Table 9.1

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Total, Aged, and Disabled Enrollees: Selected Calendar Years 1995-2012

Year	Persons Served[1]	Services Number in Thousands	Submitted Charges	Allowed Charges	Program Payments	Balance Billing
			Amounts in Thousands			
Total						
1995	30,935,680	1,141,270	$96,407,229	$55,175,723	$42,276,746	$235,301
1996	30,675,540	1,130,934	100,648,030	55,500,815	42,514,806	121,195
1997	30,218,980	1,106,604	104,830,651	56,896,798	43,620,311	101,513
1998	29,539,140	1,162,469	108,718,353	57,656,483	44,171,579	82,958
1999	29,331,640	1,200,603	116,249,395	60,563,267	46,487,527	76,730
2000	29,644,740	1,252,280	127,853,210	66,911,902	51,456,747	72,884
2001	30,688,840	1,340,531	147,219,411	76,672,497	59,113,949	70,241
2002	31,754,480	1,481,154	169,663,267	83,181,299	64,253,710	64,359
2003	32,547,900	1,573,445	191,593,731	92,638,665	71,733,844	64,560
2004	32,961,620	1,662,332	215,840,889	102,067,747	79,178,272	63,625
2005	33,434,580	1,766,256	236,285,951	108,052,939	83,747,781	61,459
2006	32,981,880	1,766,733	248,447,505	110,135,017	85,218,098	56,350
2007	32,224,600	1,766,037	259,930,435	110,633,862	85,628,319	51,039
2008	31,826,820	1,798,520	274,355,179	113,804,294	88,112,583	46,980
2009	31,646,640	1,826,304	287,934,772	117,586,191	91,115,719	46,083
2010	32,091,660	1,857,482	302,709,508	122,904,370	95,036,813	41,083
2011	32,503,040	1,845,666	315,349,685	126,314,400	97,795,615	38,654
2012	32,900,220	1,873,755	329,086,038	127,751,223	99,597,040	58,132
Aged						
1995	27,649,460	1,012,890	84,940,078	48,786,706	37,475,087	222,718
1996	27,251,260	998,001	88,225,320	48,760,710	37,448,311	115,555
1997	26,739,000	973,626	91,714,021	49,843,717	38,311,260	96,496
1998	25,965,040	1,019,731	94,762,267	50,281,005	38,634,165	78,838
1999	25,668,380	1,049,891	100,988,074	52,642,997	40,532,735	72,794
2000	25,841,920	1,091,142	110,782,785	58,004,541	44,757,179	69,143
2001	26,660,980	1,164,112	127,081,467	66,214,834	51,234,552	66,700
2002	27,464,140	1,279,875	145,779,008	71,524,366	55,443,808	61,169
2003	27,998,940	1,350,638	163,233,484	78,920,043	61,323,439	61,133
2004	28,164,840	1,418,663	182,463,880	86,306,236	67,186,296	60,135
2005	28,388,260	1,499,983	198,503,311	90,666,561	70,517,544	58,043
2006	27,908,820	1,497,394	208,561,737	92,463,220	71,776,670	53,352
2007	27,150,120	1,490,841	217,273,807	92,577,589	71,864,127	48,470
2008	26,685,820	1,510,700	228,017,745	94,678,189	73,511,787	44,672
2009	26,391,240	1,520,310	236,990,481	96,881,250	75,294,810	43,848
2010	26,625,080	1,536,278	247,177,162	100,755,671	78,096,245	39,116
2011	26,881,040	1,529,276	257,684,332	103,542,175	80,395,035	36,809
2012	27,213,580	1,543,611	267,990,335	104,450,078	81,604,653	55,246
Disabled						
1995	3,286,220	128,380	11,467,151	6,389,017	4,801,659	12,583
1996	3,424,280	132,933	12,422,710	6,740,105	5,066,495	5,640
1997	3,479,980	132,978	13,116,630	7,053,081	5,309,051	5,017
1998	3,574,100	142,738	13,956,086	7,375,478	5,537,414	4,120
1999	3,663,260	150,712	15,261,321	7,920,270	5,954,792	3,936
2000	3,802,820	161,138	17,070,425	8,907,361	6,699,568	3,741
2001	4,027,860	176,419	20,137,944	10,457,663	7,879,397	3,541
2002	4,290,340	201,279	23,884,259	11,656,933	8,809,902	3,190
2003	4,548,960	222,807	28,360,247	13,718,622	10,410,405	3,427
2004	4,796,780	243,669	33,377,009	15,761,511	11,991,976	3,490
2005	5,046,320	266,273	37,782,640	17,386,378	13,230,237	3,416
2006	5,073,060	269,339	39,885,768	17,671,797	13,441,428	2,998
2007	5,074,480	275,197	42,656,629	18,056,273	13,764,192	2,569
2008	5,141,000	287,819	46,337,433	19,126,104	14,600,796	2,308
2009	5,255,400	305,995	50,944,291	20,704,940	15,820,910	2,234
2010	5,466,580	321,204	55,532,346	22,148,699	16,940,568	1,968
2011	5,622,000	316,390	57,665,353	22,772,224	17,400,579	1,845
2012	5,686,640	330,144	61,095,703	23,301,144	17,992,387	2,886

NOTES: Medicare charges and program payments represent fee-for-service utilization only. The methodology for calculating the balance billing amount was modified for 2012.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Office of Information Products & Data Analytics.

Table 9.2

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Demographic Characteristics: Calendar Year 2012

Demographic Characteristic	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	32,900,220	1,873,755	57.0	$329,086,038	$10,003
Sex					
Male	14,195,300	787,879	55.5	145,718,522	10,265
Female	18,704,920	1,085,876	58.1	183,367,516	9,803
Age					
Under 65 Years	5,686,640	330,144	58.1	61,095,703	10,744
65-74 Years	13,568,080	688,598	50.8	125,040,247	9,216
75-84 Years	8,919,520	561,350	62.9	97,633,711	10,946
85 Years or Over	4,725,980	293,663	62.1	45,316,377	9,589
Race[3]					
White	27,419,720	1,554,719	56.7	272,830,313	9,950
Other	5,255,180	309,500	58.9	54,543,441	10,379
Type of Entitlement[4]					
Aged	26,907,440	1,501,849	55.8	258,689,792	9,614
Disabled	5,580,680	308,239	55.2	54,777,651	9,816
ESRD	412,100	63,667	154.5	15,618,595	37,900

See footnotes at end of table.

Table 9.2--Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Demographic Characteristics: Calendar Year 2012

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	$127,751,223	$3,883	$127,276,051	99.6	$99,597,040	$3,086	$58,132	$53
Sex								
Male	56,122,579	3,954	55,924,344	99.6	43,672,771	3,154	24,783	56
Female	71,628,644	3,829	71,351,707	99.6	55,924,270	3,035	33,349	50
Age								
Under 65 Years	23,301,144	4,098	23,277,180	99.9	17,992,387	3,268	2,886	55
65-74 Years	46,858,839	3,454	46,652,809	99.6	36,453,992	2,750	25,069	51
75-84 Years	38,342,676	4,299	38,170,013	99.5	30,081,292	3,407	21,218	55
85 Years or Over	19,248,563	4,073	19,176,048	99.6	15,069,369	3,222	8,959	52
Race[3]								
White	105,749,036	3,857	105,298,287	99.6	82,395,376	3,060	55,094	53
Other	21,343,766	4,061	21,321,623	99.9	16,693,011	3,254	2,762	51
Type of Entitlement[4]								
Aged	100,841,094	3,748	100,393,028	99.6	78,750,457	2,976	54,850	52
Disabled	20,935,411	3,751	20,911,216	99.9	16,111,429	2,984	2,902	55
ESRD	5,974,718	14,498	5,971,807	100.0	4,735,154	11,551	380	66

[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. The methodology for calculating the balance billing amount was modified for 2012.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Office of Information Products & Data Analytics.

Table 9.3

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Type of Service: Calendar Year 2012

Type of Service	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	32,900,220	1,873,755	57.0	$329,086,038	$10,003
Medical Care	31,915,660	756,814	23.7	116,607,068	3,654
Surgery	20,063,120	111,952	5.6	62,130,075	3,097
Consultation	583,920	1,169	2.0	206,630	354
Diagnostic X-Ray	21,964,300	131,375	6.0	25,197,663	1,147
Diagnostic Laboratory	27,398,040	549,292	20.0	38,716,053	1,413
Radiation Therapy	1,598,320	13,270	8.3	7,548,591	4,723
Anesthesia	7,419,560	15,201	2.0	14,178,041	1,911
Assistance at Surgery	953,140	1,808	1.9	3,144,166	3,299
Other Medical Services	1,058,040	6,535	6.2	1,387,260	1,311
Ambulatory Surgical Center	3,427,520	6,943	2.0	17,512,797	5,109
Psychological Therapy	3,454,900	22,852	6.6	3,012,572	872
Pneumococcal Vaccine	14,024,240	30,122	2.1	838,120	60
Physical Therapy	20	(6)	1.0	1	50
Durable Medical Equipment [4]	10,260,640	143,838	14.0	19,404,609	1,891
Other [5]	10,689,800	82,583	7.7	19,202,394	1,796

[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, and rental of DME.

[6]Less than 500.

NOTES: Medicare charges and program payments represent fee-for-service utilization only. Numbers may not add to total because of rounding. BETOS is Berenson-Eggers Type of Service System for classifying HCPCS. ESRD is end stage renal disease. The methodology for calculating the balance billing amount was modified for 2012.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Office of Information Products & Data Analytics.

Table 9.3--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 2012

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
$127,751,223	$3,883	$127,276,051	99.6	$99,597,040	$3,086	$58,132	$53
59,278,704	1,857	59,007,628	99.5	45,078,515	1,469	32,480	37
18,445,806	919	18,373,911	99.6	14,447,128	731	9,625	57
72,128	124	71,500	99.1	56,753	98	93	22
7,541,219	343	7,514,204	99.6	5,852,919	276	3,696	33
11,946,237	436	11,928,569	99.9	10,466,028	386	2,498	17
2,219,081	1,388	2,208,588	99.5	1,756,858	1,105	1,538	292
2,439,115	329	2,436,502	99.9	1,924,652	260	370	35
246,595	259	246,376	99.9	195,473	206	28	34
732,561	692	732,560	100.0	577,910	556	0	3
3,581,199	1,045	3,581,199	100.0	2,840,086	829	0	0
1,598,435	463	1,577,078	98.7	891,888	274	2,847	73
629,663	45	628,799	99.9	628,222	45	34	3
0	5	0	100.0	0	4	0	0
10,274,037	1,001	10,226,712	99.5	7,972,159	791	4,433	25
8,746,440	818	8,742,423	100.0	6,908,449	656	491	13

Table 9.4

Persons Served, Services, Submitted and Allowed Charges, Program Payments for Medicare Physician and Supplier Services, by Place of Service: Calendar Year 2012

Place of Service	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	32,900,220	1,873,755	57.0	$329,086,038	$10,003
Office	30,319,920	884,905	29.2	127,692,138	4,211
Home	10,430,760	162,665	15.6	24,373,585	2,337
Inpatient Hospital	7,729,780	185,039	23.9	57,262,524	7,408
Outpatient Hospital [4]	18,316,660	116,572	6.4	35,103,204	1,916
Emergency Room Hospital [4]	10,871,520	49,549	4.6	15,665,150	1,441
Ambulatory Surgical Center	3,755,140	18,290	4.9	27,882,766	7,425
Skilled Nursing Care Facility	2,047,500	24,426	11.9	2,715,102	1,326
Nursing Home	2,062,060	35,791	17.4	2,499,303	1,212
Hospice	4,280	14	3.3	2,190	512
Ambulance [5]	4,900,040	60,960	12.4	12,073,979	2,464
Independent Laboratory	18,105,640	285,771	15.8	17,293,363	955
All Other [6]	8,728,600	49,774	5.7	6,522,734	747

See footnotes at end of table.

Table 9.4--Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments for Medicare Physician and Supplier Services, by Place of Service: Calendar Year 2012

	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	$127,751,223	100.0	$3,883	$127,276,051	99.6	$99,597,040	100.0	$3,086
Office	60,507,824	47.4	1,996	60,141,334	99.4	46,023,474	46.2	1,562
Home	12,641,894	9.9	1,212	12,594,380	99.6	9,830,671	9.9	959
Inpatient Hospital	18,691,209	14.6	2,418	18,664,563	99.9	14,801,720	14.9	1,925
Outpatient Hospital [4]	8,961,111	7.0	489	8,940,881	99.8	6,965,339	7.0	391
Emergency Room Hospital [4]	3,668,735	2.9	337	3,665,541	99.9	2,827,024	2.8	265
Ambulatory Surgical Center	6,220,837	4.9	1,657	6,212,865	99.9	4,926,517	4.9	1,314
Skilled Nursing Care Facility	1,683,425	1.3	822	1,682,847	100.0	1,287,079	1.3	637
Nursing Home	1,533,136	1.2	743	1,532,930	100.0	1,163,298	1.2	571
Hospice	1,038	(7)	243	1,038	100.0	793	(7)	191
Ambulance [5]	5,789,103	4.5	1,181	5,789,056	100.0	4,593,168	4.6	938
Independent Laboratory	5,155,053	4.0	285	5,154,994	100.0	4,892,416	4.9	271
All Other [6]	2,897,856	2.3	332	2,895,622	99.9	2,285,541	2.3	265

[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.

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

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Office of Information Products & Data Analytics.

Table 9.5

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Physician Specialty: Calendar Year 2012

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	32,900,220	1,873,755	100.0	57.0	$329,086,038	100.0	$10,003
Total Physicians	32,188,220	1,154,519	61.6	35.9	231,625,985	70.4	7,196
General Practice	1,470,520	9,492	0.5	6.5	1,089,639	0.3	741
General Surgery	3,645,600	12,728	0.7	3.5	6,578,960	2.0	1,805
Allergy and Immunology	459,560	12,814	0.7	27.9	445,166	0.1	969
Otology, Laryngology, Rhinology	3,121,420	15,089	0.8	4.8	2,703,359	0.8	866
Anesthesiology	6,010,820	15,801	0.8	2.6	11,221,860	3.4	1,867
Cardiology	12,375,020	86,687	4.6	7.0	18,245,960	5.5	1,474
Dermatology	6,297,620	43,491	2.3	6.9	5,631,595	1.7	894
Family Practice	14,869,620	132,717	7.1	8.9	11,793,391	3.6	793
Gastroenterology	4,642,240	15,177	0.8	3.3	5,962,429	1.8	1,284
Internal Medicine	17,587,340	189,174	10.1	10.8	23,300,138	7.1	1,325
Manipulative Therapy	103,840	723	(6)	7.0	118,459	(6)	1,141
Neurology	3,627,040	17,829	1.0	4.9	3,952,145	1.2	1,090
Neurologiclal Surgery	849,060	2,716	0.1	3.2	3,237,957	1.0	3,814
Obstetrics and Gynecology	2,417,860	7,793	0.4	3.2	1,524,627	0.5	631
Ophthalmology	10,900,900	52,102	2.8	4.8	15,860,727	4.8	1,455
Oral Surgery (Dentists Only)	86,500	197	(6)	2.3	70,094	(6)	810
Orthopedic Surgery	5,645,240	37,473	2.0	6.6	13,014,831	4.0	2,305
Pathology	6,528,020	28,208	1.5	4.3	4,153,413	1.3	636
Plastic and Reconstructive Surgery	516,280	2,005	0.1	3.9	1,173,429	0.4	2,273
Physical Medicine and Rehabilitation	1,722,980	16,516	0.9	9.6	2,672,042	0.8	1,551
Psychiatry	2,271,280	15,873	0.8	7.0	2,152,554	0.7	948
Colorectal Surgery (Proctology)	298,700	807	(6)	2.7	441,161	0.1	1,477
Pulmonary Disease	3,222,700	20,927	1.1	6.5	3,696,276	1.1	1,147
Diagnostic Radiology	20,530,380	105,473	5.6	5.1	18,419,198	5.6	897
Thoracic Surgery	370,380	1,143	0.1	3.1	1,268,642	0.4	3,425
Urology	4,436,440	29,625	1.6	6.7	6,360,387	1.9	1,434
Chiropractic	2,091,920	21,760	1.2	10.4	1,017,489	0.3	486
Nuclear Medicine	453,400	871	(6)	1.9	307,415	0.1	678
Pediatric Medicine	257,600	1,303	0.1	5.1	189,768	0.1	737
Geriatric Medicine	543,760	3,100	0.2	5.7	424,153	0.1	780
Nephrology	2,096,300	20,060	1.1	9.6	4,989,198	1.5	2,380
Optometrist	5,853,040	13,050	0.7	2.2	1,388,117	0.4	237
Infectious Disease	1,039,900	9,004	0.5	8.7	1,387,914	0.4	1,335
Endocrinology	1,577,620	9,610	0.5	6.1	990,661	0.3	628
Podiatry	6,294,300	36,867	2.0	5.9	3,529,766	1.1	561

See footnotes at end of table.

Table 9.5--Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Physician Specialty: Calendar Year 2012

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
$127,751,223	100.0	$3,883	$127,276,051	99.6	$99,597,040	100.0	$3,086	$58,132	$53
91,583,159	71.7	2,845	91,159,535	99.5	70,545,484	70.8	2,250	53,134	56
589,132	0.5	401	578,315	98.2	441,510	0.4	313	1,310	59
2,176,758	1.7	597	2,172,765	99.8	1,703,180	1.7	477	565	63
261,087	0.2	568	258,650	99.1	198,399	0.2	444	276	45
1,128,539	0.9	362	1,123,487	99.6	854,625	0.9	284	696	40
2,015,387	1.6	335	2,011,624	99.8	1,584,468	1.6	265	541	45
6,880,908	5.4	556	6,866,762	99.8	5,298,156	5.3	439	1,994	47
3,181,300	2.5	505	3,152,545	99.1	2,409,683	2.4	397	3,688	40
6,469,001	5.1	435	6,438,962	99.5	4,798,365	4.8	335	3,713	36
1,949,486	1.5	420	1,941,247	99.6	1,523,685	1.5	334	1,152	50
12,146,326	9.5	691	12,076,793	99.4	9,331,393	9.4	543	9,333	44
59,831	(6)	576	58,582	97.9	46,159	(6)	456	136	114
1,844,553	1.4	509	1,838,586	99.7	1,409,584	1.4	399	869	44
718,340	0.6	846	716,231	99.7	563,543	0.6	681	277	73
633,737	0.5	262	628,468	99.2	497,930	0.5	211	599	24
7,780,927	6.1	714	7,748,689	99.6	5,934,715	6.0	570	4,351	44
32,631	(6)	377	31,248	95.8	25,337	(6)	304	141	64
3,965,342	3.1	702	3,954,611	99.7	3,059,815	3.1	558	1,508	73
1,302,972	1.0	200	1,298,987	99.7	1,031,711	1.0	161	583	31
372,721	0.3	722	370,912	99.5	291,602	0.3	578	234	70
1,161,800	0.9	674	1,159,566	99.8	906,469	0.9	533	320	42
1,166,666	0.9	514	1,149,434	98.5	790,310	0.8	360	2,271	66
159,320	0.1	533	158,016	99.2	124,626	0.1	425	191	103
1,817,054	1.4	564	1,812,295	99.7	1,418,329	1.4	447	664	49
5,048,829	4.0	246	5,025,281	99.5	3,991,064	4.0	201	3,220	56
343,491	0.3	927	342,890	99.8	271,137	0.3	744	89	135
2,349,864	1.8	530	2,344,022	99.8	1,806,867	1.8	413	836	53
715,194	0.6	342	646,640	90.4	525,399	0.5	266	6,286	28
88,097	0.1	194	88,007	99.9	69,439	0.1	157	13	18
78,175	0.1	303	78,083	99.9	59,891	0.1	240	9	14
236,004	0.2	434	234,669	99.4	180,293	0.2	339	190	59
2,238,563	1.8	1,068	2,236,880	99.9	1,754,097	1.8	849	245	37
1,060,563	0.8	181	1,055,276	99.5	748,624	0.8	138	205	14
704,566	0.6	678	704,042	99.9	555,234	0.6	539	77	44
525,977	0.4	333	519,149	98.7	406,147	0.4	263	898	34
2,174,727	1.7	346	2,169,000	99.7	1,642,577	1.6	268	532	27

Table 9.5--Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Physician Specialty: Calendar Year 2012

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	1,415,000	14,010	0.7	9.9	$2,953,133	0.9	$2,087
Vascular Surgery	1,453,360	4,979	0.3	3.4	3,137,094	1.0	2,159
Cardiac Surgery	340,340	1,156	0.1	3.4	1,338,083	0.4	3,932
Hematology/Oncology	2,102,760	60,661	3.2	28.8	14,221,232	4.3	6,763
Medical Oncology	741,560	17,271	0.9	23.3	4,240,451	1.3	5,718
Radiation Oncology	781,600	12,853	0.7	16.4	7,115,246	2.2	9,103
Emergency Medicine	9,828,280	29,224	1.6	3.0	11,888,047	3.6	1,210
All Other Physician [5]	4,068,540	26,160	1.4	6.4	7,419,780	2.3	1,824
Group Practice	464,760	3,588	0.2	7.7	67,554	(6)	145
Total Non-Physician	18,561,400	186,125	9.9	10.0	38,728,466	11.8	2,087
Total Suppliers	23,213,780	529,523	28.3	22.8	58,664,033	17.8	2,527

[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]Includes critical care (intensivist), addiction medicine, hand surgery, peripheral vascular disease, preventive medicine, maxillofacial surgery, neuropsychiatry, surgical oncology, interventional radiology, hematology, gynecologist/oncologist, pain management, interventional pain management, intensive cardiac rehabilitation, geriatric psychiatry, and unknown physician's specialty.

[6]Less than 0.05 percent.

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. The methodology for calculating the balance billing amount was modified for 2012. 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 Standard Analytical Files; data development by the Office of Information Products & Data Analytics.

Table 9.5--Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Physician Specialty: Calendar Year 2012

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
$1,611,378	1.3	$1,139	$1,604,961	99.6	$1,247,961	1.3	$900	$861	$47
928,683	0.7	639	927,520	99.9	728,573	0.7	511	169	65
370,653	0.3	1,089	368,818	99.5	292,249	0.3	872	271	301
6,113,851	4.8	2,908	6,111,029	100.0	4,846,176	4.9	2,340	406	65
1,757,092	1.4	2,369	1,756,213	99.9	1,390,391	1.4	1,904	129	41
2,059,995	1.6	2,636	2,049,051	99.5	1,628,130	1.6	2,157	1,609	725
3,013,488	2.4	307	3,009,883	99.9	2,324,163	2.3	241	525	27
2,350,148	1.8	578	2,341,348	99.6	1,833,479	1.8	462	1,152	36
38,262	(6)	82	36,845	96.3	31,772	(6)	69	173	49
11,434,448	9.0	616	11,423,076	99.9	8,792,040	8.8	483	1,189	27
24,695,354	19.3	1,064	24,656,595	99.8	20,227,745	20.3	876	3,636	26

Table 9.6

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Area of Residence: Calendar Year 2012

Area of Residence	Persons Served [1]		Services		Submitted Charges	
	Number	Percent	Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
All Areas [4]	32,900,220	100.0	1,873,755	57	$329,086,038	$10,003
United States [5]	32,787,840	99.7	1,868,137	57	328,528,606	10,020
Northeast	6,012,640	18.3	371,835	62	63,589,941	10,576
Midwest	7,835,240	23.8	396,685	51	69,825,377	8,912
South	13,184,800	40.1	793,709	60	137,796,209	10,451
West	5,755,160	17.5	305,908	53	57,317,079	9,959
New England	1,839,960	5.6	93,863	51	16,764,057	9,111
Connecticut	416,220	1.3	24,048	58	4,411,327	10,599
Maine	208,660	0.6	8,794	42	1,363,549	6,535
Massachusetts	816,420	2.5	42,339	52	7,910,533	9,689
New Hampshire	192,520	0.6	7,506	39	1,552,496	8,064
Rhode Island	104,500	0.3	6,128	59	867,876	8,305
Vermont	101,640	0.3	5,047	50	658,276	6,477
Middle Atlantic	4,172,680	12.7	277,973	67	46,825,884	11,222
New Jersey	1,068,200	3.2	78,165	73	13,964,630	13,073
New York	1,813,020	5.5	129,143	71	20,689,854	11,412
Pennsylvania	1,291,460	3.9	70,666	55	12,171,400	9,425
East North Central	5,353,100	16.3	286,675	54	51,169,527	9,559
Illinois	1,567,060	4.8	85,696	55	16,683,086	10,646
Indiana	788,060	2.4	38,823	49	7,212,145	9,152
Michigan	1,214,400	3.7	75,465	62	10,627,466	8,751
Ohio	1,173,060	3.6	60,489	52	10,241,007	8,730
Wisconsin	610,520	1.9	26,203	43	6,405,824	10,492
West North Central	2,482,140	7.5	110,010	44	18,655,849	7,516
Iowa	436,860	1.3	18,619	43	3,027,148	6,929
Kansas	364,260	1.1	17,981	49	3,023,513	8,300
Minnesota	487,780	1.5	16,679	34	3,051,253	6,255
Missouri	739,540	2.2	37,019	50	6,441,194	8,710
Nebraska	237,120	0.7	11,396	48	1,846,092	7,785
North Dakota	97,980	0.3	3,486	36	566,575	5,783
South Dakota	118,600	0.4	4,829	41	700,076	5,903
South Atlantic	7,090,520	21.6	435,837	61	76,142,775	10,739
Delaware	145,780	0.4	8,294	57	1,420,439	9,744
District of Columbia	60,040	0.2	3,191	53	567,260	9,448
Florida	2,184,340	6.6	159,810	73	28,470,947	13,034
Georgia	945,500	2.9	55,990	59	10,298,523	10,892
Maryland	678,280	2.1	39,772	59	6,920,107	10,202
North Carolina	1,216,520	3.7	67,292	55	11,404,115	9,374
South Carolina	646,520	2.0	38,069	59	6,602,959	10,213
Virginia	935,300	2.8	49,493	53	8,210,838	8,779
West Virginia	278,240	0.8	13,928	50	2,247,587	8,078

See footnotes at end of table.

Table 9.6--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 2012

Allowed Charges				Program Payments			Balance Billing	
Amount in Thousands	Percent	Per Person Served[1]	Percent of Charges Assigned[2]	Amount in Thousands	Percent	Per Person Served[3]	Amount in Thousands	Per Person With Liability
$127,751,223	100.0	$3,883	99.6	$99,597,040	100.0	$3,086	$58,132	$53
127,417,285	99.7	3,886	99.6	99,337,369	99.7	3,089	58,096	53
25,283,814	19.8	4,205	99.6	19,733,153	19.8	3,340	11,229	51
26,679,506	20.9	3,405	99.7	20,680,275	20.8	2,696	10,167	45
52,910,843	41.4	4,013	99.7	41,331,967	41.5	3,191	21,084	50
22,543,122	17.6	3,917	99.5	17,591,974	17.7	3,124	15,617	65
6,322,355	4.9	3,436	99.8	4,894,526	4.9	2,709	1,579	53
1,712,098	1.3	4,113	99.6	1,332,425	1.3	3,243	971	68
581,358	0.5	2,786	99.8	447,836	0.4	2,208	105	47
2,878,174	2.3	3,525	99.9	2,227,501	2.2	2,775	251	39
553,524	0.4	2,875	99.8	425,487	0.4	2,264	109	34
371,958	0.3	3,559	99.9	288,889	0.3	2,807	27	29
225,243	0.2	2,216	99.6	172,387	0.2	1,730	115	41
18,961,459	14.8	4,544	99.6	14,838,627	14.9	3,618	9,650	51
5,433,880	4.3	5,087	99.4	4,270,780	4.3	4,057	4,215	49
8,540,957	6.7	4,711	99.5	6,695,852	6.7	3,753	4,906	58
4,986,622	3.9	3,861	99.9	3,871,995	3.9	3,061	529	30
19,344,771	15.1	3,614	99.7	15,005,817	15.1	2,862	5,435	41
6,030,082	4.7	3,848	99.6	4,682,251	4.7	3,046	2,392	44
2,667,128	2.1	3,384	99.7	2,064,224	2.1	2,678	770	39
4,799,154	3.8	3,952	99.9	3,735,839	3.8	3,133	776	43
4,149,644	3.2	3,537	99.9	3,215,321	3.2	2,807	364	21
1,698,763	1.3	2,782	99.5	1,308,182	1.3	2,193	1,134	51
7,334,735	5.7	2,955	99.5	5,674,457	5.7	2,337	4,731	49
1,229,303	1.0	2,814	99.2	947,974	1.0	2,219	1,204	64
1,214,464	1.0	3,334	99.7	942,591	0.9	2,645	359	40
1,157,291	0.9	2,373	99.7	889,910	0.9	1,865	393	42
2,441,752	1.9	3,302	99.7	1,895,974	1.9	2,614	839	34
743,729	0.6	3,137	99.4	575,184	0.6	2,485	582	44
236,575	0.2	2,415	99.2	181,920	0.2	1,915	266	61
311,621	0.2	2,627	97.5	240,905	0.2	2,083	1,088	64
29,960,397	23.5	4,225	99.6	23,420,886	23.5	3,356	14,921	62
585,932	0.5	4,019	99.8	457,118	0.5	3,186	123	44
241,716	0.2	4,026	99.2	188,494	0.2	3,185	260	48
11,576,807	9.1	5,300	99.5	9,118,543	9.2	4,232	8,181	96
3,718,057	2.9	3,932	99.7	2,900,377	2.9	3,125	1,202	50
2,940,404	2.3	4,335	99.6	2,293,335	2.3	3,431	1,382	46
4,252,260	3.3	3,495	99.6	3,306,476	3.3	2,759	1,936	45
2,437,748	1.9	3,771	99.8	1,896,169	1.9	2,986	640	34
3,331,853	2.6	3,562	99.7	2,583,006	2.6	2,808	1,049	37
875,620	0.7	3,147	99.9	677,369	0.7	2,505	148	37

Table 9.6--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 2012

	Persons Served [1]		Services		Submitted Charges	
Area of Residence	Number	Percent	Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
East South Central	2,459,660	7.5	145,002	59	$22,573,066	$9,177
Alabama	650,720	2.0	38,815	60	5,831,115	8,961
Kentucky	615,360	1.9	35,350	57	5,258,150	8,545
Mississippi	429,300	1.3	23,405	55	4,012,868	9,347
Tennessee	764,280	2.3	47,432	62	7,470,933	9,775
West South Central	3,634,620	11.0	212,870	59	39,080,368	10,752
Arkansas	421,480	1.3	23,036	55	3,507,730	8,322
Louisiana	486,380	1.5	26,864	55	4,805,906	9,881
Oklahoma	480,920	1.5	24,279	50	3,942,110	8,197
Texas	2,245,840	6.8	138,691	62	26,824,622	11,944
Mountain	1,924,580	5.8	95,810	50	18,050,960	9,379
Arizona	558,800	1.7	33,967	61	6,020,457	10,774
Colorado	404,520	1.2	18,624	46	3,709,029	9,169
Idaho	153,960	0.5	5,882	38	923,433	5,998
Montana	136,440	0.4	4,763	35	794,382	5,822
Nevada	221,740	0.7	13,444	61	2,894,517	13,054
New Mexico	204,400	0.6	8,547	42	1,701,459	8,324
Utah	169,940	0.5	7,674	45	1,407,690	8,283
Wyoming	74,780	0.2	2,909	39	599,992	8,023
Pacific	3,830,580	11.6	210,098	55	39,266,120	10,251
Alaska	58,640	0.2	2,017	34	618,045	10,540
California	2,691,520	8.2	161,186	60	30,179,782	11,213
Hawaii	99,300	0.3	4,346	44	632,206	6,367
Oregon	334,400	1.0	13,404	40	2,646,154	7,913
Washington	646,720	2.0	29,146	45	5,189,932	8,025
Outlying Areas [6]	112,380	0.3	5,618	50	557,433	4,960

[1]Includes beneficiaries who received covered services, but for whom no program payments were reported during the 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]Consists of United States and outlying areas.

[5]Includes 50 States and District of Columbia.

[6]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. Methodology for calculating the balance billing amount was modified for 2012.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical files; data development by the Office of Information Products & Data Analytics.

Table 9.6--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 2012

Allowed Charges				Program Payments			Balance Billing	
Amount in Thousands	Percent	Per Person Served[1]	Percent of Charges Assigned[2]	Amount in Thousands	Percent	Per Person Served[3]	Amount in Thousands	Per Person With Liability
$8,893,983	7.0	$3,616	99.8	$6,935,660	7.0	$2,874	$1,689	$29
2,481,502	1.9	3,813	99.9	1,931,793	1.9	3,024	364	32
2,104,192	1.6	3,419	99.8	1,645,803	1.7	2,728	398	28
1,459,386	1.1	3,399	99.8	1,136,096	1.1	2,704	429	26
2,848,904	2.2	3,728	99.8	2,221,969	2.2	2,958	498	31
14,056,462	11.0	3,867	99.7	10,975,420	11.0	3,082	4,473	37
1,432,013	1.1	3,398	99.9	1,113,255	1.1	2,698	234	36
1,767,585	1.4	3,634	99.9	1,375,875	1.4	2,895	237	34
1,569,599	1.2	3,264	99.8	1,215,570	1.2	2,589	458	33
9,287,266	7.3	4,135	99.7	7,270,720	7.3	3,299	3,544	38
7,029,552	5.5	3,653	99.1	5,463,521	5.5	2,911	8,638	86
2,438,423	1.9	4,364	98.3	1,907,013	1.9	3,481	5,826	143
1,406,592	1.1	3,477	99.4	1,095,168	1.1	2,768	978	50
390,811	0.3	2,538	98.8	301,450	0.3	2,022	640	45
342,560	0.3	2,511	99.0	263,863	0.3	2,002	392	64
1,018,758	0.8	4,594	99.9	791,075	0.8	3,650	172	49
638,874	0.5	3,126	99.5	494,973	0.5	2,497	365	44
570,524	0.4	3,357	99.9	438,216	0.4	2,652	80	35
223,009	0.2	2,982	99.1	171,762	0.2	2,378	186	33
15,513,569	12.1	4,050	99.6	12,128,453	12.2	3,231	6,978	50
179,004	0.1	3,053	99.6	137,699	0.1	2,430	98	48
11,934,151	9.3	4,434	99.6	9,362,441	9.4	3,544	5,328	52
276,046	0.2	2,780	99.4	209,937	0.2	2,161	197	52
1,007,715	0.8	3,014	99.6	779,201	0.8	2,394	474	37
2,116,653	1.7	3,273	99.7	1,639,174	1.6	2,588	882	49
333,938	0.3	2,972	99.8	259,672	0.3	2,427	36	32

Table 9.7

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 2012

BETOS Classification	BETOS Codes	Persons Served[1]	Services			Allowed Charges			Program Payments		
			Number in Thousands	Percent	Per Person Served[1]	Amount in Thousands	Percent	Per Person Served[1]	Amount in Thousands	Percent	Per Person Served[2]
Total All BETOS Groups	Total	32,900,220	1,873,755	100.0	57	$127,751,223	100.0	$3,883	$99,597,040	100.0	$3,086
Office Visits - Established	M1B	28,652,180	222,738	11.9	8	17,506,922	13.7	611	12,426,505	12.5	458
Other Drugs	O1E	8,029,600	86,575	4.6	11	9,892,316	7.7	1,232	7,811,637	7.8	1,006
Hospital Visits - Subsequent	M2B	6,896,260	94,284	5.0	14	7,059,704	5.5	1,024	5,605,211	5.6	816
Ambulance	O1A	4,918,740	61,111	3.3	12	6,224,442	4.9	1,265	4,938,676	5.0	1,005
Minor Procedures - Other (MPFS)	P6C	10,671,420	125,258	6.7	12	4,342,209	3.4	407	3,393,747	3.4	328
Lab Tests - Other (Non-MPFS)	T1H	20,272,160	238,794	12.7	12	4,026,747	3.2	199	4,014,619	4.0	198
Hospital Visits - Initial	M2A	6,654,080	22,345	1.2	3	3,660,667	2.9	550	2,879,420	2.9	435
Other Durable Medical Equipment	D1E	7,072,960	84,206	4.5	12	3,607,303	2.8	510	2,774,791	2.8	401
Office Visits - New	M1A	15,595,080	26,803	1.4	2	3,296,163	2.6	211	2,406,674	2.4	161
Specialist - Ophthalmology	M5C	13,331,800	33,241	1.8	2	3,014,828	2.4	226	2,152,502	2.2	173
Emergency Room Visit	M3	10,021,540	20,604	1.1	2	2,641,084	2.1	264	2,032,690	2.0	207
Eye Procedures - Cataract Removal/Lens Insertion	P4B	1,210,880	3,644	0.2	3	2,605,548	2.0	2,152	2,059,651	2.1	1,702
Lab Tests - Other (MPFS)	T1G	8,748,600	39,969	2.1	5	2,534,104	2.0	290	1,986,213	2.0	231
Prosthetic/Orthotic Devices	D1F	3,352,920	23,075	1.2	7	2,479,196	1.9	739	1,947,692	2.0	586
Ambulatory Procedures - Skin	P5A	6,419,460	34,623	1.8	5	2,478,239	1.9	386	1,913,510	1.9	305
Anesthesia	P0	7,251,600	14,687	0.8	2	2,427,961	1.9	335	1,913,953	1.9	265
Nursing Home Visit	M4B	2,788,840	28,022	1.5	10	2,245,679	1.8	805	1,706,310	1.7	621
Chemotherapy	O1D	373,620	10,510	0.6	28	2,152,057	1.7	5,760	1,706,123	1.7	4,597
Other Tests - Other	T2D	9,711,540	44,737	2.4	5	2,104,124	1.6	217	1,627,705	1.6	172
Major Procedure - Other	P1G	1,816,420	4,256	0.2	2	2,089,266	1.6	1,150	1,648,197	1.7	911
All Other BETOS Groups	---	31,285,880	654,274	35.0	21	41,362,665	32.4	1,322	32,651,215	32.8	1,056

[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 Medicare fee schedule. CAT is Computerized Axial Tomography. NA is not applicable. The leading BETOS codes are based on the amount of allowed charges for 2012. 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 Standard Analytical Files; data development by the Office of Information Products & Data Analytics.

Table 9.8

Services, Submitted and Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2012

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	---	1,873,755	$329,086,038	$127,751,223	99.6	$99,597,040
Leading Diagnoses [2]	---	1,056,637	163,720,137	66,435,274	99.6	51,570,806
Infectious and Parasitic Diseases (MDC 1)	001-139	22,303	2,689,016	1,312,123	99.7	1,011,587
Dermatophytosis	110	9,868	672,985	448,793	99.8	332,056
Neoplasm (MDC 2)	140-239	140,622	43,089,412	15,842,525	99.7	12,511,955
Malignant Neoplasm of Colon	153	8,128	2,359,532	943,297	99.9	747,455
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	15,256	4,086,194	1,376,540	99.8	1,095,295
Other Malignant Neoplasm of Skin	173	8,808	3,700,284	1,716,038	99.5	1,346,288
Malignant Neoplasm of Female Breast	174	16,506	4,426,717	1,707,484	99.5	1,365,207
Malignant Neoplasm of Prostate	185	13,368	5,117,147	1,693,809	99.8	1,332,932
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	234,353	18,624,899	7,924,196	99.6	6,295,000
Thyroiditis	244	16,115	1,125,674	413,709	99.4	345,402
Diabetes Mellitus	250	127,993	8,720,536	4,362,980	99.7	3,375,591
Disorders of Lipoid Metabolism	272	52,225	3,250,643	1,164,736	99.4	964,273
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	7,168	970,668	382,780	99.9	303,586
Diseases of the Blood and Blood-Forming Organs (MDC 4)	280-289	45,322	5,805,268	2,442,564	99.9	1,978,577
Other and Unspecified Anemias	285	22,539	2,467,601	934,688	99.9	767,311
Mental Disorders (MDC 5)	290-319	47,287	6,334,731	3,182,997	99.2	2,145,170
Schizophrenic Disorders	295	6,595	770,568	389,906	99.9	261,327
Affective Psychoses	296	13,602	1,821,549	941,371	98.8	600,041
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	132,269	35,763,274	15,342,259	99.7	11,738,780
Other Retinal Disorders	362	22,212	6,581,372	3,512,639	99.9	2,735,169
Glaucoma	365	13,805	2,170,244	1,191,363	99.3	867,535
Cataract	366	15,569	11,436,685	3,887,616	99.6	2,983,542

See footnotes at end of table.

Table 9.8--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 2012

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	217,818	$41,668,927	$15,924,249	99.7	$12,288,212
Essential Hypertension	401	66,882	5,925,464	2,911,527	99.3	2,154,569
Acute Myocardial Infarction	410	2,558	964,003	327,147	99.9	258,457
Other Acute and Subacute Forms of Ischemic Heart Disease	411	1,213	527,969	168,358	99.9	132,141
Angina Pectoris	413	2,372	684,651	261,585	99.9	203,902
Other Forms of Chronic Ischemic Heart Disease	414	23,464	6,072,979	2,211,411	99.7	1,698,741
Other Diseases of Endocardium	424	5,389	2,299,883	655,158	99.6	508,959
Cardiac Dysrhythmias	427	39,801	5,588,802	2,131,787	99.7	1,658,809
Heart Failure	428	17,493	3,280,677	1,353,103	99.8	1,066,575
Ill-Defined Descriptions and Complications of Heart Disease	429	2,214	323,380	111,216	99.5	85,133
Acute, But Ill-Defined, Cerebrovascular Disease	436	4,025	744,765	366,633	99.9	287,179
Diseases of the Respiratory System (MDC 8)	460-519	119,822	17,016,803	7,207,271	99.8	5,529,450
Acute Bronchitis and Bronchiolitis	466	4,922	456,072	234,228	99.2	163,690
Allergic Rhinitis	477	19,761	532,693	294,541	99.3	219,424
Pneumonia, Organism Unspecified	486	8,925	1,505,512	647,213	99.9	507,744
Asthma	493	9,427	1,173,907	522,537	99.7	397,339
Other Diseases of Lung	518	13,264	2,873,121	1,223,830	99.9	968,323
Diseases of the Digestive System (MDC 9)	520-579	41,306	14,048,496	4,336,289	99.7	3,380,542
Diseases of the Genitourinary System (MDC 10)	580-629	90,137	16,616,223	6,314,000	99.8	4,965,115
Chronic Renal Failure	585	27,598	5,696,537	2,357,301	100.0	1,869,552
Calculus of Kidney and Ureter	592	3,328	1,157,853	283,534	99.8	221,413
Other Disorders of Urethra and Urinary Tract	599	23,505	2,561,159	999,679	99.8	795,847
Hyperplasia of Prostate	600	6,627	1,131,016	415,260	99.6	318,806
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	65,523	7,308,216	3,764,520	99.4	2,848,338
Other Dermatoses	702	27,782	1,996,347	1,092,918	99.0	809,866
Chronic Ulcer of Skin	707	9,647	1,718,047	821,285	99.9	644,859

See footnotes at end of table.

Table 9.8--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 2012

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	263,295	$47,808,576	$16,617,915	99.3	$12,867,428
Rheumatoid Arthritis and Ofher Inflammatory Polyarthrophathies	714	9,127	2,283,817	1,228,876	99.8	958,091
Osteoarthrosis and Allied Disorders	715	36,636	8,410,174	2,840,632	99.6	2,197,984
Other and Unspecified Arthropathies	716	2,977	489,860	180,776	99.3	138,466
Other and Unspecified Disorders of Joint	719	48,158	4,475,432	1,997,377	99.8	1,534,405
Other and Unspecified Disorders of Back	724	46,063	8,905,032	2,794,479	99.6	2,174,260
Peripheral Enthesopathies and Allied Syndromes	726	13,761	2,010,714	672,948	99.7	513,630
Other Disorders of Soft Tissues	729	15,356	1,966,475	808,335	99.6	618,202
Non-Allopathic Lesions, Not Elsewhere Classified	739	20,328	955,875	666,176	90.5	489,740
Congenital Anomalies (MDC 14)	740-759	1,936	600,241	197,066	99.5	152,655
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	219,958	38,226,400	14,723,119	99.8	11,492,227
General Symptoms	780	46,074	8,046,188	3,217,890	99.8	2,533,157
Symptoms Involving Respiratory System and Other Chest Symptoms	786	54,827	9,950,011	3,815,562	99.8	2,963,810
Symptoms Involving Digestive System	787	16,620	3,073,251	1,128,598	99.8	884,469
Symptoms Involving Urinary System	788	13,560	1,850,013	747,429	99.6	582,057
Sudden Death, Cause Unknown	798	12	5,774	2,780	100.0	2,073
Other Ill-Defined and Unknown Causes of Morbidity and Mortality	799	5,831	1,421,808	602,565	99.9	468,638
Injury and Poisoning (MDC 17)	800-999	58,586	17,760,726	6,058,384	99.8	4,741,740
Fracture of Neck of Femur	820	3,803	1,661,222	507,272	99.9	401,561
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	V01-V82	172,472	15,539,189	6,494,187	99.5	5,597,235
Need for Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	V04	26,470	676,344	499,673	99.9	495,840
Special Investigations and Examinations	V72	7,081	644,914	265,904	99.4	220,088

[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 and special interest.

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 Standard Analytical Files; data development by the Office of Information Products & Data Analytics.