Table 55

Medicare Supplementary Medical Insurance Disbursements for Benefits, by Type of Provider: Selected Calendar Years 1970-2003

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 1991-2003, 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

Medicare Supplementary Medical Insurance Disbursements for Benefits, by Type of Provider: Selected Calendar Years 1970-2003

1995	1997	2000	2001	2002	2003
		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	$90,552	$102,709	$112,042	$121,581
31,660	31,898	36,963	42,034	44,824	48,329
3,689	4,236	4,718	5,439	6,529	7,534
2,807	2,385	2,226	2,436	2,788	2,981
4,530	5,586	7,408	8,904	10,873	12,931
8,666	9,358	8,435	12,768	13,557	15,287
229	239	4,465	4,512	5,039	5,106
1,448	1,503	1,770	1,937	2,233	2,478
5,331	6,575	6,208	7,120	8,703	9,684
6,610	10,962	18,358	17,560	17,497	17,250
		Percent Distribution			
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	40.8	40.9	40.0	39.8
5.7	5.8	5.2	5.3	5.8	6.2
4.3	3.3	2.5	2.4	2.5	2.5
7.0	7.7	8.2	8.7	9.7	10.6
13.3	12.9	9.3	12.4	12.1	12.6
0.4	0.3	4.9	4.4	4.5	4.2
2.2	2.1	2.0	1.9	2.0	2.0
8.2	9.0	6.9	6.9	7.8	8.0
10.2	15.1	20.3	17.1	15.6	14.2

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 2003

Demographic Characteristic	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	32,547,900	1,573,445	48.3	$191,593,731	$5,887
Sex					
Male	13,577,060	652,281	48.0	84,362,114	6,214
Female	18,970,840	921,164	48.6	107,231,617	5,652
Age					
Under 65 Years	4,548,960	222,807	49.0	28,360,247	6,234
65-74 Years	13,123,040	562,230	42.8	70,629,994	5,382
75-84 Years	10,571,300	564,883	53.4	68,691,479	6,498
85 Years or Over	4,304,600	223,525	51.9	23,912,012	5,555
Race[3]					
White	27,636,000	1,319,470	47.7	160,495,277	5,807
Other	4,761,120	247,498	52.0	30,322,277	6,369
Medicare Status[4]					
Aged	27,804,860	1,319,959	47.5	159,467,404	5,735
Disabled	4,470,660	199,303	44.6	24,986,116	5,589
ESRD	272,380	54,183	198.9	7,140,211	26,214

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 2003

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	$92,638,665	$2,846	$91,733,060	99.0	$71,733,844	$2,254	$64,560	$25
Sex								
Male	40,517,842	2,984	40,148,899	99.1	31,401,813	2,380	26,667	26
Female	52,120,824	2,747	51,584,161	99.0	40,332,031	2,164	37,893	24
Age								
Under 65 Years	13,718,622	3,016	13,668,251	99.6	10,410,405	2,385	3,427	26
65-74 Years	33,175,103	2,528	32,804,094	98.9	25,630,464	2,005	26,302	24
75-84 Years	33,342,700	3,154	32,975,550	98.9	26,039,943	2,496	26,394	26
85 Years or Over	12,402,241	2,881	12,285,165	99.1	9,653,032	2,273	8,437	25
Race[3]								
White	77,278,461	2,796	76,415,440	98.9	59,772,862	2,209	61,621	25
Other	14,981,894	3,147	14,942,135	99.7	11,669,587	2,523	2,749	22
Medicare Status[4]								
Aged	77,222,201	2,777	76,371,196	98.9	59,968,301	2,199	60,851	25
Disabled	12,292,667	2,750	12,242,199	99.6	9,266,209	2,163	3,436	26
ESRD	3,123,798	11,469	3,119,665	99.9	2,499,334	9,253	273	30

[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 2003

Type of Service	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	32,547,900	1,573,445	48.3	$191,593,731	$5,887
Medical Care	31,487,740	582,370	18.5	54,230,591	1,722
Surgery	18,906,900	93,805	5.0	41,086,481	2,173
Consultation	12,419,320	30,838	2.5	5,985,698	482
Diagnostic X-Ray	21,634,200	128,620	5.9	18,875,243	872
Diagnostic Laboratory	26,539,300	444,240	16.7	23,117,593	871
Radiation Therapy	1,189,980	11,110	9.3	3,868,867	3,251
Anesthesia	6,016,800	11,469	1.9	7,357,955	1,223
Assistance at Surgery	877,500	1,450	1.7	1,529,790	1,743
Other Medical Services	755,900	5,557	7.4	2,163,619	2,862
Ambulatory Surgical Center	2,464,460	3,932	1.6	6,134,294	2,489
Renal Supplies in the Home	17,380	712	40.9	315,294	18,141
ESRD Capitation Payment	276,440	2,300	8.3	984,625	3,562
Psychological Therapy	2,712,560	18,512	6.8	1,757,394	648
Occupational Therapy	21,400	768	35.9	28,615	1,337
Pneumococcal Vaccine	13,762,860	29,108	2.1	373,029	27
Physical Therapy	557,720	20,898	37.5	735,964	1,320
Durable Medical Equipment[4]	8,633,260	120,356	13.9	14,436,611	1,672
Other[5]	NA	67,400	NA	8,612,068	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, and medical supplies.

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 2003

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
$92,638,665	$2,846	$91,733,060	99.0	$71,733,844	$2,254	$64,560	$25
34,424,272	1,093	33,997,511	98.8	25,839,949	861	30,431	17
14,156,650	749	14,035,319	99.1	11,082,324	595	9,777	29
3,767,435	303	3,734,692	99.1	2,906,358	236	2,733	18
7,594,846	351	7,537,072	99.2	5,917,064	282	4,956	19
8,291,823	312	8,253,219	99.5	7,117,152	270	3,184	9
1,292,209	1,086	1,282,738	99.3	1,024,780	865	822	123
1,602,183	266	1,598,010	99.7	1,268,098	211	311	17
205,397	234	204,508	99.6	163,013	186	77	20
1,270,466	1,681	1,270,310	99.9	1,009,386	1,342	6	5
2,164,792	878	2,164,689	99.9	1,712,455	695	9	43
103,786	5,972	103,785	99.9	81,787	4,739	0	0
551,079	1,993	551,006	99.9	434,500	1,576	7	110
1,254,814	463	1,220,974	97.3	585,780	232	2,338	34
21,125	987	21,105	99.9	16,705	791	1	48
255,939	19	254,833	99.6	255,472	19	51	1
541,319	971	537,088	99.2	424,837	768	167	41
9,769,573	1,132	9,603,376	98.3	7,659,475	899	9,086	14
5,370,957	NA	5,362,825	99.8	4,234,709	NA	604	NA

Table 58

Persons Served, Services, Submitted and Allowed Charges, Program Payments for Medicare Physician and Supplier Services, by Place of Service: Calendar Year 2003

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	32,547,900	1,573,445	48.3	$191,593,731	$5,887
Office	30,303,260	769,808	25.4	71,844,989	2,371
Home	8,832,100	131,059	14.8	16,394,554	1,856
Inpatient Hospital	8,417,360	210,196	25.0	43,801,884	5,204
Outpatient Hospital[4]	17,461,180	94,645	5.4	22,751,944	1,303
Emergency Room Hospital[4]	10,104,180	37,162	3.7	6,320,314	626
Ambulatory Surgical Center	2,805,480	10,171	3.6	10,872,067	3,875
Skilled Nursing Care Facility	2,184,920	25,180	11.5	1,915,889	877
Nursing Home	1,855,680	25,148	13.6	1,379,340	743
Hospice	5,460	13	2.4	1,326	243
Ambulance[5]	4,184,160	49,701	11.9	5,339,430	1,276
Independent Laboratory	16,130,260	189,878	11.8	8,329,406	516
All Other[6]	NA	30,484	NA	2,642,588	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 2003

	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	$92,638,665	100.0	$2,846	$91,733,060	99.0	$71,733,844	100.0	$2,254
Office	43,088,036	46.5	1,422	42,467,464	98.6	32,487,867	45.3	1,107
Home	10,987,058	11.9	1,244	10,817,853	98.5	8,605,230	12.0	987
Inpatient Hospital	16,374,549	17.7	1,945	16,305,299	99.6	12,964,325	18.1	1,548
Outpatient Hospital[4]	6,704,635	7.2	384	6,674,627	99.6	5,212,521	7.3	306
Emergency Room Hospital[4]	2,243,435	2.4	222	2,241,123	99.9	1,738,748	2.4	175
Ambulatory Surgical Center	3,611,210	3.9	1,287	3,601,720	99.7	2,853,751	4.0	1,019
Skilled Nursing Care Facility	1,294,952	1.4	593	1,292,999	99.8	971,362	1.4	453
Nursing Home	983,332	1.1	530	982,211	99.9	717,252	1.0	393
Hospice	804	(7)	147	804	100.0	626	(7)	117
Ambulance[5]	3,244,741	3.5	775	3,244,351	99.9	2,573,146	3.6	615
Independent Laboratory	2,621,530	2.8	163	2,621,216	99.9	2,477,114	3.5	154
All Other[6]	1,484,383	1.6	NA	1,483,393	99.9	1,131,902	1.6	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 2003

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	32,547,900	1,573,445	100.0	48.3	$191,593,731	100.0	$5,887
Total Physicians	32,073,740	1,100,072	69.9	34.3	145,924,165	76.2	4,550
General Practice	3,277,880	22,817	1.5	7.0	1,755,591	0.9	536
General Surgery	4,474,980	15,691	1.0	3.5	5,604,332	2.9	1,252
Allergy and Immunology	397,260	12,297	0.8	31.0	254,711	0.1	641
Otology, Laryngology, Rhinolog	2,917,720	13,684	0.9	4.7	1,621,380	0.8	556
Anesthesiology	5,495,020	13,702	0.9	2.5	6,556,959	3.4	1,193
Cardiology	10,920,200	104,958	6.7	9.6	16,308,542	8.5	1,493
Dermatology	5,132,140	34,692	2.2	6.8	2,662,380	1.4	519
Family Practice	13,376,260	119,917	7.6	9.0	7,230,219	3.8	541
Gastroenterology	4,411,120	15,846	1.0	3.6	4,316,076	2.3	978
Internal Medicine	17,894,140	205,668	13.1	11.5	16,047,096	8.4	897
Manipulative Therapy	108,080	697	(5)	6.5	58,745	(5)	544
Neurology	3,163,460	15,702	1.0	5.0	2,174,248	1.1	687
Neurologiclal Surgery	705,700	2,198	0.1	3.1	1,833,939	1.0	2,599
Obstetrics and Gynecology	2,564,540	7,737	0.5	3.0	1,146,453	0.6	447
Ophthalmology	11,551,940	39,601	2.5	3.4	9,698,592	5.1	840
Oral Surgery (Dentists Only)	95,360	196	(5)	2.1	42,950	(5)	450
Orthopedic Surgery	5,077,680	31,250	2.0	6.2	8,030,163	4.2	1,581
Pathology	6,072,880	21,018	1.3	3.5	2,266,201	1.2	373
Plastic and Reconstructive Surgery	508,940	1,765	0.1	3.5	725,018	0.4	1,425
Physical Medicine and Rehabilitatio	1,335,220	13,083	0.8	9.8	1,247,701	0.7	934
Psychiatry	2,175,900	16,376	1.0	7.5	1,655,338	0.9	761
Colorectal Surgery (Proctology	264,080	694	(5)	2.6	265,169	0.1	1,004
Pulmonary Disease	2,853,340	22,482	1.4	7.9	2,451,753	1.3	859
Diagnostic Radiology	19,807,980	95,262	6.1	4.8	13,055,580	6.8	659
Thoracic Surgery	539,980	1,682	0.1	3.1	1,462,875	0.8	2,709
Urology	4,323,820	27,815	1.8	6.4	5,050,316	2.6	1,168
Chiropractic	2,014,600	19,660	1.2	9.8	749,433	0.4	372
Nuclear Medicine	527,220	1,369	0.1	2.6	280,413	0.1	532
Pediatric Medicine	290,620	1,650	0.1	5.7	128,183	0.1	441
Geriatric Medicine	360,240	2,237	0.1	6.2	183,341	0.1	509
Nephrology	1,347,300	26,228	1.7	19.5	2,626,524	1.4	1,949
Optometrist	4,959,460	9,784	0.6	2.0	737,216	0.4	149
Infectious Disease	752,760	7,931	0.5	10.5	739,191	0.4	982
Endocrinology	1,022,560	7,521	0.5	7.3	505,778	0.3	495
Podiatry	5,861,040	30,125	1.9	5.1	2,063,124	1.1	352

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 2003

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
$92,638,665	100.0	$2,846	$91,733,060	99.0	$71,733,844	100.0	$2,254	$64,560	$25
69,400,968	74.9	2,164	68,659,808	98.9	53,208,195	74.2	1,707	55,476	27
1,127,368	1.2	344	1,111,169	98.6	845,109	1.2	269	999	16
2,164,435	2.3	484	2,152,568	99.5	1,688,095	2.4	386	975	32
178,333	0.2	449	174,208	97.7	134,767	0.2	349	293	23
789,967	0.9	271	782,161	99.0	595,800	0.8	213	643	16
1,549,694	1.7	282	1,543,533	99.6	1,219,981	1.7	223	487	22
6,795,108	7.3	622	6,758,716	99.5	5,279,163	7.4	494	2,938	29
1,814,294	2.0	354	1,774,579	97.8	1,368,587	1.9	278	3,166	18
4,592,330	5.0	343	4,530,265	98.6	3,351,370	4.7	261	4,804	17
1,611,552	1.7	365	1,597,044	99.1	1,246,411	1.7	287	1,185	27
9,591,586	10.4	536	9,454,943	98.6	7,273,940	10.1	417	11,328	22
34,457	(5)	319	33,126	96.1	26,265	(5)	251	89	25
1,224,592	1.3	387	1,212,805	99.0	941,027	1.3	305	996	25
473,136	0.5	670	468,805	99.1	370,462	0.5	538	378	43
550,243	0.6	215	538,782	97.9	417,372	0.6	168	867	13
4,829,159	5.2	418	4,776,910	98.9	3,634,894	5.1	332	4,141	19
22,643	(5)	237	20,146	89.0	17,446	(5)	189	137	19
2,999,688	3.2	591	2,981,124	99.4	2,319,163	3.2	472	1,494	36
839,236	0.9	138	833,663	99.3	663,431	0.9	111	495	17
273,249	0.3	537	270,320	98.9	213,587	0.3	432	244	38
693,466	0.7	519	690,174	99.5	543,687	0.8	413	264	23
1,067,947	1.2	491	1,032,440	96.7	668,599	0.9	318	2,450	39
107,607	0.1	407	106,340	98.8	83,132	0.1	320	108	36
1,443,668	1.6	506	1,437,355	99.6	1,126,001	1.6	401	530	25
4,736,938	5.1	239	4,691,832	99.0	3,699,295	5.2	192	3,913	35
448,031	0.5	830	445,859	99.5	353,440	0.5	664	186	65
2,888,284	3.1	668	2,875,229	99.5	2,248,893	3.1	528	1,113	27
617,300	0.7	306	518,408	84.0	457,127	0.6	238	5,077	15
119,002	0.1	226	116,801	98.2	93,498	0.1	181	196	33
72,676	0.1	250	72,322	99.5	54,816	0.1	196	21	17
119,437	0.1	332	117,670	98.5	89,903	0.1	256	158	29
1,406,744	1.5	1,044	1,402,831	99.7	1,104,915	1.5	831	346	25
613,068	0.7	124	600,175	97.9	427,877	0.6	96	251	6
415,768	0.4	552	413,498	99.5	327,046	0.5	439	184	25
312,245	0.3	305	303,897	97.3	242,089	0.3	241	698	19
1,434,395	1.5	245	1,423,374	99.2	1,074,955	1.5	189	591	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 2003

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	1,230,660	12,944	0.8	10.5	$1,289,033	0.7	$1,047
Vascular Surgery	1,065,740	3,113	0.2	2.9	1,202,546	0.6	1,128
Cardiac Surgery	314,560	969	0.1	3.1	1,160,122	0.6	3,688
Hematology/Oncology	1,464,300	54,909	3.5	37.5	7,310,658	3.8	4,993
Medical Oncology	636,660	22,542	1.4	35.4	3,301,531	1.7	5,186
Radiation Oncology	861,200	9,893	0.6	11.5	3,290,490	1.7	3,821
Emergency Medicine	8,189,560	19,683	1.3	2.4	4,376,650	2.3	534
All Other Physician [6]	NA	12,684	0.8	NA	2,457,605	1.3	NA
Group Practice	296,800	2,070	0.1	7.0	135,291	0.1	456
Total Non-Physician	10,597,100	78,483	5.0	7.4	13,107,893	6.8	1,237
Total Suppliers	21,750,980	392,819	25.0	18.1	32,426,382	16.9	1,491

[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. Due to the clarification in the billing policy of Group Practices where the actual specialty code of the performing physician within the practice is now coded, the utilization and expenditures for group practice has dropped dramatically. 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 2003

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
$845,816	0.9	$687	$831,240	98.3	$648,571	0.9	$539	$1,231	$22
442,073	0.5	415	441,342	99.8	346,234	0.5	331	62	34
336,190	0.4	1,069	332,359	98.9	266,263	0.4	858	343	48
4,164,367	4.5	2,844	4,160,843	99.9	3,299,543	4.6	2,281	304	31
1,769,182	1.9	2,779	1,768,212	99.9	1,402,389	2.0	2,236	87	23
1,129,452	1.2	1,311	1,120,890	99.2	893,188	1.2	1,071	748	145
1,645,439	1.8	201	1,643,421	99.9	1,276,505	1.8	159	164	11
1,110,803	1.2	NA	1,098,429	98.9	873,359	1.2	NA	792	NA
49,555	0.1	167	49,117	99.1	40,854	0.1	140	35	6
5,344,109	5.8	504	5,322,374	99.6	4,006,348	5.6	386	1,127	10
17,844,033	19.3	820	17,701,761	99.2	14,478,447	20.2	668	7,921	16

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 2003

	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]
All Areas[5]	32,547,900	977	1,573,445	48	$191,593,731	$5,887
United States[6]	32,118,440	978	1,551,478	48	190,137,852	5,920
Northeast	6,208,260	975	316,504	51	37,689,842	6,071
Midwest	8,249,780	991	360,145	44	43,760,904	5,304
South	12,561,620	979	633,493	50	79,208,084	6,306
West	5,098,780	960	241,336	47	29,479,023	5,782
New England	1,706,240	975	76,867	45	9,413,152	5,517
Connecticut	454,780	985	22,312	49	2,858,942	6,286
Maine	205,880	961	7,886	38	924,391	4,490
Massachusetts	702,580	978	32,500	46	3,954,982	5,629
New Hampshire	158,600	956	6,182	39	745,545	4,701
Rhode Island	98,900	979	5,152	52	546,950	5,530
Vermont	85,500	967	2,834	33	382,343	4,472
Middle Atlantic	4,502,020	974	239,637	53	28,276,690	6,281
New Jersey	1,029,120	974	59,655	58	7,191,588	6,988
New York	2,020,960	971	111,696	55	12,531,416	6,201
Pennsylvania	1,451,940	980	68,286	47	8,553,686	5,891
East North Central	5,712,400	987	256,737	45	32,028,146	5,607
Illinois	1,435,200	971	65,719	46	8,412,880	5,862
Indiana	809,020	994	34,131	42	4,510,953	5,576
Michigan	1,326,720	984	63,722	48	7,255,286	5,469
Ohio	1,414,080	996	64,054	45	7,969,759	5,636
Wisconsin	727,380	1,000	29,111	40	3,879,267	5,333
West North Central	2,537,380	1,001	103,409	41	11,732,758	4,624
Iowa	448,680	1,016	17,178	38	1,829,239	4,077
Kansas	359,760	1,000	16,387	46	1,927,376	5,357
Minnesota	562,440	1,020	20,268	36	2,319,140	4,123
Missouri	720,700	984	31,612	44	3,785,325	5,252
Nebraska	237,000	998	9,894	42	1,067,281	4,503
North Dakota	96,840	994	3,573	37	402,031	4,152
South Dakota	111,960	979	4,498	40	402,365	3,594
South Atlantic	6,738,100	982	344,755	51	43,374,953	6,437
Delaware	113,140	986	5,525	49	751,565	6,643
District of Columbia	55,440	938	2,491	45	343,188	6,190
Florida	2,257,340	981	138,999	62	17,451,998	7,731
Georgia	882,940	980	40,528	46	5,266,724	5,965
Maryland	590,780	983	28,337	48	3,859,748	6,533
North Carolina	1,106,400	992	51,231	46	6,284,081	5,680
South Carolina	573,480	985	27,118	47	3,439,648	5,998
Virginia	860,800	981	37,736	44	4,426,166	5,142
West Virginia	297,780	968	12,790	43	1,551,834	5,211

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 2003

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
$92,638,665	100.0	$2,846	99.0	$71,733,844	100.0	$2,254	$64,560	$25
91,560,685	98.8	2,851	99.0	70,898,454	98.8	2,257	64,427	25
18,927,438	20.4	3,049	99.0	14,670,838	20.5	2,411	12,163	26
20,358,252	22.0	2,468	98.8	15,688,112	21.9	1,948	16,502	25
37,354,005	40.3	2,974	99.2	28,968,614	40.4	2,356	21,714	23
14,920,989	16.1	2,926	98.8	11,570,889	16.1	2,325	14,049	30
4,490,108	4.8	2,632	99.4	3,452,167	4.8	2,067	1,666	23
1,343,391	1.5	2,954	99.0	1,038,046	1.4	2,317	1,019	30
440,561	0.5	2,140	99.6	336,862	0.5	1,684	117	20
1,911,291	2.1	2,720	99.8	1,468,194	2.0	2,133	213	13
355,271	0.4	2,240	99.2	271,620	0.4	1,763	169	15
269,597	0.3	2,726	99.9	208,606	0.3	2,159	17	9
169,997	0.2	1,988	98.9	128,838	0.2	1,556	131	26
14,437,330	15.6	3,207	98.8	11,218,671	15.6	2,541	10,497	27
3,698,259	4.0	3,594	98.3	2,884,884	4.0	2,850	4,566	27
6,680,525	7.2	3,306	98.7	5,189,072	7.2	2,614	5,276	29
4,058,546	4.4	2,795	99.6	3,144,716	4.4	2,217	655	15
14,795,624	16.0	2,590	99.1	11,413,421	15.9	2,044	8,996	22
3,803,706	4.1	2,650	98.6	2,935,163	4.1	2,092	3,787	24
1,979,209	2.1	2,446	98.9	1,518,657	2.1	1,932	1,307	18
3,800,285	4.1	2,864	99.5	2,941,297	4.1	2,260	1,450	25
3,695,879	4.0	2,614	99.6	2,853,730	4.0	2,064	693	13
1,516,546	1.6	2,085	98.4	1,164,573	1.6	1,639	1,760	24
5,562,628	6.0	2,192	98.2	4,274,692	6.0	1,730	7,506	28
882,196	1.0	1,966	97.0	674,137	0.9	1,547	2,056	40
909,355	1.0	2,528	99.0	702,421	1.0	1,996	618	23
1,080,708	1.2	1,921	99.1	827,280	1.2	1,512	653	19
1,735,704	1.9	2,408	98.9	1,337,822	1.9	1,904	1,238	19
528,594	0.6	2,230	96.7	405,868	0.6	1,760	1,383	32
207,016	0.2	2,138	98.0	159,120	0.2	1,681	332	37
219,055	0.2	1,957	93.3	168,043	0.2	1,547	1,227	36
20,815,467	22.5	3,089	99.1	16,163,190	22.5	2,447	14,348	26
343,081	0.4	3,032	99.3	266,364	0.4	2,405	147	16
160,086	0.2	2,888	98.1	124,359	0.2	2,280	248	43
9,075,881	9.8	4,021	99.0	7,108,921	9.9	3,200	6,871	37
2,364,091	2.6	2,678	99.2	1,826,703	2.5	2,115	1,529	22
1,825,954	2.0	3,091	99.0	1,414,709	2.0	2,435	1,307	24
2,737,912	3.0	2,475	98.9	2,104,490	2.9	1,943	2,192	20
1,528,993	1.7	2,666	99.3	1,179,204	1.6	2,105	837	17
2,084,630	2.3	2,422	99.3	1,602,807	2.2	1,903	1,033	20
694,840	0.8	2,333	99.6	535,633	0.7	1,852	185	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 2003

	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	2,401,460	983	115,423	48	$13,738,503	$5,721
Alabama	635,960	988	30,127	47	3,459,232	5,439
Kentucky	588,480	980	27,501	47	3,143,834	5,342
Mississippi	407,060	972	19,491	48	2,390,141	5,872
Tennessee	769,960	987	38,303	50	4,745,296	6,163
West South Central	3,422,060	970	173,316	51	22,094,628	6,457
Arkansas	411,980	975	19,433	47	2,130,829	5,172
Louisiana	505,980	976	24,939	49	3,200,372	6,325
Oklahoma	452,760	984	19,593	43	2,278,888	5,033
Texas	2,051,340	965	109,351	53	14,484,539	7,061
Mountain	1,703,400	973	71,474	42	8,873,941	5,210
Arizona	466,300	959	22,627	49	2,723,132	5,840
Colorado	331,920	999	13,668	41	1,672,404	5,039
Idaho	155,960	1,008	5,365	34	579,323	3,715
Montana	132,900	965	4,867	37	546,747	4,114
Nevada	168,980	945	9,076	54	1,340,718	7,934
New Mexico	184,900	946	6,662	36	893,792	4,834
Utah	198,180	989	6,879	35	844,574	4,262
Wyoming	64,260	981	2,331	36	273,252	4,252
Pacific	3,395,380	954	169,862	50	20,605,081	6,069
Alaska	39,340	900	1,272	32	232,105	5,900
California	2,339,760	940	129,370	55	15,719,043	6,718
Hawaii	110,660	1,048	4,299	39	475,700	4,299
Oregon	329,680	1,026	11,374	35	1,368,529	4,151
Washington	575,940	959	23,548	41	2,809,704	4,878
Outlying Areas[7]	429,460	884	21,966	51	1,455,879	3,390

[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. Because the denominator is the mid-point fee-for-service (FFS) enrollment and essentially every FFS person alive and enrolled at some point during the year has used a service, rates over 1,000 may be seen.

[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 2003

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
$6,384,948	6.9	$2,659	99.5	$4,925,032	6.9	$2,100	$2,316	$17
1,723,700	1.9	2,710	99.6	1,332,250	1.9	2,142	437	17
1,477,217	1.6	2,510	99.3	1,136,840	1.6	1,984	665	18
1,072,697	1.2	2,635	99.4	830,826	1.2	2,095	430	17
2,111,333	2.3	2,742	99.4	1,625,116	2.3	2,155	783	18
10,153,591	11.0	2,967	99.3	7,880,392	11.0	2,357	5,050	19
1,032,568	1.1	2,506	99.6	795,271	1.1	1,985	287	21
1,528,393	1.6	3,021	99.6	1,186,051	1.7	2,406	450	14
1,154,969	1.2	2,551	99.1	889,979	1.2	2,016	698	18
6,437,661	6.9	3,138	99.3	5,009,092	7.0	2,494	3,616	20
4,399,813	4.7	2,583	97.9	3,394,266	4.7	2,048	7,105	34
1,392,567	1.5	2,986	97.1	1,083,736	1.5	2,374	3,272	52
821,220	0.9	2,474	98.3	634,088	0.9	1,960	1,079	27
312,866	0.3	2,006	95.8	239,059	0.3	1,581	1,047	26
289,743	0.3	2,180	97.9	222,139	0.3	1,732	474	32
604,506	0.7	3,577	99.6	466,534	0.7	2,831	199	28
402,697	0.4	2,178	98.6	309,303	0.4	1,735	391	23
434,931	0.5	2,195	99.3	331,050	0.5	1,715	181	19
141,283	0.2	2,199	95.7	108,357	0.2	1,761	462	28
10,521,176	11.4	3,099	99.1	8,176,623	11.4	2,463	6,943	27
95,566	0.1	2,429	98.4	73,535	0.1	1,931	123	26
8,091,795	8.7	3,458	99.2	6,310,892	8.8	2,756	4,708	29
222,512	0.2	2,011	98.9	167,844	0.2	1,552	178	26
684,417	0.7	2,076	98.4	525,012	0.7	1,639	860	23
1,426,885	1.5	2,477	99.0	1,099,340	1.5	1,953	1,074	23
1,077,980	1.2	2,510	99.7	835,390	1.2	2,010	133	20

Table 61

Medicare Assignment Rates and Ratio of Submitted Charges to Allowed Charges for Physician Services, by Area of Residence: Selected Calendar Years 1983, 1988, and 2003

	Assignment Rate[1]			Ratio of Submitted Charges to Allowed Charges		
Area of Residence	1983	1988	2003	1983	1988	2003
United States	0.51	0.77	0.99	1.31	1.78	2.08
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	1.96
Arkansas	0.58	0.82	0.99	1.32	1.85	2.06
California	0.53	0.79	0.99	1.28	1.74	1.94
Colorado	0.42	0.66	0.98	1.37	1.67	2.04
Connecticut	0.44	0.74	0.99	1.31	1.86	2.13
Delaware	0.75	0.80	0.99	1.28	2.05	2.19
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	1.92
Georgia	0.55	0.75	0.99	1.30	1.89	2.23
Hawaii	0.42	0.75	0.99	1.34	2.02	2.14
Idaho	0.22	0.40	0.96	1.32	1.43	1.85
Illinois	0.36	0.67	0.99	1.29	1.65	2.21
Indiana	0.28	0.87	0.99	1.33	1.85	2.28
Iowa	0.33	0.63	0.97	1.34	1.66	2.07
Kansas	0.48	0.82	0.99	1.30	1.82	2.12
Kentucky	0.39	0.89	0.99	1.29	1.84	2.13
Louisiana	0.37	0.79	0.99	1.37	1.80	2.09
Maine	0.73	0.84	0.99	1.28	1.90	2.10
Maryland	0.72	0.87	0.99	1.30	1.98	2.11
Massachusetts	0.85	0.93	0.99	1.28	1.92	2.07
Michigan	0.79	0.93	0.99	1.32	1.77	1.91
Minnesota	0.27	0.53	0.99	1.30	1.66	2.15
Mississippi	0.58	0.72	0.99	1.37	1.85	2.23
Missouri	0.44	0.76	0.99	1.28	1.72	2.18
Montana	0.19	0.53	0.98	1.27	1.42	1.89
Nebraska	0.19	0.54	0.97	1.28	1.59	2.02
Nevada	0.61	0.86	0.99	1.30	1.92	2.22
New Hampshire	0.51	0.69	0.99	1.32	1.86	2.10
New Jersey	0.58	0.70	0.98	1.34	1.67	1.94
New Mexico	0.41	0.70	0.99	1.34	1.68	2.22
New York	0.62	0.89	0.99	1.37	1.71	1.88
North Carolina	0.49	0.75	0.99	1.31	1.95	2.30
North Dakota	0.29	0.47	0.98	1.27	1.80	1.94

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: Selected Calendar Years 1983, 1988, and 2003

	Assignment Rate[1]			Ratio of Submitted Charges to Allowed Charges		
Area of Residence	1983	1988	2003	1983	1988	2003
Ohio	0.34	0.73	0.99	1.32	1.82	2.16
Oklahoma	0.30	0.63	0.99	1.37	1.65	1.97
Oregon	0.25	0.57	0.98	1.28	1.55	2.00
Pennsylvania	0.76	0.88	0.99	1.28	1.94	2.11
Rhode Island	0.90	0.90	0.99	1.39	2.05	2.03
South Carolina	0.57	0.76	0.99	1.32	1.89	2.25
South Dakota	0.18	0.46	0.93	1.29	1.46	1.84
Tennessee	0.46	0.75	0.99	1.34	1.85	2.25
Texas	0.53	0.75	0.99	1.37	1.75	2.25
Utah	0.45	0.73	0.99	1.27	1.67	1.94
Vermont	0.58	0.78	0.99	1.31	2.01	2.25
Virginia	0.56	0.73	0.99	1.31	1.91	2.12
Washington	0.30	0.57	0.99	1.27	1.54	1.97
West Virginia	0.51	0.81	0.99	1.39	1.96	2.23
Wisconsin	0.32	0.61	0.98	1.25	1.67	2.56
Wyoming	0.26	0.46	0.96	1.32	1.50	1.93

[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 2003

BETOS Classification	BETOS Codes	Persons Served[1]	Services		
			Number in Thousands	Percent	Per Person Served[1]
Total All BETOS Groups	Total	32,547,900	1,573,445	100.0	48
Office Visits - Established	M1B	28,296,360	208,823	13.3	7
Hospital Visit - Subsequent	M2B	6,931,660	96,135	6.1	14
Other Drugs	O1E	5,902,040	61,032	3.9	10
Chemotherapy	O1D	582,300	22,505	1.4	39
Consultations	M6	12,313,980	29,742	1.9	2
Ambulance	O1A	4,195,120	48,826	3.1	12
Oxygen and Supplies	D1C	1,236,320	17,302	1.1	14
Minor Procedures - Other (MFS)	P6C	7,601,320	68,935	4.4	9
Eye Procedure - Cataract Removal/Lens Insertion	P4B	1,340,740	3,254	0.2	2
Specialist - Ophthalmology	M5C	12,801,900	28,927	1.8	2
Other Durable Medical Equipment	D1E	5,542,440	48,997	3.1	9
Lab Tests, Other (Non-MFS)	T1H	18,910,260	158,200	10.1	8
Wheelchairs	D1D	1,321,020	8,743	0.6	7
Emergency Room Visit	M3	9,509,000	18,080	1.1	2
Standard Imaging - Nuclear Medicine	I1E	4,018,320	14,389	0.9	4
Anesthesia	P0	6,019,780	11,560	0.7	2
Orthotic Devices	D1F	2,915,460	23,883	1.5	8
Lab Tests, Other (MFS)	T1G	7,970,920	28,965	1.8	4
Specialist - Psychiatry	M5B	2,302,500	19,598	1.2	9
Drugs Administered Through Durable Medical Equipment	D1G	1,029,280	15,967	1.0	16
All Other BETOS Groups		NA	639,582	40.6	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: BETOS is the Berenson-Eggers Type of Service system for classifying HCPCS (Healthcare Common Procedure Coding System) codes. Data by BETOS category in this table may differ from other sources because of the update of the HCPCS-BETOS crosswalk used to code the services rendered. MFS is the Medicare fee schedule. NA is not applicable. The leading BETOS codes are based on amount of allowed charges for 2003. Medicare program payments represent fee-for-service only. Numbers may not add to total because of rounding.

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 2003

Allowed Charges			Program Payments		
Amount in Thousands	Percent	Per Person Served[1]	Amount in Thousands	Percent	Per Person Served[2]
$92,638,665	100.0	$2,846	$71,733,844	100.0	$2,254
11,256,832	12.2	398	7,870,455	11.0	296
5,255,315	5.7	758	4,170,812	5.8	604
5,046,640	5.4	855	3,981,206	5.5	700
3,724,897	4.0	6,397	2,951,120	4.1	5,085
3,702,046	4.0	301	2,854,561	4.0	234
3,374,564	3.6	804	2,676,365	3.7	638
2,414,855	2.6	1,953	1,897,414	2.6	1,536
2,367,482	2.6	311	1,855,397	2.6	250
2,182,802	2.4	1,628	1,730,982	2.4	1,292
2,167,732	2.3	169	1,539,024	2.1	129
2,054,644	2.2	371	1,586,814	2.2	291
1,926,654	2.1	102	1,921,528	2.7	102
1,850,283	2.0	1,401	1,462,190	2.0	1,125
1,698,675	1.8	179	1,315,619	1.8	142
1,694,109	1.8	422	1,336,933	1.9	335
1,608,803	1.7	267	1,271,427	1.8	212
1,601,182	1.7	549	1,260,115	1.8	436
1,462,540	1.6	183	1,146,641	1.6	146
1,414,540	1.5	614	761,280	1.1	342
1,364,643	1.5	1,326	1,076,728	1.5	1,049
34,469,427	37.2	NA	27,067,233	37.7	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 2003

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	---	1,573,445	$191,593,731	$92,638,665	99.0	$71,733,844
Leading Diagnoses [2]	---	927,738	102,642,173	50,626,677	99.0	39,160,417
Infectious and Parasitic Diseases (MDC 1)	001-139	20,265	1,639,502	957,232	99.3	736,233
Dermatophytosis	110	8,343	433,890	309,888	99.3	225,569
Neoplasm (MDC 2)	140-239	131,355	24,781,501	11,889,735	99.3	9,383,503
Malignant Neoplasm of Colon	153	9,289	1,240,687	584,108	99.7	464,718
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	16,719	2,559,406	1,247,534	99.8	990,890
Other Malignant Neoplasm of Skin	173	7,142	1,764,644	986,611	98.8	771,952
Malignant Neoplasm of Female Breast	174	15,610	2,356,136	1,106,209	98.6	875,878
Malignant Neoplasm of Prostate	185	15,436	3,814,875	2,165,174	99.7	1,711,470
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	170,021	9,071,520	4,786,027	97.9	3,781,226
Thyroiditis	244	12,392	591,576	262,684	98.5	222,049
Diabetes Mellitus	250	90,292	4,546,991	2,798,362	97.2	2,162,978
Disorders of Lipoid Metabolism	272	44,732	1,886,417	755,593	98.5	622,976
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	7,695	592,517	301,120	99.6	240,091
Diseases of the Blood and Blood-Forming Organs (MDC 4)	280-289	45,805	4,751,803	2,545,355	99.8	2,058,500
Other and Unspecified Anemias	285	23,458	2,594,006	1,357,828	99.9	1,098,867
Mental Disorders (MDC 5)	290-319	36,780	3,655,718	2,356,398	98.4	1,449,345
Schizophrenic Disorders	295	6,328	542,384	334,622	99.4	205,250
Affective Psychoses	296	10,933	1,125,468	748,828	97.7	431,915
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	81,884	18,260,965	8,894,324	99.0	6,754,742
Other Retinal Disorders	362	9,049	1,875,174	1,134,655	99.5	866,149
Glaucoma	365	12,698	1,469,923	948,507	98.8	693,243
Cataract	366	16,843	8,659,572	3,425,912	99.1	2,628,738

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 2003

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	242,671	$32,597,118	$14,657,164	99.1	$11,318,810
Essential Hypertensior	401	59,808	3,613,032	2,169,343	98.0	1,572,574
Acute Myocardial Infarctior	410	4,525	860,846	339,946	99.7	268,557
Other Acute and Subacute Forms of Ischemic Heart Disease	411	3,918	1,059,831	352,981	99.7	277,828
Angina Pectoris	413	5,426	1,085,680	466,885	99.5	364,156
Other Forms of Chronic Ischemic Heart Disease	414	34,708	7,097,245	2,800,824	99.3	2,173,188
Other Diseases of Endocardium	424	8,698	1,911,857	690,689	99.1	540,579
Cardiac Dysrhythmias	427	35,829	3,428,745	1,532,064	99.1	1,193,907
Heart Failure	428	26,762	3,093,426	1,628,607	99.5	1,282,260
Ill-Defined Descriptions and Complications of Heart Disease	429	5,181	469,805	199,941	99.1	154,147
Acute, But Ill-Defined, Cerebrovascular Disease	436	9,608	1,223,393	736,606	99.5	578,129
Diseases of the Respiratory System (MDC 8)	460-519	129,473	13,221,114	7,485,077	99.5	5,792,260
Acute Bronchitis and Bronchiolitis	466	5,078	331,347	215,211	98.2	150,709
Allergic Rhinitis	477	17,470	318,932	223,479	98.0	164,410
Pneumonia, Organism Unspecified	486	10,018	1,012,582	545,178	99.6	426,841
Asthma	493	10,185	824,787	505,883	99.4	387,785
Other Diseases of Lung	518	12,575	1,730,866	870,412	99.6	688,866
Diseases of the Digestive System (MDC 9)	520-579	39,429	8,716,629	3,397,077	99.3	2,644,127
Diseases of the Genitourinary System (MDC 1C	580-629	85,050	9,847,540	4,455,824	99.4	3,506,731
Chronic Renal Failure	585	28,492	3,172,281	1,484,252	99.9	1,184,600
Calculus of Kidney and Urete	592	1,992	476,771	146,263	99.5	114,271
Other Disorders of Urethra and Urinary Trac	599	18,307	1,239,523	609,783	99.3	484,959
Hyperplasia of Prostate	600	4,853	672,788	342,427	99.1	259,943
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	52,301	4,012,342	2,484,862	98.6	1,876,956
Other Dermatoses	702	21,585	1,019,172	667,451	97.8	494,124
Chronic Ulcer of Skin	707	7,721	1,151,653	653,270	99.7	513,414

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 2003

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	173,599	$22,133,208	$10,284,452	98.3	$7,926,166
Rheumatoid Arthritis and Ofher Inflammatory Polyarthrophathies	714	8,572	1,112,453	722,251	99.2	559,643
Osteoarthrosis and Allied Disorders	715	26,728	4,663,518	2,105,402	98.9	1,629,850
Other and Unspecified Arthropathies	716	3,640	426,414	257,061	98.8	197,725
Other and Unspecified Disorders of Joint	719	25,757	1,937,326	1,000,347	99.3	768,906
Other and Unspecified Disorders of Back	724	27,769	4,048,630	1,668,981	98.8	1,292,341
Peripheral Enthesopathies and Allied Syndromes	726	10,957	903,962	445,640	99.1	338,536
Other Disorders of Soft Tissues	729	11,510	997,436	506,033	98.9	386,147
Non-Allopathic Lesions, Not Elsewhere Classified	739	14,905	585,834	476,860	85.5	354,367
Congenital Anomalies (MDC 14)	740-759	2,460	489,130	202,056	99.0	156,984
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	184,590	21,903,773	10,480,939	99.4	8,182,376
General Symptoms	780	41,237	4,648,557	2,360,610	99.5	1,856,598
Symptoms Involving Respiratory System and Other Chest Symptoms	786	54,391	6,445,529	3,000,770	99.5	2,331,161
Symptoms Involving Digestive System	787	13,718	1,637,860	811,434	99.6	635,709
Symptoms Involving Urinary System	788	10,343	881,205	457,336	99.0	357,530
Sudden Death, Cause Unknown	798	17	3,848	1,927	99.9	1,456
Other Ill-Defined and Unknown Causes of Morbidity and Mortali	799	3,688	529,575	289,009	99.9	228,077
Injury and Poisoning (MDC 17	800-999	53,004	9,291,476	4,063,241	99.1	3,172,274
Fracture of Neck of Femu	820	4,581	1,349,909	521,287	99.6	412,122
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	V01-V82	119,680	6,757,606	3,438,506	98.1	2,786,064
Need for Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	V04	24,105	296,931	205,473	99.5	203,762
Special Investigations and Examinations	V72	6,126	324,956	147,130	98.5	118,504

[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.