Table 55

Medicare Supplementary Medical Insurance Disbursements for Benefits, by Type of Provider: Selected Calendar Years 1970-1999

Type of Provider	1970	1975	1983	1985	1986	1988	1990
				Dollars in Millions			
Total Old Format[1]	$1,975	$4,273	$18,106	$22,947	$26,239	$33,970	$42,468
Physicians and Suppliers[2]	1,790	3,416	14,062	17,312	19,213	24,372	29,609
Outpatient Facilities[3]	114	643	3,385	4,319	5,157	6,549	8,482
Managed Care[4]	26	80	410	720	1,113	2,019	2,827
Home Health Agencies[5]	34	95	25	38	31	47	74
Independent Laboratories	11	39	224	558	725	983	1,476
Total New Format[1]	---	---	---	---	---	---	---
Physician Fee Schedule	---	---	---	---	---	---	---
Durable Medical Equipment	---	---	---	---	---	---	---
Carrier Lab	---	---	---	---	---	---	---
Other Carrier	---	---	---	---	---	---	---
Hospital	---	---	---	---	---	---	---
Home Health Agencies[5]	---	---	---	---	---	---	---
Intermediary Lab	---	---	---	---	---	---	---
Other Intermediary	---	---	---	---	---	---	---
Managed Care	---	---	---	---	---	---	---
				Percent Distribution			
Total Old Format[1]	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Physicians and Suppliers[2]	90.6	79.9	77.7	75.4	73.2	71.7	69.7
Outpatient Facilities[3]	5.8	15.0	18.7	18.8	19.7	19.3	20.0
	1.3	1.9	2.3	3.1	4.2	5.9	6.7
Home Health Agencies[5]	1.7	2.2	0.1	0.2	0.1	0.1	0.2
Independent Laboratories	0.6	0.9	1.2	2.4	2.8	2.9	3.5
Total New Format[1]	---	---	---	---	---	---	---
Physician Fee Schedule	---	---	---	---	---	---	---
Durable Medical Equipment	---	---	---	---	---	---	---
Carrier Lab	---	---	---	---	---	---	---
Other Carrier	---	---	---	---	---	---	---
Hospital	---	---	---	---	---	---	---
Home Health Agencies[5]	---	---	---	---	---	---	---
Intermediary Lab	---	---	---	---	---	---	---
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, outpatient rehabilitation facilities, and ambulatory surgical centers.
[4]Includes disbursements for health maintenance organizations, competitive medical plans, and other prepaid health plans.
[5]As a result of the Omnibus Budget Reconciliation Act 1980 legislation, most home health agency services were covered under the hospital insurance program beginning in 1981. The Balanced Budget Act of 1997 provided that home health services unassociated with a hospital or skilled nursing facility stay would gradually be transferred from Part A (HI) to Part B (SMI).

NOTE: Numbers may not add to totals because of rounding.

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 1970-1999

1991	1992	1993	1995	1997	1998	1999
			Dollars in Millions			
$47,336	$49,260	$53,979	$64,972	$72,757	---	---
31,915	32,480	34,589	40,474	42,411	---	---
9,925	10,702	12,632	15,625	17,416	---	---
3,804	4,124	4,632	6,608	10,980	---	---
65	78	120	200	228	---	---
1,627	1,876	2,006	2,065	1,722	---	---
$47,336	$49,260	$53,979	$64,972	$72,757	$76,673	$81,333
26,002	25,325	26,329	31,660	31,898	32,449	33,348
2,109	2,367	2,805	3,689	4,236	4,038	4,286
2,863	2,862	2,972	2,807	2,385	2,087	2,077
3,345	3,624	4,017	4,530	5,586	5,940	6,451
5,946	6,479	7,490	8,668	9,373	8,738	8,801
92	116	148	229	239	160	1,244
1,026	1,232	1,398	1,448	1,503	1,541	1,674
2,680	3,126	4,148	5,331	6,575	6,382	5,750
3,275	4,128	4,672	6,610	10,962	15,338	17,702
			Percent Distribution			
100.0	100.0	100.0	100.0	100.0	---	---
67.4	65.9	64.1	62.3	58.3	---	---
21.0	21.7	23.4	24.0	23.9	---	---
8.0	8.4	8.6	10.2	15.1	---	---
0.1	0.2	0.2	0.3	0.3	---	---
3.4	3.8	3.7	3.2	2.4	---	---
100.0	100.0	100.0	100.0	100.0	100.0	100.0
54.9	51.4	48.8	48.7	43.8	42.3	41.0
4.5	4.8	5.2	5.7	5.8	5.3	5.3
6.0	5.8	5.5	4.3	3.3	2.7	2.6
7.1	7.4	7.4	7.0	7.7	7.7	7.9
12.6	13.2	13.9	13.3	12.9	11.4	10.8
0.2	0.2	0.3	0.4	0.3	0.2	1.5
2.2	2.5	2.6	2.2	2.1	2.0	2.1
5.7	6.3	7.7	8.2	9.0	8.3	7.1
6.9	8.4	8.7	10.2	15.1	20.0	21.8

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 1999

Demographic Characteristic	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	29,331,640	1,200,603	40.9	$116,249,395	$3,963
Sex					
Male	11,985,960	493,043	41.1	50,877,697	4,245
Female	17,345,680	707,560	40.8	65,371,699	3,769
Age					
Under 65 Years	3,663,260	150,712	41.1	15,261,321	4,166
65-74 Years	12,030,060	440,824	36.6	43,389,677	3,607
75-84 Years	9,711,460	434,920	44.8	42,310,073	4,357
85 Years or Over	3,926,860	174,147	44.3	15,288,325	3,893
Race[4]					
White	25,194,340	1,019,470	40.5	98,175,828	3,897
Other	3,177,120	137,357	43.2	13,897,608	4,374
Medicare Status[5]					
Aged	25,530,600	1,033,961	40.5	99,247,065	3,887
Disabled	3,582,920	134,282	37.5	13,188,863	3,681
End Stage Renal Disease	218,120	32,361	148.4	3,813,467	17,483

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 1999

Demographic Characteristic	Allowed Charges: Amount in Thousands	Allowed Charges: Per Person Served[1]	Allowed Charges: Assigned in Thousands	Allowed Charges: Percent of Charges Assigned	Program Payments: Amount in Thousands	Program Payments: Per Person Served[2]	Balance Billing: Amount in Thousands	Balance Billing: Per Person with Liability[3]
Total	$60,563,267	$2,065	$59,480,788	98.2	$46,487,527	$1,638	$76,730	$23
Sex								
Male	26,332,771	2,197	25,887,888	98.3	20,257,595	1,760	31,822	24
Female	34,230,496	1,973	33,592,899	98.1	26,229,931	1,554	44,909	22
Age								
Under 65 Years	7,920,270	2,162	7,860,780	99.2	5,954,792	1,723	3,936	24
65-74 Years	21,924,017	1,822	21,480,723	98.0	16,787,176	1,450	30,894	22
75-84 Years	22,135,159	2,279	21,703,396	98.0	17,125,126	1,802	31,014	24
85 Years or Over	8,583,821	2,186	8,435,888	98.3	6,620,433	1,720	10,886	24
Race[4]								
White	51,162,997	2,031	50,128,887	98.0	39,226,490	1,606	73,411	23
Other	7,139,228	2,247	7,103,417	99.5	5,511,063	1,814	2,453	19
Medicare Status[5]								
Aged	51,779,209	2,028	50,761,322	98.0	39,847,164	1,607	72,463	23
Disabled	6,931,580	1,935	6,873,262	99.2	5,159,400	1,529	3,868	24
End Stage Renal Disease	1,852,478	8,493	1,846,204	99.7	1,480,963	6,888	399	34

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

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

[3]Excludes persons with no balance billing in calendar year.

[4]Excludes unknown race.

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

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

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

Table 57

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Type of Service: Calendar Year 1999

Type of Service	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	29,331,640	1,200,603	40.9	$116,249,395	$3,963
Medical Care	28,271,880	442,833	15.7	31,665,151	1,120
Surgery	16,211,140	77,355	4.8	28,692,288	1,770
Consultation	9,731,000	23,924	2.5	3,845,922	395
Diagnostic X-Ray	18,938,040	98,075	5.2	10,236,139	541
Diagnostic Laboratory	23,309,800	357,329	15.3	14,164,554	608
Radiation Therapy	807,460	9,903	12.3	2,349,820	2,910
Anesthesia	4,961,740	9,621	1.9	4,959,993	1,000
Assistance at Surgery	759,740	1,155	1.5	927,701	1,221
Other Medical Services	330,440	4,309	13.0	735,007	2,224
Ambulatory Surgical Center	1,448,520	2,191	1.5	2,838,775	1,960
Renal Supplies in the Home	42,380	610	14.4	252,067	5,948
ESRD Capitation Payment	225,840	2,047	9.1	696,471	3,084
Psychological Therapy	2,242,960	15,604	7.0	1,294,083	577
Occupational Therapy	14,920	331	22.2	10,120	678
Pneumococcal Vaccine	11,834,900	24,754	2.1	218,962	19
Physical Therapy	369,160	10,546	28.6	294,397	797
Durable Medical Equipment [c]	6,011,700	81,302	13.5	7,884,068	1,311
Other[b]	NA	38,715	NA	5,183,876	NA

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

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

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

[4]Represents the amount of beneficiary Part B cost-sharing liability that non-participating physicians can charge beneficiaries on unassigned claims. In 1998, a non-participating physician could not charge a beneficiary more than 15 percent of the difference between the submitted charge and the allowed charge (the Medicare fee schedule amount) on the unassigned claims.

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

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

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

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

Table 57—Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Type of Service: Calendar Year 1999

Allowed Charges				Program Payments		Balance Billing[4]	
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
$60,563,267	$2,065	$59,480,788	98.2	$46,487,527	$1,638	$76,730	$23
21,867,026	773	21,373,391	97.7	16,114,706	612	35,077	15
11,289,807	696	11,147,393	98.7	8,824,774	559	11,573	25
2,673,248	275	2,641,571	98.8	2,057,974	215	2,582	14
4,353,938	230	4,307,471	98.9	3,354,283	185	3,848	10
5,608,019	241	5,566,637	99.3	4,806,091	208	3,399	7
873,175	1,081	868,605	99.5	694,297	864	405	57
1,394,307	281	1,386,308	99.4	1,104,136	223	655	19
194,596	256	192,980	99.2	154,474	204	138	20
421,605	1,276	417,448	99.0	335,773	1,019	217	68
1,235,949	853	1,235,909	99.9	980,964	678	4	36
167,233	3,946	167,150	99.9	132,736	3,147	7	30
404,213	1,790	403,980	99.9	318,304	1,414	20	101
967,380	431	929,496	96.1	448,042	217	2,495	31
7,138	478	7,132	99.9	5,628	382	---	4
112,633	10	108,691	96.5	112,513	10	224	1
211,757	574	207,320	97.9	166,357	454	252	35
5,331,347	887	5,191,800	97.4	4,165,019	705	6,653	14
3,449,895	NA	3,327,504	96.5	2,711,456	NA	9,184	NA

Table 58

Persons Served, Services, Submitted and Allowed Charges, Program Payments for Medicare Physician and Supplier Services, by Place of Service: Calendar Year 1999

Place of Service	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	29,331,640	1,200,603	40.9	$116,249,395	$3,963
Office	26,939,000	545,814	20.3	36,327,309	1,349
Home	6,475,000	85,304	13.2	8,783,459	1,357
Inpatient Hospital	7,713,280	167,463	21.7	30,522,229	3,957
Outpatient Hospital[4]	14,882,140	70,652	4.7	14,841,291	997
Emergency Room Hospital[4]	8,438,080	26,381	3.1	3,338,767	396
Ambulatory Surgical Center	1,707,420	6,265	3.7	5,142,045	3,012
Skilled Nursing Care Facility	2,149,200	25,636	11.9	1,776,847	827
Nursing Home	1,629,160	17,383	10.7	825,394	507
Hospice	7,200	15	2.1	1,241	172
Ambulance[5]	3,298,940	22,999	7.0	2,890,292	876
Independent Laboratory	13,173,360	148,117	11.2	4,269,795	324
All Other[6]	---	84,574	NA	7,530,726	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 1999

	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	$60,563,267	100.0	$2,065	$59,480,788	98.2	$46,487,527	100.0	$1,638
Office	22,883,656	37.8	849	22,271,234	97.3	16,764,602	36.1	652
Home	5,911,726	9.8	913	5,751,384	97.3	4,611,280	9.9	726
Inpatient Hospital	13,540,828	22.4	1,756	13,445,629	99.3	10,714,264	23.0	1,398
Outpatient Hospital[4]	5,219,779	8.6	351	5,180,885	99.3	4,061,208	8.7	281
Emergency Room Hospital[4]	1,489,371	2.5	177	1,487,218	99.9	1,143,368	2.5	139
Ambulatory Surgical Center	2,078,955	3.4	1,218	2,069,079	99.5	1,646,927	3.5	966
Skilled Nursing Care Facility	1,296,161	2.1	603	1,292,009	99.7	964,868	2.1	459
Nursing Home	583,432	1.0	358	581,881	99.7	418,319	0.9	263
Hospice	753	(7)	105	748	99.3	579	(7)	85
Ambulance[5]	1,953,403	3.2	592	1,874,270	95.9	1,543,742	3.3	468
Independent Laboratory	1,501,029	2.5	114	1,499,795	99.9	1,436,798	3.1	109
All Other[6]	4,104,174	6.8	NA	4,026,656	98.1	3,181,572	6.8	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 Decision Support Access Facility; data development by the Office of Research, Development, and Information.

Table 59

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Physician Specialty: Calendar Year 1999

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	29,331,640	1,200,603	100.0	40.9	$116,249,395	100.0	$3,963
Total Physicians	28,726,760	851,399	70.9	29.6	89,580,564	77.1	3,118
General Practice	3,475,040	23,057	1.9	6.6	1,343,391	1.2	387
General Surgery	4,034,240	14,284	1.2	3.5	4,379,918	3.8	1,086
Allergy and Immunology	321,000	10,821	0.9	33.7	162,906	0.1	507
Otology, Laryngology, Rhinology	2,579,240	11,408	1.0	4.4	1,062,362	0.9	412
Anesthesiology	4,654,280	10,953	0.9	2.4	4,416,736	3.8	949
Cardiology	8,415,120	73,716	6.1	8.8	9,447,709	8.1	1,123
Dermatology	4,301,800	26,539	2.2	6.2	1,572,612	1.4	366
Family Practice	10,748,740	93,348	7.8	8.7	4,418,592	3.8	411
Gastroenterology	3,237,680	13,444	1.1	4.2	2,718,925	2.3	840
Internal Medicine	14,797,420	162,636	13.5	11.0	10,113,444	8.7	683
Manipulative Therapy	79,960	593	(5)	7.4	34,890	(5)	436
Neurology	2,541,220	11,908	1.0	4.7	1,326,370	1.1	522
Neurologiclal Surgery	535,740	1,639	0.1	3.1	1,093,689	0.9	2,041
Obstetrics and Gynecology	2,230,120	5,902	0.5	2.6	778,453	0.7	349
Ophthalmology	10,357,800	32,260	2.7	3.1	6,985,519	6.0	674
Oral Surgery (Dentists Only)	82,220	166	(5)	2.0	30,270	(5)	368
Orthopedic Surgery	4,157,240	22,761	1.9	5.5	4,945,084	4.3	1,190
Pathology	5,130,220	15,323	1.3	3.0	1,472,196	1.3	287
Plastic and Reconstructive Surgery	448,720	1,537	0.1	3.4	517,813	0.4	1,154
Physical Medicine and Rehabilitation	936,980	11,134	0.9	11.9	768,367	0.7	820
Psychiatry	1,838,040	15,424	1.3	8.4	1,385,195	1.2	754
Colorectal Surgery (Proctology)	215,320	554	(5)	2.6	170,319	0.1	791
Pulmonary Disease	2,160,300	18,657	1.6	8.6	1,637,070	1.4	758
Diagnostic Radiology	16,782,940	72,724	6.1	4.3	7,845,488	6.7	467
Thoracic Surgery	534,260	1,605	0.1	3.0	1,337,252	1.2	2,503
Urology	3,775,980	23,937	2.0	6.3	3,408,147	2.9	903
Chiropractic	1,426,700	13,187	1.1	9.2	429,015	0.4	301
Nuclear Medicine	411,380	979	0.1	2.4	157,264	0.1	382
Pediatric Medicine	240,360	1,342	0.1	5.6	78,068	0.1	325
Geriatric Medicine	269,440	1,863	0.2	6.9	112,854	0.1	419
Nephrology	886,320	19,093	1.6	21.5	1,586,169	1.4	1,790
Optometrist	4,010,940	11,226	0.9	2.8	430,832	0.4	107
Infectious Disease	531,260	4,919	0.4	9.3	412,340	0.4	776
Endocrinology	737,780	5,829	0.5	7.9	317,531	0.3	430
Podiatry	5,033,300	23,556	2.0	4.7	1,353,942	1.2	269

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 1999

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
$60,563,267	100.0	$2,065	$59,480,788	98.2	$46,487,527	100.0	$1,638	$76,730	$23
46,007,639	76.0	1,602	45,168,456	98.2	34,919,122	75.1	1,266	61,829	23
883,667	1.5	254	855,349	96.8	641,589	1.4	197	1,774	14
1,874,730	3.1	465	1,859,108	99.2	1,459,070	3.1	373	1,256	27
123,770	0.2	386	116,703	94.3	92,732	0.2	297	461	24
547,923	0.9	212	538,848	98.3	406,521	0.9	168	703	12
1,305,905	2.2	281	1,295,990	99.2	1,029,733	2.2	223	811	20
4,402,638	7.3	523	4,362,908	99.1	3,408,306	7.3	416	3,232	26
1,101,948	1.8	256	1,064,313	96.6	813,422	1.7	202	2,995	13
2,977,329	4.9	277	2,893,902	97.2	2,123,356	4.6	209	6,323	14
1,280,583	2.1	396	1,263,633	98.7	991,738	2.1	313	1,393	27
6,469,871	10.7	437	6,303,913	97.4	4,848,562	10.4	340	13,738	19
23,164	(5)	290	21,529	92.9	17,159	(5)	227	106	19
800,789	1.3	315	788,536	98.5	613,413	1.3	249	994	20
346,765	0.6	647	341,611	98.5	271,676	0.6	524	445	52
378,256	0.6	170	363,192	96.0	280,427	0.6	133	1,117	12
3,428,080	5.7	331	3,367,414	98.2	2,540,518	5.5	269	4,960	16
17,147	(5)	209	15,157	88.4	13,090	(5)	167	129	18
2,097,982	3.5	505	2,076,156	99.0	1,613,915	3.5	407	1,805	36
571,096	0.9	111	566,609	99.2	450,654	1.0	89	388	12
202,009	0.3	450	198,515	98.3	157,274	0.3	365	278	29
465,888	0.8	497	463,938	99.6	366,124	0.8	397	150	19
955,560	1.6	520	916,331	95.9	595,374	1.3	337	2,592	37
78,405	0.1	364	77,195	98.5	60,208	0.1	286	105	23
1,058,360	1.7	490	1,051,413	99.3	823,929	1.8	389	594	23
3,094,654	5.1	184	3,066,268	99.1	2,401,952	5.2	148	2,382	19
507,998	0.8	951	504,747	99.4	401,612	0.9	769	281	72
2,089,221	3.4	553	2,062,873	98.7	1,618,032	3.5	437	2,178	33
376,650	0.6	264	301,244	80.0	275,217	0.6	202	2,982	13
67,372	0.1	164	65,590	97.4	52,686	0.1	131	137	20
47,591	0.1	198	47,079	98.9	35,436	0.1	155	23	10
80,307	0.1	298	78,880	98.2	59,718	0.1	230	125	25
904,281	1.5	1,020	900,597	99.6	709,627	1.5	815	320	24
362,823	0.6	90	349,931	96.4	240,167	0.5	71	238	5
265,483	0.4	500	263,710	99.3	208,718	0.4	399	152	18
210,751	0.3	286	202,055	95.9	162,615	0.3	225	719	17
968,429	1.6	192	954,461	98.6	708,283	1.5	147	741	10

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 1999

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	995,160	10,037	0.8	10.1	$450,424	0.4	$453
Vascular Surgery	718,640	1,956	0.2	2.7	752,727	0.6	1,047
Cardiac Surgery	213,160	591	(5)	2.8	758,473	0.7	3,558
Hematology/Oncology	1,063,780	35,253	2.9	33.1	2,998,746	2.6	2,819
Medical Oncology	423,300	13,063	1.1	30.9	1,168,368	1.0	2,760
Radiation Oncology	531,840	7,866	0.7	14.8	1,781,486	1.5	3,350
Emergency Medicine	5,815,700	13,103	1.1	2.3	2,055,874	1.8	354
All Other Physician [6]	NA	11,205	0.9	NA	1,363,735	1.2	NA
Group Practice	3,015,320	33,158	2.8	11.0	3,403,804	2.9	1,129
Total Non-Physician	5,746,280	30,275	2.5	5.3	5,709,862	4.9	994
Total Suppliers	18,153,260	284,123	23.7	15.7	17,182,490	14.8	947
Invalid Physician/Supplier Specialty Code	1,599,500	1,649	0.1	1.0	372,675	0.3	233

[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, and unknown physician's specialty.

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

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

Table 59—Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Physician Specialty: Calendar Year 1999

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
$298,090	0.5	$300	$279,455	93.7	$224,056	0.5	$231	$1,564	$20
313,132	0.5	436	311,423	99.5	245,006	0.5	350	145	39
286,448	0.5	1,344	283,553	99.0	226,877	0.5	1,086	260	171
1,766,541	2.9	1,661	1,756,417	99.4	1,402,214	3.0	1,341	793	56
651,021	1.1	1,538	645,343	99.1	516,741	1.1	1,245	488	68
682,393	1.1	1,283	678,417	99.4	540,982	1.2	1,057	352	70
962,566	1.6	166	960,891	99.8	739,954	1.6	131	137	9
680,024	1.1	NA	653,256	96.1	530,436	1.1	NA	1,462	NA
1,685,212	2.8	559	1,682,550	99.8	1,284,796	2.8	442	218	20
2,615,217	4.3	455	2,594,429	99.2	1,938,820	4.2	344	1,113	9
10,067,566	16.6	555	9,848,174	97.8	8,195,872	17.6	454	13,535	20
187,633	0.3	117	187,179	99.8	148,917	0.3	101	36	8

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 1999

	Persons Served[1]		Services		Submitted Charges	
Area of Residence	Number	Per 1,000 Enrollees	Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
All Areas[4]	29,331,640	975	1,200,603	40.9	$116,249,395	$3,963
United States[5]	28,951,180	976	1,182,661	40.9	115,125,072	3,977
Northeast	5,800,700	975	251,271	43.3	24,878,944	4,289
Midwest	7,733,120	985	280,906	36.3	26,870,603	3,475
South	11,074,980	975	474,688	42.9	46,263,683	4,177
West	4,342,380	967	175,796	40.5	17,111,842	3,941
New England	1,521,340	976	57,978	38.1	5,962,389	3,919
Connecticut	375,800	980	15,134	40.3	1,624,111	4,322
Maine	194,200	954	6,365	32.8	648,519	3,339
Massachusetts	638,320	981	25,455	39.9	2,618,386	4,102
New Hampshire	134,740	966	4,389	32.6	418,430	3,105
Rhode Island	98,480	985	4,487	45.6	412,587	4,190
Vermont	79,800	976	2,148	26.9	240,357	3,012
Middle Atlantic	4,279,360	974	193,294	45.2	18,916,555	4,420
New Jersey	921,520	973	43,676	47.4	4,252,168	4,614
New York	1,958,060	967	91,185	46.6	8,437,295	4,309
Pennsylvania	1,399,780	985	58,433	41.7	6,227,092	4,449
East North Central	5,308,640	982	198,025	37.3	19,557,742	3,684
Illinois	1,316,440	971	49,382	37.5	4,969,197	3,775
Indiana	756,100	984	27,164	35.9	2,683,197	3,549
Michigan	1,229,540	977	49,390	40.2	4,745,500	3,860
Ohio	1,316,220	990	48,859	37.1	4,976,009	3,781
Wisconsin	690,340	992	23,231	33.7	2,183,839	3,163
West North Central	2,424,480	992	82,881	34.2	7,312,861	3,016
Iowa	444,180	999	14,904	33.6	1,211,865	2,728
Kansas	342,280	998	12,456	36.4	1,214,219	3,547
Minnesota	530,840	999	15,734	29.6	1,394,458	2,627
Missouri	676,460	978	24,710	36.5	2,291,032	3,387
Nebraska	226,220	986	7,811	34.5	652,183	2,883
North Dakota	96,240	991	3,266	33.9	275,567	2,863
South Dakota	108,260	959	4,000	36.9	273,537	2,527
South Atlantic	5,925,160	979	256,500	43.3	25,686,545	4,335
Delaware	99,440	977	3,933	39.6	442,349	4,448
District of Columbia	54,180	909	2,409	44.5	280,157	5,171
Florida	1,904,820	992	100,215	52.6	9,707,425	5,096
Georgia	792,380	972	31,466	39.7	3,238,724	4,087
Maryland	490,240	963	21,386	43.6	2,409,675	4,915
North Carolina	1,009,700	982	38,084	37.7	3,811,010	3,774
South Carolina	519,400	971	20,097	38.7	2,011,231	3,872
Virginia	765,640	974	28,497	37.2	2,725,143	3,559
West Virginia	289,360	967	10,413	36.0	1,060,830	3,666

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 1999

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 Liablity
$60,563,267	100.0	$2,065	98	$46,487,527	100.0	$1,638	$76,730	$23
59,771,675	98.7	2,065	98	45,877,324	98.7	1,637	76,588	23
13,276,480	21.9	2,289	98	10,204,749	22.0	1,811	15,502	24
13,788,947	22.8	1,783	98	10,528,401	22.6	1,411	21,529	24
23,417,210	38.7	2,114	99	18,001,943	38.7	1,679	21,296	18
9,289,038	15.3	2,139	97	7,142,232	15.4	1,697	18,262	30
3,038,470	5.0	1,997	99	2,315,294	5.0	1,570	1,862	22
824,301	1.4	2,193	98	630,586	1.4	1,724	1,127	31
319,856	0.5	1,647	99	243,094	0.5	1,298	145	16
1,351,507	2.2	2,117	99	1,030,143	2.2	1,660	266	15
217,141	0.4	1,612	98	163,631	0.4	1,260	201	15
209,616	0.3	2,129	99	161,046	0.3	1,699	26	11
116,048	0.2	1,454	99	86,794	0.2	1,132	97	18
10,238,010	16.9	2,392	98	7,889,454	17.0	1,896	13,640	24
2,399,096	4.0	2,603	97	1,855,002	4.0	2,069	5,731	25
4,795,431	7.9	2,449	98	3,694,230	7.9	1,935	7,214	26
3,043,483	5.0	2,174	99	2,340,223	5.0	1,728	695	14
9,967,571	16.5	1,878	98	7,622,315	16.4	1,487	11,982	22
2,554,584	4.2	1,941	97	1,956,451	4.2	1,540	5,435	25
1,281,317	2.1	1,695	98	973,018	2.1	1,341	1,955	18
2,606,580	4.3	2,120	99	2,004,382	4.3	1,679	1,839	23
2,471,254	4.1	1,878	99	1,887,987	4.1	1,484	588	13
1,053,836	1.7	1,527	97	800,476	1.7	1,202	2,166	25
3,821,376	6.3	1,576	97	2,906,087	6.3	1,246	9,547	27
651,882	1.1	1,468	96	492,977	1.1	1,152	1,938	30
606,407	1.0	1,772	99	463,946	1.0	1,406	533	17
715,432	1.2	1,348	97	538,799	1.2	1,059	1,567	30
1,191,162	2.0	1,761	98	911,746	2.0	1,399	1,706	18
350,278	0.6	1,548	94	266,013	0.6	1,226	1,789	31
139,944	0.2	1,454	95	106,340	0.2	1,143	581	33
166,271	0.3	1,536	89	126,266	0.3	1,209	1,433	34
13,030,258	21.5	2,199	99	10,027,066	21.6	1,743	12,224	18
210,340	0.3	2,115	98	161,519	0.3	1,672	218	16
135,297	0.2	2,497	98	104,205	0.2	1,971	241	37
5,397,828	8.9	2,834	99	4,196,352	9.0	2,253	3,879	20
1,567,612	2.6	1,978	99	1,200,230	2.6	1,566	1,585	17
1,156,378	1.9	2,359	98	890,334	1.9	1,864	1,385	21
1,758,752	2.9	1,742	98	1,337,664	2.9	1,369	2,675	17
964,705	1.6	1,857	99	735,825	1.6	1,467	817	14
1,346,340	2.2	1,758	99	1,025,257	2.2	1,383	1,191	18
493,007	0.8	1,704	99	375,681	0.8	1,351	233	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 1999

	Persons Served[1]		Services		Submitted Charges	
Area of Residence	Number	Per 1,000 Enrollees	Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
East South Central	2,215,880	973	89,110	40.2	$8,521,453	$3,846
Alabama	580,120	976	23,888	41.2	2,325,331	4,008
Kentucky	539,700	975	22,135	41.0	1,977,363	3,664
Mississippi	377,800	959	13,911	36.8	1,418,682	3,755
Tennessee	718,260	975	29,175	40.6	2,800,077	3,898
West South Central	2,933,940	970	129,078	44.0	12,055,684	4,109
Arkansas	386,800	978	15,308	39.6	1,366,302	3,532
Louisiana	442,840	985	18,226	41.2	1,821,106	4,112
Oklahoma	421,300	973	15,649	37.1	1,376,612	3,268
Texas	1,683,000	964	79,896	47.5	7,491,665	4,451
Mountain	1,428,320	971	49,628	34.7	4,792,057	3,355
Arizona	357,540	962	14,444	40.4	1,319,025	3,689
Colorado	272,620	995	9,194	33.7	902,388	3,310
Idaho	144,640	999	4,330	29.9	341,816	2,363
Montana	125,240	990	3,692	29.5	326,078	2,604
Nevada	131,880	925	5,994	45.5	717,447	5,440
New Mexico	154,880	910	4,956	32.0	510,480	3,296
Utah	183,520	987	5,223	28.5	514,047	2,801
Wyoming	58,000	971	1,795	31.0	160,778	2,772
Pacific	2,914,060	965	126,168	43.3	12,319,785	4,228
Alaska	31,980	859	942	29.5	121,011	3,784
California	1,999,840	951	96,091	48.0	9,617,029	4,809
Hawaii	103,580	999	3,263	31.5	320,578	3,095
Oregon	293,680	999	8,569	29.2	751,968	2,561
Washington	484,980	972	17,303	35.7	1,509,199	3,112
Outlying Areas[6]	380,460	877	17,942	47.2	1,124,323	2,955

[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]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.

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

Table 60—Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Area of Residence: Calendar Year 1999

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 Liablity
$4,210,126	7.0	$1,900	99	$3,215,828	6.9	$1,506	$2,600	$15
1,175,064	1.9	2,026	99	901,556	1.9	1,610	460	15
968,508	1.6	1,795	99	739,671	1.6	1,426	691	15
693,090	1.1	1,835	99	530,538	1.1	1,464	503	13
1,373,465	2.3	1,912	99	1,044,064	2.2	1,504	946	16
6,176,826	10.2	2,105	99	4,759,049	10.2	1,682	6,472	18
710,533	1.2	1,837	99	543,398	1.2	1,462	510	20
932,253	1.5	2,105	99	718,204	1.5	1,688	604	14
765,420	1.3	1,817	98	586,602	1.3	1,443	1,141	21
3,768,620	6.2	2,239	98	2,910,844	6.3	1,790	4,218	18
2,600,946	4.3	1,821	96	1,986,647	4.3	1,440	8,630	33
747,633	1.2	2,091	94	576,903	1.2	1,655	3,407	51
482,346	0.8	1,769	97	367,337	0.8	1,389	1,223	25
210,688	0.3	1,457	88	159,693	0.3	1,151	2,023	34
188,399	0.3	1,504	96	142,605	0.3	1,182	487	23
334,824	0.6	2,539	99	256,958	0.6	2,019	248	26
265,347	0.4	1,713	98	202,835	0.4	1,374	452	22
278,675	0.5	1,518	99	209,731	0.5	1,187	251	16
93,035	0.2	1,604	93	70,585	0.2	1,268	539	26
6,688,092	11.0	2,295	98	5,155,584	11.1	1,823	9,632	28
55,393	0.1	1,732	97	42,245	0.1	1,374	115	20
5,198,656	8.6	2,600	98	4,023,987	8.7	2,070	6,172	31
156,303	0.3	1,509	99	117,065	0.3	1,169	145	24
430,388	0.7	1,465	95	327,193	0.7	1,154	1,500	25
847,353	1.4	1,747	97	645,095	1.4	1,371	1,700	24
791,592	1.3	2,081	99	610,203	1.3	1,673	142	19

Table 61

Medicare Assignment Rates and Ratio of Submitted Charges to Allowed Charges for Physician Services, by Area of Residence: Calendar Years 1983, 1988, and 1999

	Assignment Rate [1]			Ratio of Submitted Charges to Allowed Charges		
Area of Residence	1983	1988	1999	1983	1988	1999
United States	0.51	0.77	0.98	1.31	1.78	1.92
Alabama	0.56	0.84	0.99	1.35	1.92	1.98
Alaska	0.46	0.71	0.97	1.33	1.82	2.18
Arizona	0.34	0.70	0.94	1.30	1.58	1.76
Arkansas	0.58	0.82	0.99	1.32	1.85	1.92
California	0.53	0.79	0.98	1.28	1.74	1.85
Colorado	0.42	0.66	0.97	1.37	1.67	1.87
Connecticut	0.44	0.74	0.98	1.31	1.86	1.97
Delaware	0.75	0.80	0.98	1.28	2.05	2.10
District of Columbia	0.76	0.86	0.98	1.33	2.07	2.07
Florida	0.34	0.76	0.99	1.29	1.72	1.80
Georgia	0.55	0.75	0.99	1.30	1.89	2.07
Hawaii	0.42	0.75	0.99	1.34	2.02	2.05
Idaho	0.22	0.40	0.88	1.32	1.43	1.62
Illinois	0.36	0.67	0.97	1.29	1.65	1.95
Indiana	0.28	0.87	0.98	1.33	1.85	2.09
Iowa	0.33	0.63	0.96	1.34	1.66	1.86
Kansas	0.48	0.82	0.99	1.30	1.82	2.00
Kentucky	0.39	0.89	0.99	1.29	1.84	2.04
Louisiana	0.37	0.79	0.99	1.37	1.80	1.95
Maine	0.73	0.84	0.99	1.28	1.90	2.03
Maryland	0.72	0.87	0.98	1.30	1.98	2.08
Massachusetts	0.85	0.93	0.99	1.28	1.92	1.94
Michigan	0.79	0.93	0.99	1.32	1.77	1.82
Minnesota	0.27	0.53	0.97	1.30	1.66	1.95
Mississippi	0.58	0.72	0.99	1.37	1.85	2.05
Missouri	0.44	0.76	0.98	1.28	1.72	1.92
Montana	0.19	0.53	0.96	1.27	1.42	1.73
Nebraska	0.19	0.54	0.94	1.28	1.59	1.86
Nevada	0.61	0.86	0.99	1.30	1.92	2.14
New Hampshire	0.51	0.69	0.98	1.32	1.86	1.93
New Jersey	0.58	0.70	0.97	1.34	1.67	1.77
New Mexico	0.41	0.70	0.98	1.34	1.68	1.92
New York	0.62	0.89	0.98	1.37	1.71	1.76
North Carolina	0.49	0.75	0.98	1.31	1.95	2.17
North Dakota	0.29	0.47	0.95	1.27	1.80	1.97

See footnotes at end of table.

Table 61—Continued

Medicare Assignment Rates and Ratio of Submitted Charges to Allowed Charges for Physician Services, by Area of Residence: Calendar Years 1983, 1988, and 1999

Area of Residence	Assignment Rate [1]			Ratio of Submitted Charges to Allowed Charges		
	1983	1988	1999	1983	1988	1999
Ohio	0.34	0.73	0.99	1.32	1.82	2.01
Oklahoma	0.30	0.63	0.98	1.37	1.65	1.80
Oregon	0.25	0.57	0.95	1.28	1.55	1.75
Pennsylvania	0.76	0.88	0.99	1.28	1.94	2.05
Rhode Island	0.90	0.90	0.99	1.39	2.05	1.97
South Carolina	0.57	0.76	0.99	1.32	1.89	2.08
South Dakota	0.18	0.46	0.89	1.29	1.46	1.65
Tennessee	0.46	0.75	0.99	1.34	1.85	2.04
Texas	0.53	0.75	0.98	1.37	1.75	1.99
Utah	0.45	0.73	0.99	1.27	1.67	1.84
Vermont	0.58	0.78	0.99	1.31	2.01	2.07
Virginia	0.56	0.73	0.99	1.31	1.91	2.02
Washington	0.30	0.57	0.97	1.27	1.54	1.78
West Virginia	0.51	0.81	0.99	1.39	1.96	2.15
Wisconsin	0.32	0.61	0.97	1.25	1.67	2.07
Wyoming	0.26	0.46	0.93	1.32	1.50	1.73

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

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

Table 62

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 1999

BETOS Classification	BETOS Codes	Persons Served[1]	Services		
			Number in Thousands	Percent	Per Person Served[1]
Total All BETOS Groups	Total	29,331,640	1,199,617	100.0	41
Office Visits - Established	M1B	25,066,700	171,926	14.3	7
Hospital Visit - Subsequent	M2B	6,161,720	80,408	6.7	13
Consultations	M6	9,616,100	22,995	1.9	2
Ambulance	O1A	3,408,640	23,125	1.9	7
Chemotherapy	O1D	478,940	11,837	1.0	25
Eye Procedure - Cataract Removal/Lens Insertion	P4B	1,240,520	6,790	0.6	5
Lab Tests, Other (Non-MFS)	T1H	16,836,520	159,511	13.3	9
Other Drugs	O1E	4,258,260	39,745	3.3	9
Anesthesia	P0	4,964,100	9,706	0.8	2
Emergency Room Visit	M3	7,991,120	14,433	1.2	2
Major Procedure, Cardiovascular-Other	P2F	1,927,420	4,515	0.4	2
Specialist - Psychiatry	M5B	1,923,120	17,322	1.4	9
Hospital Visit - Initial	M2A	5,383,560	9,007	0.8	2
Specialist - Ophthalmology	M5C	10,577,880	20,436	1.7	2
Nursing Home Visit	M4B	2,550,180	19,827	1.7	8
Minor Procedures - Skin	P6A	6,993,540	18,710	1.6	3
Office Visits - New	M1A	8,841,340	11,977	1.0	1
Minor Procedures - Other (MFS)	P6C	5,036,880	34,616	2.9	7
Echography - Heart	I3C	3,761,660	12,732	1.1	3
Durable Medical Equipment[3]	D1A-D1F	8,752,560	81,235	6.8	9
All Other BETOS Groups	---	NA	428,764	35.7	NA

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

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

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

NOTES: Numbers may not add to totals because of rounding. BETOS is the Berenson-Eggers Type of Service system for classifying HCPCS (Healthcare Common Procedure Coding System) codes. MFS is the Medicare Fee Schedule. NA is not applicable. The leading BETOS codes are based on amount of allowed charges for 1999. Medicare program payments represent fee for service only.

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

Table 62—Continued

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 1999

Allowed Charges			Program Payments		
Amount in Thousands	Percent	Per Person Served[1]	Amount in Thousands	Percent	Per Person Served[2]
$60,555,566	100.0	$2,065	$46,481,392	100.0	$1,637
7,434,012	12.3	297	5,022,585	10.8	219
4,276,573	7.1	694	3,395,443	7.3	553
2,623,749	4.3	273	2,018,585	4.3	213
2,072,107	3.4	608	1,638,219	3.5	481
1,991,702	3.3	4,159	1,580,887	3.4	3,314
1,864,179	3.1	1,503	1,481,074	3.2	1,195
1,523,473	2.5	90	1,519,075	3.3	90
1,440,943	2.4	338	1,139,643	2.5	287
1,400,127	2.3	282	1,107,101	2.4	224
1,224,199	2.0	153	939,849	2.0	121
1,223,204	2.0	635	971,280	2.1	506
1,142,551	1.9	594	620,111	1.3	336
1,132,066	1.9	210	880,785	1.9	164
1,131,954	1.9	107	754,162	1.6	81
960,021	1.6	376	701,400	1.5	283
936,569	1.5	134	684,877	1.5	104
931,816	1.5	105	626,146	1.3	78
921,809	1.5	183	712,951	1.5	149
913,899	1.5	243	717,310	1.5	192
5,325,163	8.8	608	4,160,208	9.0	NA
20,085,450	33.2	NA	15,809,701	34.0	NA

Table 63

Services, Submitted and Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 1999

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Services in Thousands	Submitted Charges in Thousands	Allowed Charges		Program Payments in Thousands
				Amount in Thousands	Percent of Charges Assigned	
Total All Diagnoses	---	1,195,970	$116,249,395	$60,563,266	98.2	$46,487,526
Leading Diagnoses[2]	---	697,071	62,646,087	32,966,768	98.2	25,287,881
Infectious and Parasitic Diseases (MDC 1)	001-139	17,080	1,138,680	730,090	98.6	551,895
Dermatophytosis	110	6,992	337,100	258,049	98.8	183,905
Neoplasm (MDC 2)	140-239	100,616	14,098,803	7,208,407	98.6	5,679,308
Malignant Neoplasm of Colon	153	6,856	693,887	332,171	99.1	264,250
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	12,413	1,523,025	775,625	99.5	616,485
Other Malignant Neoplasm of Skin	173	5,656	1,062,174	597,232	98.1	463,935
Malignant Neoplasm of Female Breast	174	12,832	1,402,252	697,105	97.5	551,402
Malignant Neoplasm of Prostate	185	12,572	2,373,401	1,501,257	98.8	1,186,272
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	119,798	5,037,734	2,863,779	96.8	2,258,112
Thyroiditis	244	9,044	372,245	188,473	97.8	159,244
Diabetes Mellitus	250	61,559	2,461,865	1,590,231	95.7	1,220,752
Disorders of Lipoid Metabolism	272	32,238	991,906	434,335	97.8	358,592
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	6,020	403,834	238,212	99.0	189,203
Diseases of the Blood and Blood-Forming Organs (MDC 4)	280-289	34,573	1,889,324	1,033,270	99.3	844,826
Other and Unspecified Anemias	285	16,273	916,125	492,431	99.3	404,799
Mental Disorders (MDC 5)	290-319	32,189	2,810,145	1,930,780	97.7	1,199,963
Schizophrenic Disorders	295	5,860	440,885	294,386	99.3	180,971
Affective Psychoses	296	9,381	861,122	596,473	96.7	354,462
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	65,409	12,397,233	6,206,705	98.4	4,652,559
Other Retinal Disorders	362	6,537	1,053,832	634,380	98.9	473,835
Glaucoma	365	8,476	824,042	495,069	97.9	343,541
Cataract	366	15,616	6,546,536	2,810,031	98.6	2,144,811

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 1999

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Services in Thousands	Submitted Charges in Thousands	Allowed Charges		Program Payments in Thousands
				Amount in Thousands	Percent of Charges Assigned	
Diseases of the Circulatory System (MDC 7)	390-459	200,312	$22,178,320	$10,987,206	98.5	$8,438,286
Essential Hypertension	401	43,746	2,008,010	1,304,109	96.4	909,046
Acute Myocardial Infarction	410	4,535	704,827	322,653	98.8	254,484
Other Acute and Subacute Forms of Ischemic Heart Disease	411	4,455	1,016,570	408,117	99.2	321,534
Angina Pectoris	413	4,905	691,117	325,594	98.7	251,431
Other Forms of Chronic Ischemic Heart Disease	414	28,307	4,692,986	2,063,387	98.8	1,596,704
Other Diseases of Endocardium	424	6,474	1,227,292	508,451	98.7	397,551
Cardiac Dysrhythmias	427	27,246	2,167,514	1,113,297	98.5	863,529
Heart Failure	428	24,873	2,174,700	1,243,796	99.1	973,612
Ill-Defined Descriptions and Complications of Heart Disease	429	5,468	395,740	185,729	98.5	142,276
Acute, But Ill-Defined, Cerebrovascular Disease	436	9,321	1,020,897	655,255	98.9	512,066
Diseases of the Respiratory System (MDC 8)	460-519	102,957	8,522,282	5,166,383	98.9	3,959,185
Acute Bronchitis and Bronchiolitis	466	5,098	272,953	185,738	96.8	125,438
Allergic Rhinitis	477	14,664	207,011	156,510	95.6	113,695
Pneumonia, Organism Unspecified	486	9,482	776,729	473,033	99.0	367,863
Asthma	493	7,448	461,481	298,870	98.4	225,820
Other Diseases of Lung	518	9,612	1,071,632	605,904	99.4	479,294
Diseases of the Digestive System (MDC 9)	520-579	34,049	5,829,340	2,632,138	98.8	2,046,221
Diseases of the Genitourinary System (MDC 10)	580-629	68,445	6,512,913	3,218,729	98.9	2,511,687
Chronic Renal Failure	585	20,281	2,072,429	1,070,234	99.9	853,559
Calculus of Kidney and Ureter	592	1,341	275,460	100,923	98.9	78,817
Other Disorders of Urethra and Urinary Tract	599	15,182	815,116	438,318	98.9	346,814
Hyperplasia of Prostate	600	7,201	569,296	280,486	98.3	215,635
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	40,538	2,509,205	1,619,477	97.8	1,199,356
Other Dermatoses	702	15,642	604,085	419,246	96.6	302,677
Chronic Ulcer of Skin	707	5,760	689,740	398,210	99.4	310,764

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 1999

Principal ICD-9-CM[1] Diagnosis Within MDC	ICD-9-CM Code	Services in Thousands	Submitted Charges in Thousands	Allowed Charges		Program Payments in Thousands
				Amount in Thousands	Percent of Charges Assigned	
Diseases of the Musculoskeletal System and Connective Tissue (MDC 13)	710-739	109,690	$10,835,887	$5,369,184	97.1	$4,086,716
Rheumatoid Arthritis and Ofher Inflammatory Polyarthrophathies	714	7,101	294,707	170,059	95.7	130,553
Osteoarthrosis and Allied Disorders	715	18,166	2,467,225	1,190,271	97.8	909,035
Other and Unspecified Arthropathies	716	3,553	248,585	143,714	97.4	106,657
Other and Unspecified Disorders of Joint	719	14,358	935,679	489,418	98.4	371,082
Other and Unspecified Disorders of Back	724	15,169	1,987,303	875,915	97.8	671,842
Peripheral Enthesopathies and Allied Syndromes	726	7,164	454,341	254,343	98.0	188,308
Other Disorders of Soft Tissues	729	7,606	550,216	293,165	98.0	220,938
Non-Allopathic Lesions, Not Elsewhere Classified	739	7,971	269,130	231,603	81.0	169,984
Congenital Anomalies (MDC 14)	740-759	2,223	338,487	156,768	98.3	120,767
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	126,208	12,009,219	6,257,423	98.5	4,853,491
General Symptoms	780	26,443	2,274,016	1,262,306	98.4	989,531
Symptoms Involving Respiratory System and Other Chest Symptoms	786	38,759	3,645,598	1,862,975	98.4	1,434,756
Symptoms Involving Digestive System	787	8,296	1,007,464	557,005	99.1	436,294
Symptoms Involving Urinary System	788	7,768	487,183	264,303	98.6	203,769
Sudden Death, Cause Unknown	798	13	2,084	1,165	99.4	883
Other Ill-Defined and Unknown Causes of Morbidity and Mortality	799	2,804	282,203	171,445	97.3	135,878
Injury and Poisoning (MDC 17)	800-999	44,500	6,175,628	3,028,631	98.3	2,352,218
Fracture of Neck of Femur	820	4,193	1,127,318	506,943	99.2	400,067
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	V01-V82	87,231	3,275,875	1,744,879	95.9	1,403,838
Need for Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	V04	20,635	166,456	86,394	96.6	85,473
Special Investigations and Examinations	V72	7,680	266,739	112,396	98.6	93,733

[1]ICD-9-CM is *International Classification of Diseases, 9th Revision, Clinical Modification.* Only the first listed or principal diagnosis has been used.
[2]Specific diagnostic categories were selected for presentation based on amount of allowed charges.

NOTES: Numbers may not add to totals because of rounding. MDCs 11 {Complications of Pregnancy, Childbirth, and the Puerperium (630-676)} and 15 {Certain Conditions Originating in the Perinatal Period (780-799)} were not shown separately (but are included in the totals) because these diagnostic conditions are, for the most part, not applicable to Medicare beneficiaries. E Codes {Supplementary Classifications of External Causes of Injury and Poisoning (E800-E999)} are also not broken out separately. Medicare program payments represent fee-for-service only.

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