.99	1.31	1.78	2.05
Alabama	0.56	0.84	0.99	1.35	1.92	2.01
Alaska	0.46	0.71	0.98	1.33	1.82	2.43
Arizona	0.34	0.70	0.97	1.30	1.58	1.90
Arkansas	0.58	0.82	0.99	1.32	1.85	2.03
California	0.53	0.79	0.99	1.28	1.74	1.92
Colorado	0.42	0.66	0.98	1.37	1.67	2.00
Connecticut	0.44	0.74	0.99	1.31	1.86	2.09
Delaware	0.75	0.80	0.99	1.28	2.05	2.15
District of Columbia	0.76	0.86	0.98	1.33	2.07	2.14
Florida	0.34	0.76	0.99	1.29	1.72	1.91
Georgia	0.55	0.75	0.99	1.30	1.89	2.19
Hawaii	0.42	0.75	0.99	1.34	2.02	2.07
Idaho	0.22	0.40	0.95	1.32	1.43	1.80
Illinois	0.36	0.67	0.98	1.29	1.65	2.16
Indiana	0.28	0.87	0.99	1.33	1.85	2.25
Iowa	0.33	0.63	0.97	1.34	1.66	2.04
Kansas	0.48	0.82	0.99	1.30	1.82	2.11
Kentucky	0.39	0.89	0.99	1.29	1.84	2.12
Louisiana	0.37	0.79	0.99	1.37	1.80	2.08
Maine	0.73	0.84	0.99	1.28	1.90	2.08
Maryland	0.72	0.87	0.99	1.30	1.98	2.12
Massachusetts	0.85	0.93	0.99	1.28	1.92	2.01
Michigan	0.79	0.93	0.99	1.32	1.77	1.90
Minnesota	0.27	0.53	0.99	1.30	1.66	2.12
Mississippi	0.58	0.72	0.99	1.37	1.85	2.21
Missouri	0.44	0.76	0.99	1.28	1.72	2.13
Montana	0.19	0.53	0.98	1.27	1.42	1.82
Nebraska	0.19	0.54	0.97	1.28	1.59	2.00
Nevada	0.61	0.86	0.99	1.30	1.92	2.21
New Hampshire	0.51	0.69	0.99	1.32	1.86	2.05
New Jersey	0.58	0.70	0.98	1.34	1.67	1.92
New Mexico	0.41	0.70	0.98	1.34	1.68	2.16
New York	0.62	0.89	0.98	1.37	1.71	1.85
North Carolina	0.49	0.75	0.99	1.31	1.95	2.27
North Dakota	0.29	0.47	0.97	1.27	1.80	2.05

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 2002

Area of Residence	Assignment Rate[1]			Ratio of Submitted Charges to Allowed Charges		
	1983	1988	2002	1983	1988	2002
Ohio	0.34	0.73	0.99	1.32	1.82	2.14
Oklahoma	0.30	0.63	0.99	1.37	1.65	1.93
Oregon	0.25	0.57	0.98	1.28	1.55	1.91
Pennsylvania	0.76	0.88	0.99	1.28	1.94	2.09
Rhode Island	0.90	0.90	0.99	1.39	2.05	2.05
South Carolina	0.57	0.76	0.99	1.32	1.89	2.22
South Dakota	0.18	0.46	0.93	1.29	1.46	1.71
Tennessee	0.46	0.75	0.99	1.34	1.85	2.22
Texas	0.53	0.75	0.99	1.37	1.75	2.20
Utah	0.45	0.73	0.99	1.27	1.67	1.90
Vermont	0.58	0.78	0.99	1.31	2.01	2.21
Virginia	0.56	0.73	0.99	1.31	1.91	2.10
Washington	0.30	0.57	0.99	1.27	1.54	1.91
West Virginia	0.51	0.81	0.99	1.39	1.96	2.25
Wisconsin	0.32	0.61	0.98	1.25	1.67	2.49
Wyoming	0.26	0.46	0.95	1.32	1.50	1.90

[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 Data Extract System; 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 2002

BETOS Classification	BETOS Codes	Persons Served[1]	Services		
			Number in Thousands	Percent	Per Person Served[1]
Total All BETOS Groups	Total	31,754,480	1,481,154	100.0	47
Office Visits - Established	M1B	27,543,520	199,500	13.5	7
Hospital Visit - Subsequent	M2B	6,732,360	92,470	6.2	14
Other Drugs	O1E	5,372,320	53,182	3.6	10
Consultations	M6	11,793,960	28,296	1.9	2
Chemotherapy	O1D	569,320	21,377	1.4	38
Ambulance	O1A	3,965,780	39,731	2.7	10
Oxygen and Supplies	D1C	1,114,540	15,728	1.1	14
Minor Procedures - Other (MFS)	P6C	6,939,440	63,414	4.3	9
Eye Procedure - Cataract Removal/Lens Insertion	P4B	1,319,180	3,119	0.2	2
Specialist - Ophthalmology	M5C	12,433,140	27,111	1.8	2
Other Durable Medical Equipment	D1E	5,044,980	46,193	3.1	9
Lab Tests, Other (Non-MFS)	T1H	18,373,420	151,551	10.2	8
Emergency Room Visit	M3	9,192,400	17,361	1.2	2
Anesthesia	P0	5,749,360	11,116	0.8	2
Standard Imaging - Nuclear Medicine	I1E	3,781,920	12,729	0.9	3
Wheelchairs	D1D	1,247,660	8,276	0.6	7
Lab Tests, Other (MFS)	T1G	7,802,540	27,351	1.8	4
Orthotic Devices	D1F	2,684,400	18,155	1.2	7
Specialist - Psychiatry	M5B	2,207,700	18,743	1.3	8
Ambulatory Procedures - Skin	P5A	5,467,960	27,420	1.9	5
All Other BETOS Groups		NA	598,331	40.4	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.

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 2002. Medicare program payments represent fee-for-service only.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Table 62—Continued

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 2002

Allowed Charges			Program Payments		
Amount in Thousands	Percent	Per Person Served[1]	Amount in Thousands	Percent	Per Person Served[2]
$83,181,299	100.0	$2,620	$64,253,710	100.0	$2,073
10,485,122	12.6	381	7,288,138	11.3	282
4,924,957	5.9	732	3,909,234	6.1	583
3,598,072	4.3	670	2,842,235	4.4	552
3,443,346	4.1	292	2,653,215	4.1	227
3,210,668	3.9	5,639	2,541,776	4.0	4,480
2,998,097	3.6	756	2,377,173	3.7	600
2,184,210	2.6	1,960	1,715,957	2.7	1,541
2,084,196	2.5	300	1,631,979	2.5	242
2,059,889	2.5	1,561	1,634,398	2.5	1,240
2,015,132	2.4	162	1,421,259	2.2	124
1,817,566	2.2	360	1,405,448	2.2	283
1,763,491	2.1	96	1,758,997	2.7	96
1,564,840	1.9	170	1,208,172	1.9	135
1,520,497	1.8	264	1,201,030	1.9	209
1,419,072	1.7	375	1,119,933	1.7	298
1,414,241	1.7	1,134	1,115,179	1.7	909
1,355,054	1.6	174	1,061,696	1.7	139
1,354,786	1.6	505	1,064,144	1.7	401
1,344,547	1.6	609	723,408	1.1	339
1,318,177	1.6	241	1,004,047	1.6	188
31,305,339	37.6	NA	24,576,292	38.2	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 2002

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	---	1,481,154	$169,663,267	$83,181,299	98.9	$64,253,710
Leading Diagnoses [2]	---	871,318	91,322,043	45,582,078	98.8	35,170,085
Infectious and Parasitic Diseases (MDC 1)	001-139	19,754	1,514,264	899,668	99.2	689,177
Dermatophytosis	110	8,132	408,257	294,878	99.2	213,658
Neoplasm (MDC 2)	140-239	125,870	21,712,250	10,495,677	99.3	8,276,598
Malignant Neoplasm of Colon	153	9,398	1,060,780	488,142	99.6	387,368
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	15,656	2,230,881	1,095,749	99.7	869,465
Other Malignant Neoplasm of Skin	173	6,982	1,594,762	908,868	98.7	710,699
Malignant Neoplasm of Female Breast	174	15,364	2,041,438	958,047	98.4	757,303
Malignant Neoplasm of Prostate	185	15,182	3,497,411	1,999,440	99.7	1,579,975
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	158,336	8,032,880	4,344,610	97.7	3,432,243
Thyroiditis	244	12,228	566,128	252,425	98.5	214,401
Diabetes Mellitus	250	84,086	4,036,666	2,542,491	96.9	1,960,892
Disorders of Lipoid Metabolism	272	40,805	1,660,965	681,682	98.4	561,190
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	7,287	547,322	286,115	99.5	228,035
Diseases of the Blood and Blood-Forming Organs (MDC 4)	280-289	44,399	3,694,534	1,911,432	99.8	1,552,847
Other and Unspecified Anemias	285	22,465	2,091,264	1,083,521	99.8	880,468
Mental Disorders (MDC 5)	290-319	35,228	3,418,021	2,243,934	98.2	1,382,316
Schizophrenic Disorders	295	6,116	509,634	323,444	99.4	198,579
Affective Psychoses	296	10,485	1,057,740	711,139	97.3	412,515
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	77,513	16,676,941	8,243,560	98.9	6,241,998
Other Retinal Disorders	362	8,466	1,726,103	1,055,060	99.5	803,446
Glaucoma	365	11,378	1,265,284	843,574	98.7	612,749
Cataract	366	16,585	8,073,997	3,261,978	99.0	2,498,237

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 2002

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	228,912	$29,642,544	$13,393,835	99.0	$10,316,754
Essential Hypertension	401	53,559	3,088,565	1,924,313	97.8	1,378,612
Acute Myocardial Infarction	410	4,619	825,588	331,680	99.5	261,662
Other Acute and Subacute Forms of Ischemic Heart Disease	411	4,175	1,059,622	361,605	99.7	284,554
Angina Pectoris	413	5,435	1,008,244	427,894	99.5	333,014
Other Forms of Chronic Ischemic Heart Disease	414	32,798	6,451,664	2,546,177	99.2	1,973,263
Other Diseases of Endocardium	424	8,049	1,703,137	617,172	99.0	482,857
Cardiac Dysrhythmias	427	33,837	3,142,402	1,419,191	99.0	1,105,397
Heart Failure	428	25,734	2,762,469	1,457,419	99.4	1,143,169
Ill-Defined Descriptions and Complications of Heart Disease	429	5,186	435,281	189,176	98.8	145,499
Acute, But Ill-Defined, Cerebrovascular Disease	436	9,856	1,211,723	733,437	99.4	575,257
Diseases of the Respiratory System (MDC 8)	460-519	120,289	11,663,497	6,691,054	99.4	5,159,718
Acute Bronchitis and Bronchiolitis	466	4,889	305,027	203,215	98.0	139,475
Allergic Rhinitis	477	16,892	295,707	212,872	97.7	155,925
Pneumonia, Organism Unspecified	486	9,609	918,247	505,844	99.4	394,685
Asthma	493	9,293	687,407	430,148	99.3	328,095
Other Diseases of Lung	518	11,762	1,530,452	781,541	99.6	618,752
Diseases of the Digestive System (MDC 9)	520-579	37,985	7,939,843	3,192,820	99.2	2,484,094
Diseases of the Genitourinary System (MDC 10)	580-629	80,931	8,959,371	4,202,551	99.3	3,302,329
Chronic Renal Failure	585	26,114	2,837,358	1,392,420	99.9	1,110,522
Calculus of Kidney and Ureter	592	1,813	420,246	130,096	99.5	101,377
Other Disorders of Urethra and Urinary Tract	599	17,047	1,102,914	551,030	99.3	437,051
Hyperplasia of Prostate	600	6,702	734,980	382,205	99.1	296,687
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	49,562	3,548,591	2,276,328	98.4	1,710,903
Other Dermatoses	702	20,910	956,351	682,993	97.6	506,101
Chronic Ulcer of Skin	707	6,833	944,823	518,573	99.7	406,280

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 2002

Principal ICD-9-CM [1] Diagnosis Within MDC	ICD-9-CM Code	Services in Thousands	Submitted Charges in Thousands	Allowed Charges		Program Payments in Thousands
				Amount in Thousands	Percent of Charges Assigned	
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	158,060	$18,701,042	$8,865,518	98.1	$6,819,281
Rheumatoid Arthritis and Ofher Inflammatory Polyarthrophathies	714	8,266	863,830	557,158	98.9	433,707
Osteoarthrosis and Allied Disorders	715	25,049	4,004,555	1,850,471	98.8	1,429,108
Other and Unspecified Arthropathies	716	3,593	382,185	230,143	98.6	176,332
Other and Unspecified Disorders of Joint	719	22,819	1,635,885	843,666	99.1	646,767
Other and Unspecified Disorders of Back	724	24,780	3,398,743	1,415,769	98.7	1,093,267
Peripheral Enthesopathies and Allied Syndromes	726	10,005	772,782	401,340	98.9	304,097
Other Disorders of Soft Tissues	729	10,445	871,842	443,083	98.9	336,714
Non-Allopathic Lesions, Not Elsewhere Classified	739	13,262	510,052	417,121	84.0	309,062
Congenital Anomalies (MDC 14)	740-759	2,366	453,332	190,998	98.9	148,279
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	169,173	19,083,104	9,204,741	99.3	7,170,594
General Symptoms	780	36,857	3,920,129	1,992,749	99.3	1,566,158
Symptoms Involving Respiratory System and Other Chest Symptoms	786	50,241	5,675,005	2,661,737	99.4	2,061,610
Symptoms Involving Digestive System	787	12,602	1,467,071	741,152	99.6	580,013
Symptoms Involving Urinary System	788	9,210	740,822	389,211	98.9	301,881
Sudden Death, Cause Unknown	798	16	3,507	1,713	99.9	1,296
Other Ill-Defined and Unknown Causes of Morbidity and Mortality	799	3,937	476,177	272,589	99.7	215,876
Injury and Poisoning (MDC 17)	800-999	50,336	8,308,202	3,714,899	99.0	2,895,398
Fracture of Neck of Femur	820	4,433	1,269,913	507,034	99.6	400,795
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	V01-V82	114,299	5,620,689	2,910,221	97.8	2,351,423
Need for Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	V04	23,708	249,889	142,040	99.5	140,825
Special Investigations and Examinations	V72	6,365	288,817	129,547	98.7	105,364

[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 (760-779)] 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.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.