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 1995-2008

Year	Persons Served[1]	Services Number in Thousands	Submitted Charges	Allowed Charges	Program Payments	Balanced 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
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
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

NOTES: 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 Data Extract System; data development by the Office of Research, Development, and Information.

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 2008

Demographic Characteristic	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	31,826,820	1,798,520	56.5	$274,355,179	$8,620
Sex					
Male	13,534,880	753,461	55.7	121,149,917	8,951
Female	18,291,940	1,045,058	57.1	153,205,261	8,376
Age					
Under 65 Years	5,141,000	287,819	56.0	46,337,433	9,013
65-74 Years	12,727,460	640,722	50.3	101,823,926	8,000
75-84 Years	9,437,200	592,607	62.8	89,327,340	9,465
85 Years or Over	4,521,160	277,371	61.3	36,866,479	8,154
Race[3]					
White	26,815,700	1,504,469	56.1	229,303,108	8,551
Other	4,902,140	288,757	58.9	44,253,571	9,027
Type of Entitlement[4]					
Aged	26,402,920	1,465,080	55.5	219,998,684	8,332
Disabled	5,047,760	258,290	51.2	40,255,194	7,975
ESRD	376,140	75,150	199.8	14,101,301	37,490

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 2008

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	$113,804,294	$3,576	$113,178,340	99.4	$88,112,583	$2,834	$46,980	$29
Sex								
Male	49,791,230	3,679	49,527,338	99.5	38,548,725	2,935	20,259	32
Female	64,013,064	3,500	63,651,002	99.4	49,563,859	2,760	26,721	28
Age								
Under 65 Years	19,126,104	3,720	19,094,851	99.8	14,600,796	2,959	2,308	29
65-74 Years	40,743,508	3,201	40,489,568	99.4	31,443,571	2,539	18,910	28
75-84 Years	37,328,598	3,955	37,080,582	99.3	29,135,597	3,129	18,732	31
85 Years or Over	16,606,083	3,673	16,513,340	99.4	12,932,619	2,900	7,030	29
Race[3]								
White	94,886,057	3,538	94,288,828	99.4	73,390,946	2,798	44,834	29
Other	18,585,391	3,791	18,558,478	99.9	14,466,903	3,042	2,002	25
Type of Entitlement[4]								
Aged	91,530,242	3,467	90,939,211	99.4	70,997,949	2,743	44,390	29
Disabled	16,830,202	3,334	16,799,016	99.8	12,753,222	2,637	2,295	29
ESRD	5,443,849	14,473	5,440,113	99.9	4,361,412	11,661	295	33

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

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

[3]Excludes unknown race.

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

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

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

Table 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 2008

Type of Service	Persons Served [1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served [1]	Amount in Thousands	Per Person Served [1]
Total	31,826,820	1,798,520	56.5	$274,355,179	$8,620
Medical Care	30,807,060	662,746	21.5	80,695,472	2,619
Surgery	19,331,520	107,186	5.5	52,697,064	2,726
Consultation	12,784,940	29,611	2.3	7,566,821	592
Diagnostic X-Ray	21,733,840	146,495	6.7	27,536,086	1,267
Diagnostic Laboratory	26,617,200	532,123	20.0	34,917,782	1,312
Radiation Therapy	1,267,400	12,598	9.9	6,391,907	5,043
Anesthesia	6,651,520	13,301	2.0	10,605,690	1,594
Assistance at Surgery	880,200	1,612	1.8	2,241,233	2,546
Other Medical Services	1,128,520	7,556	6.7	1,427,307	1,265
Ambulatory Surgical Center	3,266,640	6,195	1.9	12,229,366	3,744
Renal Supplies in the Home	1,520	41	26.8	49,445	32,529
ESRD Capitation Payment	332,500	2,933	8.8	1,561,049	4,695
Psychological Therapy	2,809,600	20,029	7.1	2,236,357	796
Occupational Therapy	4,320	19	4.4	697	161
Pneumococcal Vaccine	13,069,900	27,546	2.1	620,641	47
Physical Therapy	60	(6)	1.0	12	207
Durable Medical Equipment [4]	10,173,100	140,655	13.8	18,536,538	1,822
Other [5]	NA	87,874	NA	15,041,712	NA

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

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

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

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

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

[6]Less than 500.

[7]Less than $500.

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

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

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 2008

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
$113,804,294	$3,576	$113,178,340	99.4	$88,112,583	$2,834	$46,980	$29
43,525,729	1,413	43,218,354	99.3	32,697,123	1,116	23,082	20
15,920,466	824	15,831,567	99.4	12,430,253	655	7,147	31
4,337,382	339	4,312,246	99.4	3,325,354	264	2,136	21
9,069,593	417	9,026,311	99.5	7,039,253	337	3,450	21
11,266,175	423	11,234,934	99.7	9,694,560	368	2,443	11
2,110,873	1,666	2,099,041	99.4	1,677,029	1,329	993	195
2,024,075	304	2,021,340	99.9	1,598,626	241	235	18
210,278	239	209,960	99.8	166,855	190	28	22
725,233	643	725,228	99.9	572,541	512	(7)	2
3,023,215	925	3,023,196	99.9	2,382,758	730	2	85
17,953	11,811	17,953	99.9	14,109	9,282	0	0
745,031	2,241	744,964	99.9	587,583	1,770	6	60
1,350,841	481	1,330,954	98.5	627,227	240	1,488	34
214	50	214	99.9	162	39	0	0
460,929	35	459,769	99.7	460,024	35	35	2
6	100	6	99.9	5	85	0	0
10,734,668	1,055	10,647,108	99.2	8,334,887	834	5,422	15
8,281,633	NA	8,275,195	99.9	6,504,234	NA	513	NA

Table 9.4

Persons Served, Services, Submitted and Allowed Charges, Program Payments for Medicare Physician and Supplier Services, by Place of Service: Calendar Year 2008

Place of Service	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	31,826,820	1,798,520	56.5	$274,355,179	$8,620
Office	29,591,620	882,230	29.8	109,572,266	3,703
Home	10,532,720	157,566	15.0	22,030,459	2,092
Inpatient Hospital	7,933,460	205,735	25.9	51,872,068	6,538
Outpatient Hospital [4]	17,195,300	102,832	6.0	28,255,264	1,643
Emergency Room Hospital [4]	10,090,660	42,626	4.2	10,299,548	1,021
Ambulatory Surgical Center	3,585,780	16,877	4.7	20,393,195	5,687
Skilled Nursing Care Facility	2,055,080	23,847	11.6	2,286,002	1,112
Nursing Home	1,939,460	29,318	15.1	1,892,822	976
Hospice	6,860	23	3.4	2,536	370
Ambulance [5]	4,580,820	60,052	13.1	8,923,553	1,948
Independent Laboratory	17,369,720	251,185	14.5	14,495,669	835
All Other [6]	NA	26,229	NA	4,331,797	NA

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 2008

	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	$113,804,294	100.0	$3,576	$113,178,340	99.4	$88,112,583	100.0	$2,834
Office	53,894,306	47.4	1,821	53,433,128	99.1	40,649,113	46.1	1,420
Home	12,790,781	11.2	1,214	12,703,806	99.3	9,929,991	11.3	959
Inpatient Hospital	17,809,478	15.6	2,245	17,767,408	99.8	14,094,466	16.0	1,786
Outpatient Hospital [4]	7,203,313	6.3	419	7,183,349	99.7	5,568,406	6.3	333
Emergency Room Hospital [4]	2,958,369	2.6	293	2,955,638	99.9	2,284,090	2.6	231
Ambulatory Surgical Center	5,092,899	4.5	1,420	5,084,504	99.8	4,010,639	4.6	1,120
Skilled Nursing Care Facility	1,537,500	1.4	748	1,536,665	99.9	1,158,579	1.3	573
Nursing Home	1,224,178	1.1	631	1,223,733	99.9	901,478	1.0	472
Hospice	1,500	(7)	219	1,500	99.9	1,132	(7)	172
Ambulance [5]	5,006,963	4.4	1,093	5,006,963	99.9	3,969,155	4.5	867
Independent Laboratory	4,134,764	3.6	238	4,134,250	99.9	3,890,677	4.4	224
All Other [6]	2,150,243	1.9	NA	2,147,396	99.9	1,654,857	1.9	NA

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

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

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

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

[5]Excludes air or water services.

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

[7]Less than 0.05 percent.

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

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

Table 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 2008

Physician/Supplier Specialty [1]	Persons Served [2]	Services			Submitted Charges		
		Number in Thousands	Percent	Per Person Served [2]	Amount in Thousands	Percent	Per Person Served [2]
Total All Specialties	31,826,820	1,798,520	100.0	56.5	$274,355,179	100.0	$8,620
Total Physicians	31,283,420	1,173,125	65.2	37.5	198,212,855	72.2	6,336
General Practice	2,220,580	14,922	0.8	6.7	1,398,197	0.5	630
General Surgery	3,987,520	14,275	0.8	3.6	6,290,217	2.3	1,577
Allergy and Immunology	405,700	11,429	0.6	28.2	320,643	0.1	790
Otology, Laryngology, Rhinology	2,968,080	14,742	0.8	5.0	2,182,128	0.8	735
Anesthesiology	5,675,460	15,787	0.9	2.8	9,016,140	3.3	1,589
Cardiology	11,806,780	114,906	6.4	9.7	20,442,725	7.5	1,731
Dermatology	5,740,480	39,956	2.2	7.0	4,181,095	1.5	728
Family Practice	13,690,320	123,566	6.9	9.0	9,401,175	3.4	687
Gastroenterology	4,508,980	15,230	0.8	3.4	5,249,276	1.9	1,164
Internal Medicine	17,419,260	201,217	11.2	11.6	20,151,704	7.3	1,157
Manipulative Therapy	130,640	930	0.1	7.1	106,627	(5)	816
Neurology	3,363,320	17,268	1.0	5.1	3,168,111	1.2	942
Neurologiclal Surgery	775,760	2,703	0.2	3.5	2,626,650	1.0	3,386
Obstetrics and Gynecology	2,406,400	7,666	0.4	3.2	1,404,413	0.5	584
Ophthalmology	10,940,320	46,659	2.6	4.3	12,206,778	4.4	1,116
Oral Surgery (Dentists Only)	83,420	198	(5)	2.4	49,630	(5)	595
Orthopedic Surgery	5,354,100	35,782	2.0	6.7	10,902,122	4.0	2,036
Pathology	5,984,260	24,470	1.4	4.1	3,208,683	1.2	536
Plastic and Reconstructive Surgery	457,800	1,703	0.1	3.7	873,684	0.3	1,908
Physical Medicine and Rehabilitation	1,483,380	14,391	0.8	9.7	1,912,209	0.7	1,289
Psychiatry	2,179,260	15,512	0.9	7.1	1,847,780	0.7	848
Colorectal Surgery (Proctology)	276,360	755	(5)	2.7	349,022	0.1	1,263
Pulmonary Disease	3,104,580	23,254	1.3	7.5	3,307,692	1.2	1,065
Diagnostic Radiology	19,878,980	106,744	5.9	5.4	17,665,794	6.4	889
Thoracic Surgery	443,900	1,430	0.1	3.2	1,373,665	0.5	3,095
Urology	4,408,000	30,059	1.7	6.8	5,965,232	2.2	1,353
Chiropractic	2,082,700	22,261	1.2	10.7	964,588	0.4	463
Nuclear Medicine	513,000	1,313	0.1	2.6	352,407	0.1	687
Pediatric Medicine	265,720	1,494	0.1	5.6	150,122	0.1	565
Geriatric Medicine	439,900	2,615	0.1	5.9	285,743	0.1	650
Nephrology	1,798,580	19,126	1.1	10.6	4,213,053	1.5	2,342
Optometrist	5,335,180	11,799	0.7	2.2	1,074,091	0.4	201
Infectious Disease	925,560	8,553	0.5	9.2	1,123,590	0.4	1,214
Endocrinology	1,306,760	8,827	0.5	6.8	771,871	0.3	591
Podiatry	6,117,400	35,646	2.0	5.8	2,841,862	1.0	465

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 2008

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
$113,804,294	100.0	$3,576	$113,178,340	99.4	$88,112,583	100.0	$2,834	$46,980	$29
81,822,495	71.9	2,616	81,285,460	99.3	62,636,561	71.1	2,064	41,357	32
775,619	0.7	349	767,453	98.9	574,008	0.7	270	501	18
2,119,969	1.9	532	2,113,687	99.7	1,652,160	1.9	425	516	32
195,587	0.2	482	192,692	98.5	147,443	0.2	376	215	27
969,672	0.9	327	964,023	99.4	730,318	0.8	256	475	20
1,794,235	1.6	316	1,790,155	99.8	1,408,584	1.6	250	347	24
8,050,408	7.1	682	8,024,760	99.7	6,226,181	7.1	540	2,044	29
2,463,971	2.2	429	2,427,603	98.5	1,855,445	2.1	337	2,825	22
5,366,978	4.7	392	5,326,881	99.3	3,903,341	4.4	298	3,021	19
1,763,211	1.5	391	1,751,366	99.3	1,357,265	1.5	307	977	29
11,025,985	9.7	633	10,936,323	99.2	8,359,487	9.5	494	7,469	25
54,294	(5)	416	52,886	97.4	41,303	(5)	326	108	38
1,561,628	1.4	464	1,551,877	99.4	1,195,492	1.4	365	845	33
590,736	0.5	761	586,625	99.3	463,457	0.5	615	362	62
580,160	0.5	241	572,561	98.7	439,188	0.5	188	529	14
5,696,576	5.0	521	5,660,030	99.4	4,292,110	4.9	416	2,940	23
24,848	(5)	298	23,247	93.6	19,224	(5)	240	91	21
3,407,963	3.0	637	3,394,891	99.6	2,624,182	3.0	507	1,068	40
1,014,051	0.9	169	1,008,100	99.4	804,910	0.9	137	383	18
285,677	0.3	624	283,518	99.2	223,289	0.3	501	172	38
891,800	0.8	601	888,692	99.7	694,663	0.8	476	273	25
1,066,763	0.9	490	1,045,380	98.0	676,770	0.8	324	1,614	38
129,578	0.1	469	128,654	99.3	100,074	0.1	370	81	30
1,764,032	1.6	568	1,758,256	99.7	1,375,628	1.6	451	502	27
5,277,709	4.6	265	5,240,715	99.3	4,099,335	4.7	213	2,896	39
391,143	0.3	881	389,011	99.5	308,723	0.4	707	188	89
2,372,598	2.1	538	2,364,622	99.7	1,825,387	2.1	421	684	30
686,957	0.6	330	609,626	88.7	503,868	0.6	256	5,147	18
119,011	0.1	232	116,784	98.1	93,314	0.1	188	197	39
71,802	0.1	270	71,639	99.8	54,228	0.1	213	8	16
172,436	0.2	392	171,142	99.2	129,904	0.1	304	115	32
1,934,193	1.7	1,075	1,931,694	99.9	1,516,434	1.7	855	216	22
816,490	0.7	153	809,450	99.1	569,898	0.6	117	183	7
586,125	0.5	633	584,457	99.7	461,528	0.5	504	139	26
427,731	0.4	327	420,013	98.2	329,617	0.4	258	614	20
1,810,420	1.6	296	1,802,924	99.6	1,357,042	1.5	229	435	15

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 2008

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	1,303,420	13,971	0.8	10.7	$2,169,522	0.8	$1,664
Vascular Surgery	1,279,720	4,234	0.2	3.3	2,044,726	0.7	1,598
Cardiac Surgery	357,260	1,269	0.1	3.6	1,290,780	0.5	3,613
Hematology/Oncology	1,867,720	66,089	3.7	35.4	12,434,290	4.5	6,657
Medical Oncology	754,380	23,132	1.3	30.7	4,587,481	1.7	6,081
Radiation Oncology	833,000	11,661	0.6	14.0	5,762,038	2.1	6,917
Emergency Medicine	8,812,620	24,682	1.4	2.8	7,621,699	2.8	865
All Other Physician [6]	NA	20,899	1.2	NA	4,923,600	1.8	NA
Group Practice	1,064,960	4,604	0.3	4.3	806,241	0.3	757
Total Non-Physician	14,314,200	134,805	7.5	9.4	25,515,316	9.3	1,783
Total Suppliers	22,527,540	485,983	27.0	21.6	49,820,521	18.2	2,212

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

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

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

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

[5]Less than 0.05 percent.

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

NOTES: Medicare charges and program payments represent fee-for-service utilization only. Due to the clarification in the billing policy of Group Practices where the actual specialty code of the performing physician within the practice is now coded, the utilization and expenditures for group practice has dropped dramatically. Numbers may not add to total because of rounding. NA is not applicable.

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

Table 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 2008

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
$1,197,004	1.1	$918	$1,187,311	99.2	$922,154	1.0	$728	$793	$27
624,154	0.5	488	623,335	99.9	488,336	0.6	389	73	42
359,363	0.3	1,006	357,044	99.4	284,008	0.3	806	207	79
5,466,389	4.8	2,927	5,463,412	99.9	4,327,300	4.9	2,349	247	28
1,955,306	1.7	2,592	1,953,745	99.9	1,545,926	1.8	2,083	138	36
1,906,778	1.7	2,289	1,896,486	99.5	1,511,792	1.7	1,885	916	344
2,360,832	2.1	268	2,357,831	99.9	1,822,500	2.1	211	258	15
1,692,313	1.5	NA	1,684,559	99.5	1,320,745	1.5	NA	545	NA
328,655	0.3	309	328,140	99.8	255,168	0.3	249	42	18
8,309,087	7.3	580	8,293,719	99.8	6,287,720	7.1	448	968	14
23,343,889	20.5	1,036	23,270,853	99.7	18,933,001	21.5	845	4,614	17

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 2008

Area of Residence	Persons Served [1]		Services		Submitted Charges	
	Number	Per 1,000 Enrollees [2]	Number in Thousands	Per Person Served [1]	Amount in Thousands	Per Person Served [1]
All Areas [5]	31,826,820	997	1,798,520	57	$274,355,179	$8,620
United States [6]	31,675,080	998	1,788,829	57	273,564,405	8,637
Northeast	5,919,160	1,002	361,857	61	52,844,896	8,928
Midwest	7,739,440	1,009	393,101	51	60,878,330	7,866
South	12,674,040	1,003	752,459	59	115,098,221	9,081
West	5,342,440	968	281,412	53	44,742,958	8,375
New England	1,737,720	992	88,428	51	13,629,363	7,843
Connecticut	430,140	1,017	25,019	58	3,936,108	9,151
Maine	213,420	959	8,517	40	1,213,484	5,686
Massachusetts	733,700	999	39,038	53	5,979,345	8,150
New Hampshire	172,560	955	7,119	41	1,228,440	7,119
Rhode Island	94,940	989	5,528	58	741,405	7,809
Vermont	92,960	985	3,206	35	530,582	5,708
Middle Atlantic	4,181,440	1,007	273,429	65	39,215,533	9,378
New Jersey	1,046,180	1,002	75,275	72	11,219,947	10,725
New York	1,846,420	990	128,201	69	17,450,716	9,451
Pennsylvania	1,288,840	1,036	69,953	54	10,544,869	8,182
East North Central	5,315,000	1,004	281,283	53	44,622,855	8,396
Illinois	1,464,820	987	79,362	54	13,310,648	9,087
Indiana	786,260	1,005	38,995	50	6,374,304	8,107
Michigan	1,156,680	1,004	65,723	57	9,304,183	8,044
Ohio	1,294,540	1,025	69,582	54	10,445,112	8,069
Wisconsin	612,700	1,003	27,621	45	5,188,609	8,468
West North Central	2,424,440	1,021	111,818	46	16,255,474	6,705
Iowa	425,040	1,013	18,341	43	2,531,120	5,955
Kansas	356,060	1,005	18,212	51	2,638,344	7,410
Minnesota	478,400	1,074	19,195	40	2,932,067	6,129
Missouri	732,820	1,008	36,574	50	5,496,305	7,500
Nebraska	228,440	1,018	10,889	48	1,540,519	6,744
North Dakota	94,200	1,023	3,834	41	528,492	5,610
South Dakota	109,480	981	4,774	44	588,628	5,377
South Atlantic	6,801,680	1,007	411,760	61	62,948,104	9,255
Delaware	127,700	1,011	7,559	59	1,176,267	9,211
District of Columbia	55,600	1,003	2,810	51	479,485	8,624
Florida	2,191,180	1,006	160,517	73	24,535,510	11,197
Georgia	941,160	1,007	51,911	55	8,305,255	8,824
Maryland	621,020	1,007	35,170	57	5,564,997	8,961
North Carolina	1,125,200	1,009	61,791	55	9,174,466	8,154
South Carolina	593,720	1,003	33,353	56	5,233,924	8,815
Virginia	877,240	1,012	45,547	52	6,530,257	7,444
West Virginia	268,860	993	13,102	49	1,947,943	7,245

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 2008

Allowed Charges				Program Payments			Balance Billing	
Amount in Thousands	Per-cent	Per Person Served [1]	Percent of Charges Assigned [3]	Amount in Thousands	Per-cent	Per Person Served [4]	Amount in Thousands	Per Person With Liability
$113,804,294	100.0	3,576	99.4	$88,112,583	100.0	$2,834	$46,980	$29
113,265,972	99.5	3,576	99.4	87,692,856	99.5	2,834	46,943	29
22,976,010	20.2	3,882	99.4	17,809,842	20.2	3,075	8,771	29
24,533,008	21.6	3,170	99.4	18,894,269	21.4	2,503	10,661	28
46,702,664	41.0	3,685	99.5	36,211,355	41.1	2,920	16,414	28
19,054,290	16.7	3,567	99.3	14,777,390	16.8	2,839	11,097	35
5,584,305	4.9	3,214	99.7	4,288,238	4.9	2,526	1,170	26
1,647,584	1.4	3,830	99.4	1,274,194	1.4	3,018	756	35
526,683	0.5	2,468	99.8	401,522	0.5	1,942	65	21
2,408,763	2.1	3,283	99.9	1,847,246	2.1	2,571	145	16
475,844	0.4	2,758	99.6	363,699	0.4	2,168	121	19
325,323	0.3	3,427	99.9	250,872	0.3	2,706	17	18
200,107	0.2	2,153	99.5	150,707	0.2	1,680	65	17
17,391,705	15.3	4,159	99.4	13,521,603	15.3	3,303	7,601	29
4,904,212	4.3	4,688	99.1	3,831,590	4.3	3,722	3,262	28
8,010,115	7.0	4,338	99.3	6,231,676	7.1	3,441	3,820	33
4,477,378	3.9	3,474	99.8	3,458,336	3.9	2,758	518	19
17,828,103	15.7	3,354	99.6	13,743,026	15.6	2,649	5,614	25
5,115,595	4.5	3,492	99.4	3,943,757	4.5	2,755	2,400	26
2,450,856	2.2	3,117	99.5	1,885,836	2.1	2,467	812	23
4,315,761	3.8	3,731	99.7	3,336,254	3.8	2,953	863	30
4,328,609	3.8	3,344	99.8	3,341,038	3.8	2,644	526	16
1,617,282	1.4	2,640	99.2	1,236,140	1.4	2,067	1,014	28
6,704,905	5.9	2,766	99.0	5,151,244	5.8	2,183	5,047	32
1,068,590	0.9	2,514	98.0	816,190	0.9	1,975	1,753	49
1,104,865	1.0	3,103	99.5	851,817	1.0	2,453	346	23
1,165,810	1.0	2,437	99.5	892,480	1.0	1,920	418	23
2,224,452	2.0	3,035	99.5	1,714,680	1.9	2,401	779	19
642,931	0.6	2,814	99.0	493,731	0.6	2,219	503	26
226,984	0.2	2,410	98.1	174,254	0.2	1,908	370	61
271,272	0.2	2,478	96.2	208,092	0.2	1,956	878	36
26,119,179	23.0	3,840	99.4	20,270,939	23.0	3,039	11,584	33
487,695	0.4	3,819	99.7	377,909	0.4	3,007	98	24
203,319	0.2	3,657	98.8	158,192	0.2	2,905	186	34
10,660,842	9.4	4,865	99.3	8,337,649	9.5	3,867	6,225	50
3,226,569	2.8	3,428	99.5	2,491,831	2.8	2,708	1,263	27
2,396,542	2.1	3,859	99.4	1,857,549	2.1	3,043	1,020	25
3,615,222	3.2	3,213	99.5	2,786,246	3.2	2,528	1,314	24
2,016,571	1.8	3,397	99.6	1,557,922	1.8	2,679	564	20
2,734,740	2.4	3,117	99.6	2,105,090	2.4	2,449	766	20
777,680	0.7	2,893	99.7	598,551	0.7	2,300	148	28

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 2008

	Persons Served [1]		Services		Submitted Charges	
Area of Residence	Number	Per 1,000 Enrollees [2]	Number in Thousands	Per Person Served [1]	Amount in Thousands	Per Person Served [1]
East South Central	2,379,500	1,008	134,315	56	$19,463,623	$8,180
Alabama	622,140	1,020	34,658	56	4,839,860	7,779
Kentucky	588,460	998	32,865	56	4,550,079	7,732
Mississippi	412,720	994	21,852	53	3,490,341	8,457
Tennessee	756,180	1,015	44,940	59	6,583,343	8,706
West South Central	3,492,860	992	206,384	59	32,686,494	9,358
Arkansas	409,720	978	22,005	54	2,963,300	7,233
Louisiana	481,720	998	26,084	54	4,227,901	8,777
Oklahoma	466,820	1,001	23,737	51	3,447,700	7,386
Texas	2,134,600	992	134,559	63	22,047,592	10,329
Mountain	1,756,240	991	85,518	49	13,767,640	7,839
Arizona	489,700	983	28,362	58	4,298,830	8,778
Colorado	362,160	1,030	17,050	47	2,756,366	7,611
Idaho	147,100	985	5,791	39	810,221	5,508
Montana	126,500	989	4,711	37	689,722	5,452
Nevada	196,280	977	11,278	58	2,143,948	10,923
New Mexico	195,240	953	8,172	42	1,457,939	7,467
Utah	171,560	999	7,525	44	1,170,408	6,822
Wyoming	67,700	999	2,628	39	440,205	6,502
Pacific	3,586,200	958	195,894	55	30,975,318	8,637
Alaska	48,560	904	1,815	37	440,441	9,070
California	2,504,600	949	149,080	60	23,682,192	9,455
Hawaii	111,900	1,074	4,796	43	588,975	5,263
Oregon	303,520	980	11,884	39	1,959,104	6,455
Washington	617,620	968	28,319	46	4,304,607	6,970
Outlying Areas [7]	151,740	750	9,690	64	790,773	5,211

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

[2] The numerator is a count of enrollees who received a service at any time during the year regardless of how long or when they were actually enrolled. The denominator is the count of SMI enrollees as of July 1. Because the denominator is the mid-point fee-for-service (FFS) enrollment and essentially every FFS person alive and enrolled at some point during the year has used a service, rates over 1,000 may be seen.

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

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

[5] Consists of United States and outlying areas.

[6] Includes 50 States and District of Columbia.

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

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

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 2008

Allowed Charges				Program Payments			Balance Billing	
Amount in Thousands	Percent	Per Person Served [1]	Percent of Charges Assigned [3]	Amount in Thousands	Percent	Per Person Served [4]	Amount in Thousands	Per Person With Liability
$7,895,778	6.9	$3,318	99.7	$6,097,524	6.9	$2,624	$1,516	$18
2,107,429	1.9	3,387	99.8	1,629,037	1.8	2,690	298	18
1,893,975	1.7	3,219	99.7	1,463,300	1.7	2,545	417	18
1,303,769	1.1	3,159	99.7	1,006,619	1.1	2,501	296	16
2,590,605	2.3	3,426	99.7	1,998,568	2.3	2,699	505	20
12,687,707	11.1	3,632	99.6	9,842,891	11.2	2,889	3,314	20
1,282,945	1.1	3,131	99.8	990,511	1.1	2,487	218	24
1,649,042	1.4	3,423	99.8	1,275,957	1.4	2,729	254	18
1,472,732	1.3	3,155	99.6	1,135,019	1.3	2,497	413	21
8,282,988	7.3	3,880	99.6	6,441,404	7.3	3,088	2,430	20
5,759,390	5.1	3,279	98.7	4,445,806	5.0	2,608	5,970	43
1,869,126	1.6	3,817	97.7	1,454,695	1.7	3,040	3,615	72
1,150,648	1.0	3,177	99.2	889,327	1.0	2,515	762	30
359,942	0.3	2,447	98.0	274,736	0.3	1,936	602	25
310,915	0.3	2,458	98.8	237,390	0.3	1,965	266	32
817,956	0.7	4,167	99.7	631,208	0.7	3,310	195	38
567,034	0.5	2,904	99.5	436,457	0.5	2,321	227	24
504,548	0.4	2,941	99.7	384,742	0.4	2,308	93	19
179,221	0.2	2,647	98.5	137,251	0.2	2,133	211	23
13,294,900	11.7	3,707	99.5	10,331,585	11.7	2,951	5,127	29
137,035	0.1	2,822	99.4	105,380	0.1	2,265	66	25
10,258,028	9.0	4,096	99.5	8,000,363	9.1	3,268	3,788	31
268,570	0.2	2,400	99.3	203,479	0.2	1,866	141	30
794,582	0.7	2,618	99.3	609,008	0.7	2,063	413	21
1,836,685	1.6	2,974	99.5	1,413,356	1.6	2,347	719	25
538,322	0.5	3,548	99.9	419,727	0.5	2,914	37	19

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

Table 9.7

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 2008

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	31,826,820	1,798,520	100.0	57	$113,804,294	100.0	$3,576	$88,112,583	100.0	$2,834
Office Visits - Established	M1B	27,791,920	212,345	11.8	8	14,007,215	12.3	504	9,803,400	11.1	375
Other Drugs	O1E	7,660,040	85,906	4.8	11	7,620,438	6.7	995	5,989,056	6.8	813
Hospital Visit - Subsequent	M2B	6,778,820	96,505	5.4	14	6,415,707	5.6	946	5,091,235	5.8	754
Ambulance	O1A	4,595,880	60,170	3.3	13	5,329,248	4.7	1,160	4,225,400	4.8	920
Consultations	M6	12,676,960	28,503	1.6	2	4,271,148	3.8	337	3,273,125	3.7	262
Minor Procedures - Other (MFS)	P6C	9,793,200	105,881	5.9	11	3,594,534	3.2	367	2,804,926	3.2	296
Other Durable Medical Equipment	D1E	6,896,140	75,375	4.2	11	3,268,299	2.9	474	2,500,707	2.8	371
Lab Tests, Other (Non-MFS)	T1H	19,756,100	207,227	11.5	10	2,989,906	2.6	151	2,981,519	3.4	151
Oxygen and Supplies	D1C	1,579,520	21,800	1.2	14	2,941,875	2.6	1,863	2,283,951	2.6	1,447
Specialist - Ophthalmology	M5C	12,958,520	36,697	2.0	3	2,657,734	2.3	205	1,888,969	2.1	157
Chemotherapy	O1D	450,300	15,323	0.9	34	2,354,578	2.1	5,229	1,865,766	2.1	4,169
Eye Procedure - Cataract Removal/Lens Insertion	P4B	1,239,360	3,434	0.2	3	2,285,477	2.0	1,844	1,807,581	2.1	1,460
Standard Imaging - Nuclear Medicine	I1E	5,151,960	19,516	1.1	4	2,179,720	1.9	423	1,717,089	1.9	336
Emergency Room Visit	M3	9,330,100	18,341	1.0	2	2,158,457	1.9	231	1,665,434	1.9	183
Lab Tests, Other (MFS)	T1G	8,370,860	35,278	2.0	4	2,150,581	1.9	257	1,688,335	1.9	205
Anesthesia	P0	6,498,960	12,859	0.7	2	2,014,236	1.8	310	1,588,496	1.8	245
Orthotic Devices	D1F	3,529,180	25,094	1.4	7	1,999,908	1.8	567	1,569,505	1.8	449
Ambulatory Procedure - Skin	P5A	5,902,500	31,307	1.7	5	1,957,716	1.7	332	1,503,649	1.7	263
Oncology - Radiation Therapy	P7A	321,960	9,641	0.5	30	1,839,565	1.6	5,714	1,461,976	1.7	4,551
Other Tests - Other	T2D	6,774,220	36,613	2.0	5	1,727,251	1.5	255	1,340,103	1.5	202
All Other BETOS Groups	---	NA	660,705	36.7	NA	40,040,701	35.2	NA	31,062,361	35.3	NA

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

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

NOTES: BETOS is the Berenson-Eggers Type of Service system for classifying HCPCS (Healthcare Common Procedure Coding System) codes. Data by BETOS category in this table may differ from other sources because of the update of the HCPCS-BETOS crosswalk used to code the services rendered. MFS is Medicare fee schedule. NA is not applicable. The leading BETOS codes are based on the amount of allowed charges for 2008. Medicare program payments represent fee-for-service only. Numbers may not add to total because of rounding.

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

Table 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 2008

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	---	1,798,520	$274,355,179	$113,804,294	99.4	$88,112,583
Leading Diagnoses [2]	---	1,058,417	142,806,055	61,355,672	99.4	47,448,407
Infectious and Parasitic Diseases (MDC 1)	001-139	21,802	2,139,597	1,121,356	99.6	861,535
Dermatophytosis	110	9,683	571,884	392,946	99.6	287,327
Neoplasm (MDC 2)	140-239	143,786	37,916,182	14,641,811	99.5	11,545,663
Malignant Neoplasm of Colon	153	9,340	2,482,780	1,062,627	99.9	844,960
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	16,727	3,924,722	1,434,694	99.7	1,137,444
Other Malignant Neoplasm of Skin	173	8,316	2,842,072	1,388,256	99.2	1,086,366
Malignant Neoplasm of Female Breast	174	17,461	4,140,479	1,677,529	99.3	1,331,655
Malignant Neoplasm of Prostate	185	15,687	4,910,582	1,706,883	99.6	1,346,080
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	216,396	14,145,734	6,597,209	99.3	5,191,576
Thyroiditis	244	13,878	837,812	324,797	99.2	272,538
Diabetes Mellitus	250	124,364	7,388,152	3,977,412	99.3	3,068,349
Disorders of Lipoid Metabolism	272	50,714	2,776,658	1,018,288	99.1	831,117
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	7,887	787,462	348,475	99.8	277,344
Diseases of the Blood and Blood-Forming Organs (MDC 4)	280-289	54,193	6,298,605	2,451,446	99.9	1,996,667
Other and Unspecified Anemias	285	28,023	3,210,190	1,178,944	99.9	967,152
Mental Disorders (MDC 5)	290-319	41,158	4,767,869	2,695,907	99.2	1,683,278
Schizophrenic Disorders	295	6,686	663,811	370,796	99.8	228,646
Affective Psychoses	296	11,997	1,431,639	821,705	98.6	471,849
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	104,919	26,301,466	11,471,972	99.4	8,721,282
Other Retinal Disorders	362	16,489	3,779,982	2,092,866	99.8	1,613,974
Glaucoma	365	14,677	1,911,498	1,051,900	99.2	759,848
Cataract	366	16,630	10,314,373	3,518,605	99.5	2,694,089

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 2008

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	247,962	$39,637,276	$16,256,645	99.5	$12,533,783
Essential Hypertension	401	68,670	5,108,704	2,677,698	99.0	1,963,359
Acute Myocardial Infarction	410	3,258	821,735	306,070	99.8	241,595
Other Acute and Subacute Forms of Ischemic Heart Disease	411	2,329	718,493	238,309	99.9	187,610
Angina Pectoris	413	3,881	928,461	365,148	99.8	284,457
Other Forms of Chronic Ischemic Heart Disease	414	33,801	7,631,550	2,918,888	99.6	2,253,099
Other Diseases of Endocardium	424	9,804	2,440,697	814,611	99.4	635,158
Cardiac Dysrhythmias	427	40,771	4,497,064	1,872,447	99.5	1,455,588
Heart Failure	428	22,273	3,292,149	1,546,108	99.8	1,216,718
Ill-Defined Descriptions and Complications of Heart Disease	429	3,712	411,794	159,877	99.2	122,991
Acute, But Ill-Defined, Cerebrovascular Disease	436	5,403	788,414	449,494	99.7	351,672
Diseases of the Respiratory System (MDC 8)	460-519	126,951	16,733,995	7,816,302	99.7	6,000,976
Acute Bronchitis and Bronchiolitis	466	5,389	420,810	236,786	98.9	162,185
Allergic Rhinitis	477	17,987	412,834	256,192	98.9	189,518
Pneumonia, Organism Unspecified	486	9,668	1,322,501	633,759	99.7	495,280
Asthma	493	9,464	1,092,984	519,264	99.6	394,941
Other Diseases of Lung	518	14,129	2,676,649	1,168,623	99.8	923,043
Diseases of the Digestive System (MDC 9)	520-579	40,277	11,601,390	3,920,684	99.6	3,051,336
Diseases of the Genitourinary System (MDC 10)	580-629	90,796	14,804,022	5,840,315	99.7	4,616,859
Chronic Renal Failure	585	25,228	4,737,101	1,989,882	99.9	1,587,246
Calculus of Kidney and Ureter	592	2,799	820,147	224,740	99.7	175,218
Other Disorders of Urethra and Urinary Tract	599	22,561	2,087,676	902,491	99.7	718,242
Hyperplasia of Prostate	600	6,428	1,078,183	471,885	99.6	362,212
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	59,594	5,632,491	3,053,094	99.1	2,301,187
Other Dermatoses	702	25,056	1,511,794	847,626	98.5	623,434
Chronic Ulcer of Skin	707	8,758	1,452,955	728,879	99.8	572,474

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 2008

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	228,476	$36,172,062	$13,446,242	99.0	$10,350,875
Rheumatoid Arthritis and Ofher Inflammatory Polyarthrophathies	714	9,197	1,836,518	992,053	99.6	771,550
Osteoarthrosis and Allied Disorders	715	33,659	6,588,668	2,414,855	99.3	1,863,696
Other and Unspecified Arthropathies	716	3,265	421,233	203,398	98.9	155,964
Other and Unspecified Disorders of Joint	719	37,978	3,301,268	1,515,439	99.6	1,162,565
Other and Unspecified Disorders of Back	724	39,536	6,907,148	2,321,725	99.4	1,795,091
Peripheral Enthesopathies and Allied Syndromes	726	12,874	1,464,347	548,387	99.4	416,697
Other Disorders of Soft Tissues	729	13,680	1,531,942	666,283	99.4	507,419
Non-Allopathic Lesions, Not Elsewhere Classified	739	19,319	855,374	601,753	89.2	443,072
Congenital Anomalies (MDC 14)	740-759	2,156	564,135	199,365	99.1	154,072
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	222,173	32,700,488	14,001,964	99.7	10,911,719
General Symptoms	780	50,121	7,180,097	3,301,578	99.7	2,585,639
Symptoms Involving Respiratory System and Other Chest Symptoms	786	59,318	9,009,871	3,810,620	99.7	2,958,059
Symptoms Involving Digestive System	787	16,916	2,412,836	989,409	99.7	774,134
Symptoms Involving Urinary System	788	12,248	1,399,556	609,564	99.4	474,998
Sudden Death, Cause Unknown	798	13	4,371	2,531	99.9	1,899
Other Ill-Defined and Unknown Causes of Morbidity and Mortality	799	5,182	1,063,104	535,998	99.9	419,030
Injury and Poisoning (MDC 17)	800-999	55,267	13,627,218	5,114,133	99.7	3,995,967
Fracture of Neck of Femur	820	4,172	1,522,536	512,421	99.8	404,933
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	V01-V82	141,363	11,084,089	5,066,323	99.1	4,109,706
Need for Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	V04	24,305	529,886	389,276	99.7	385,154
Special Investigations and Examinations	V72	6,708	550,511	244,882	99.1	193,731

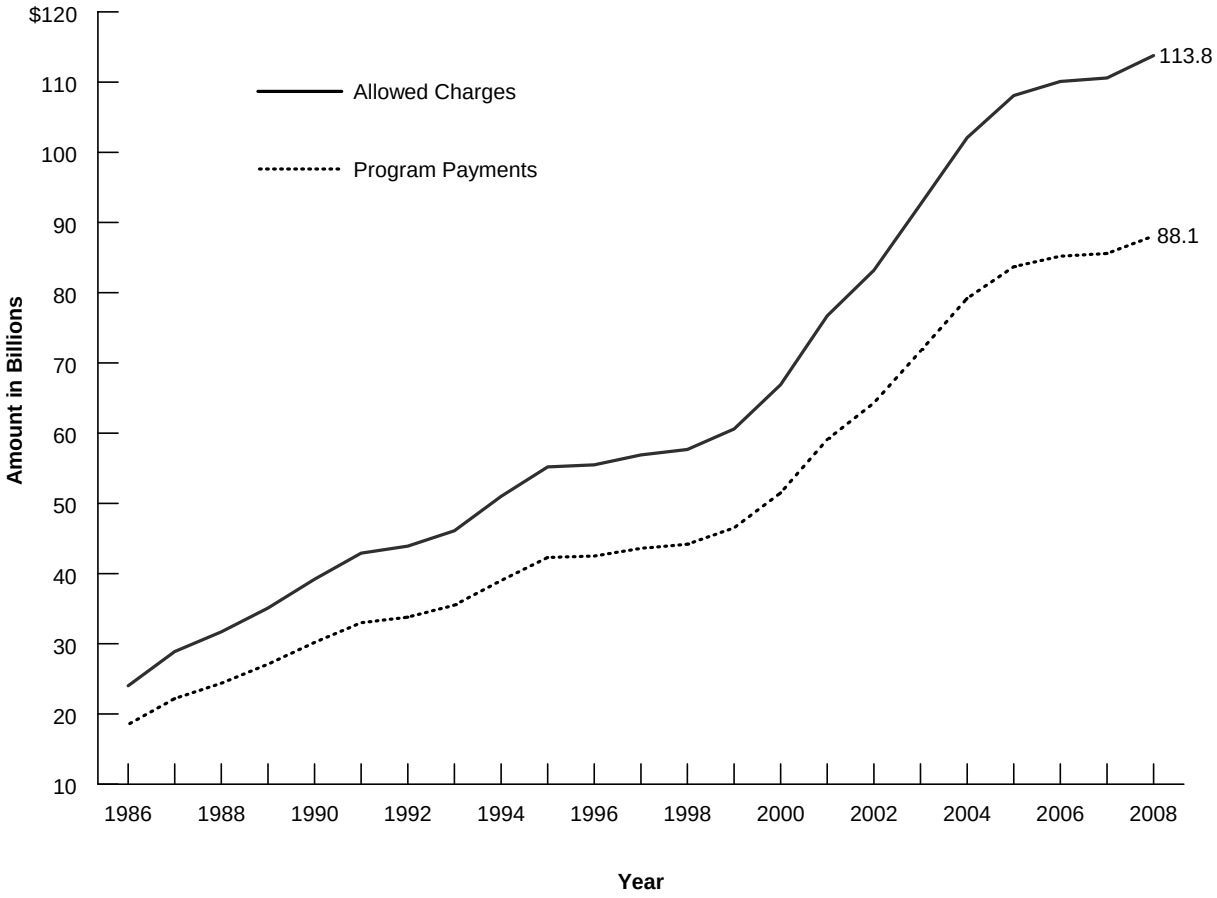
[1]ICD-9-CM is International Classification of Diseases, 9th Revision, Clinical Modification. Only the first listed or principal diagnosis has been used.

[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.

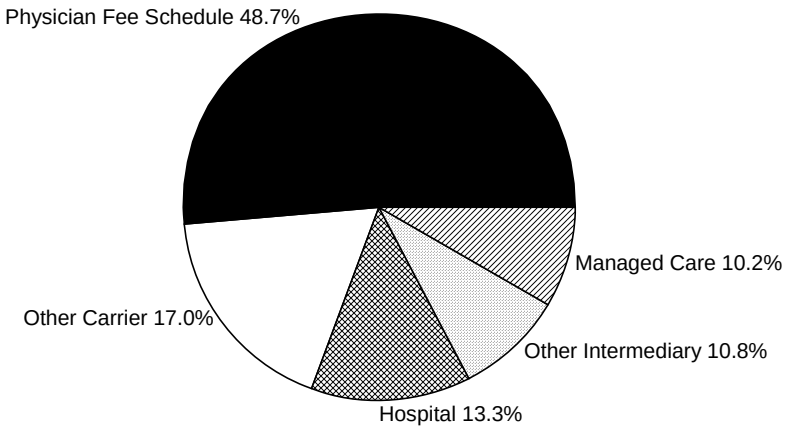
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Figure 9.1
Trends in Medicare Physician and Supplier Allowed Charges and Program Payments: Calendar Years 1986-2008



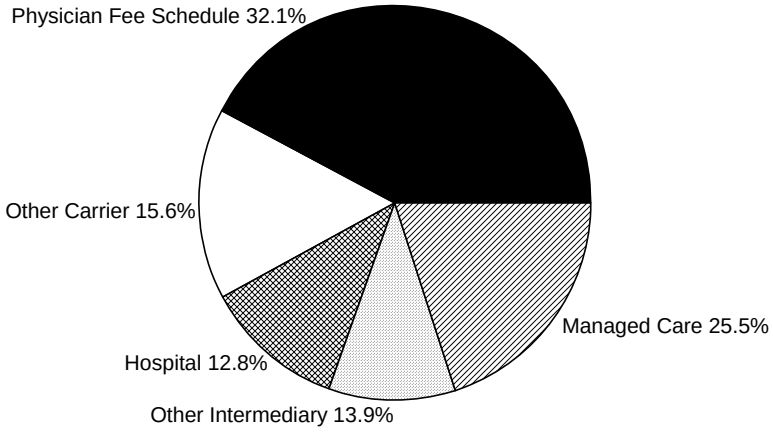
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Figure 9.2
Distribution of Medicare Supplementary Medical Insurance Benefit Payments, by Type of Provider: Calendar Years 1995 and 2008



1995

(Total Benefit Payments = $65.0 Billion)



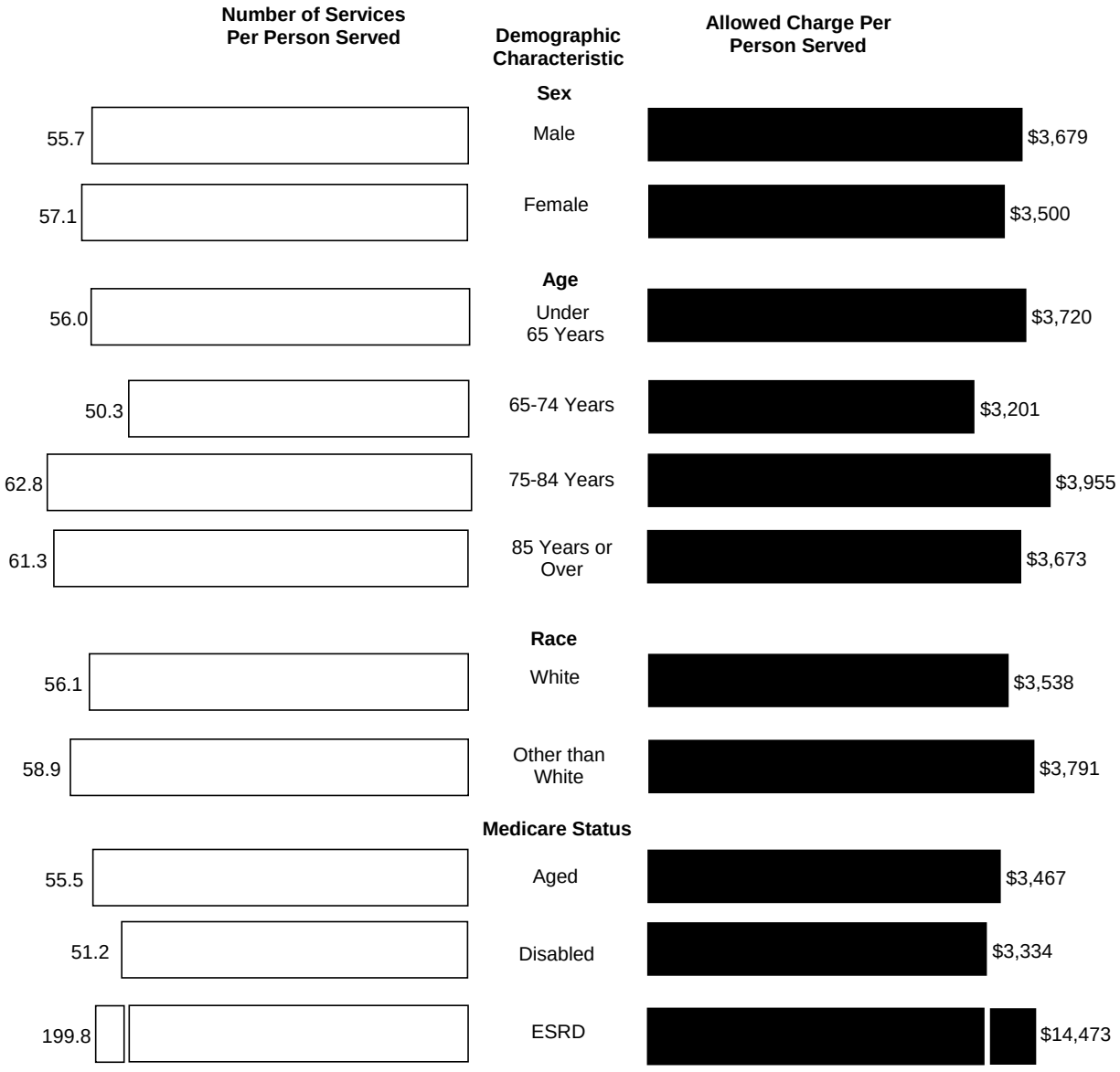
2008

(Total Benefit Payments = $188.6 Billion)

NOTES: Distribution may not add to 100 percent because of rounding. Other carrier includes durable medical equipment, carrier lab, and other carrier processed claims. Other intermediary includes home health Part B, intermediary lab, and other intermediary processed claims.

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

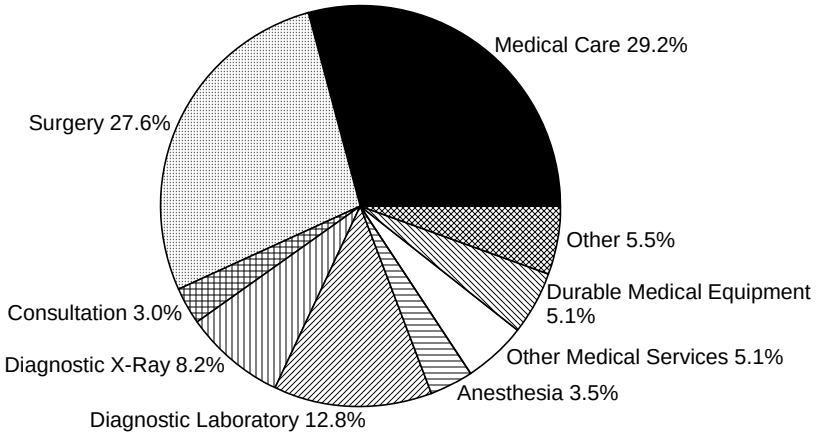
Figure 9.3
Number of Medicare Physician and Supplier Services, and Allowed Charges per Person Served, by Selected Demographic Characteristics: Calendar Year 2008



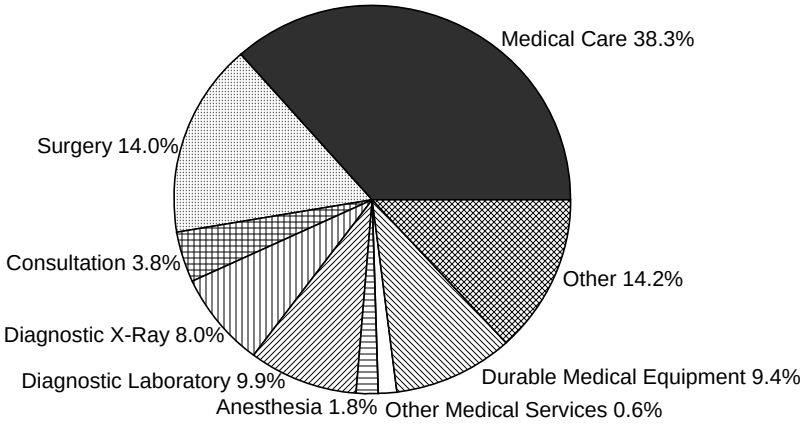
NOTE: ESRD is end stage renal disease.

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

Figure 9.4
Percent Distribution of Medicare-Allowed Charges for Physician and Supplier Services, by Type of Service: Calendar Years 1990 and 2008



1990
(Total Allowed Charges = $37.4 Billion)

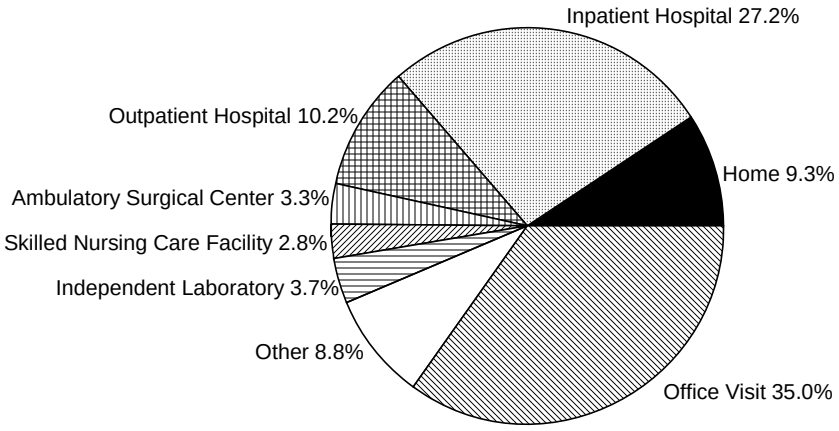


2008
(Total Allowed Charges = $113.8 Billion)

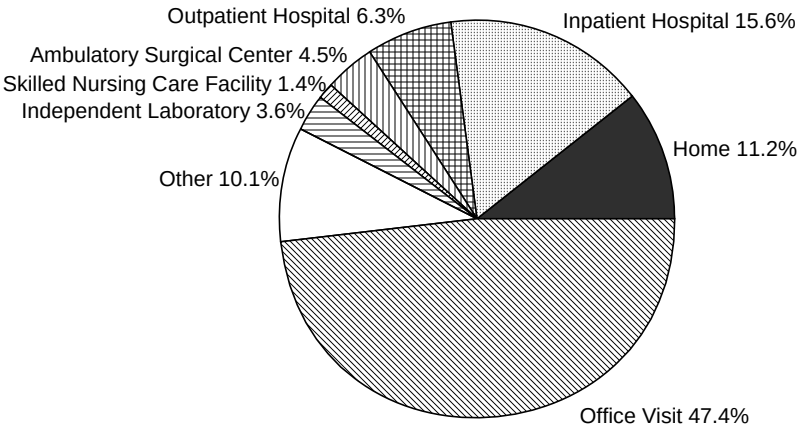
NOTE: Other includes ambulatory surgery center services, therapeutic radiology, psychological therapy assistance at surgery, monthly capitation dialysis services, etc.

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

Figure 9.5
Percent Distribution of Medicare-Allowed Charges for Physician and Supplier Services, by Place of Service: Calendar Years 1995 and 2008



1995
(Total Allowed Charges = $55.2 Billion)

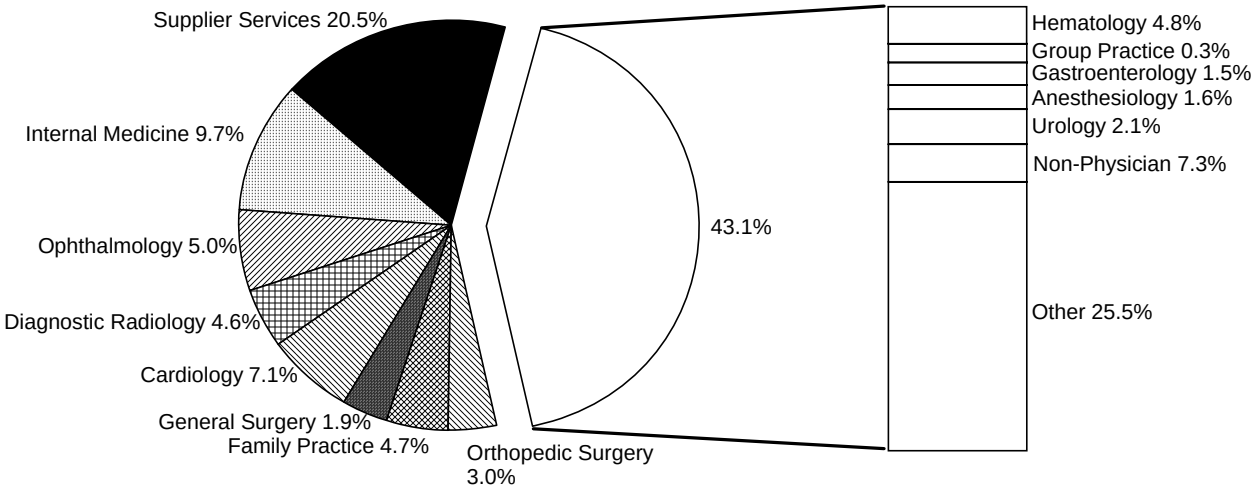


2008
(Total Allowed Charges = $113.8 Billion)

NOTES: Other includes custodial care facilities, comprehensive inpatient rehabilitation facilities, end stage renal disease treatment facilities, hospice, ambulance, nursing homes, community mental health centers, other medical services, emergency room services, etc. Distribution may not add to 100 percent because of rounding.

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

Figure 9.6
Percent Distribution of Medicare-Allowed Charges for Selected Physician and Related Services, by Type of Physician Specialty: Calendar Year 2008

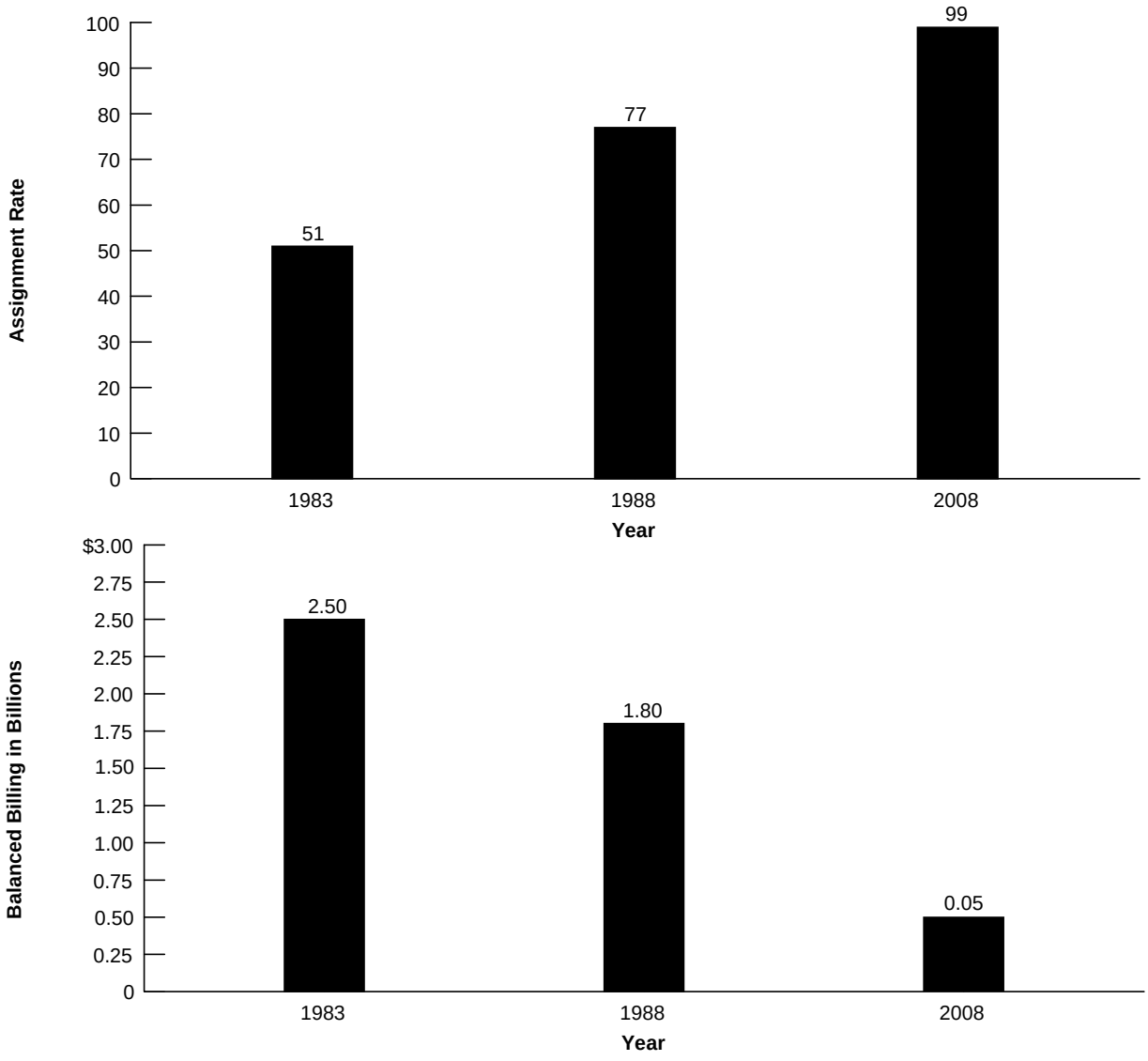


(Total Allowed Charges=$113.8 Billion)

NOTES: Other includes dermatology, medical oncology, emergency medicine, pulmonary disease, and other physician specialties not listed separately. Numbers may not add to total because of rounding.

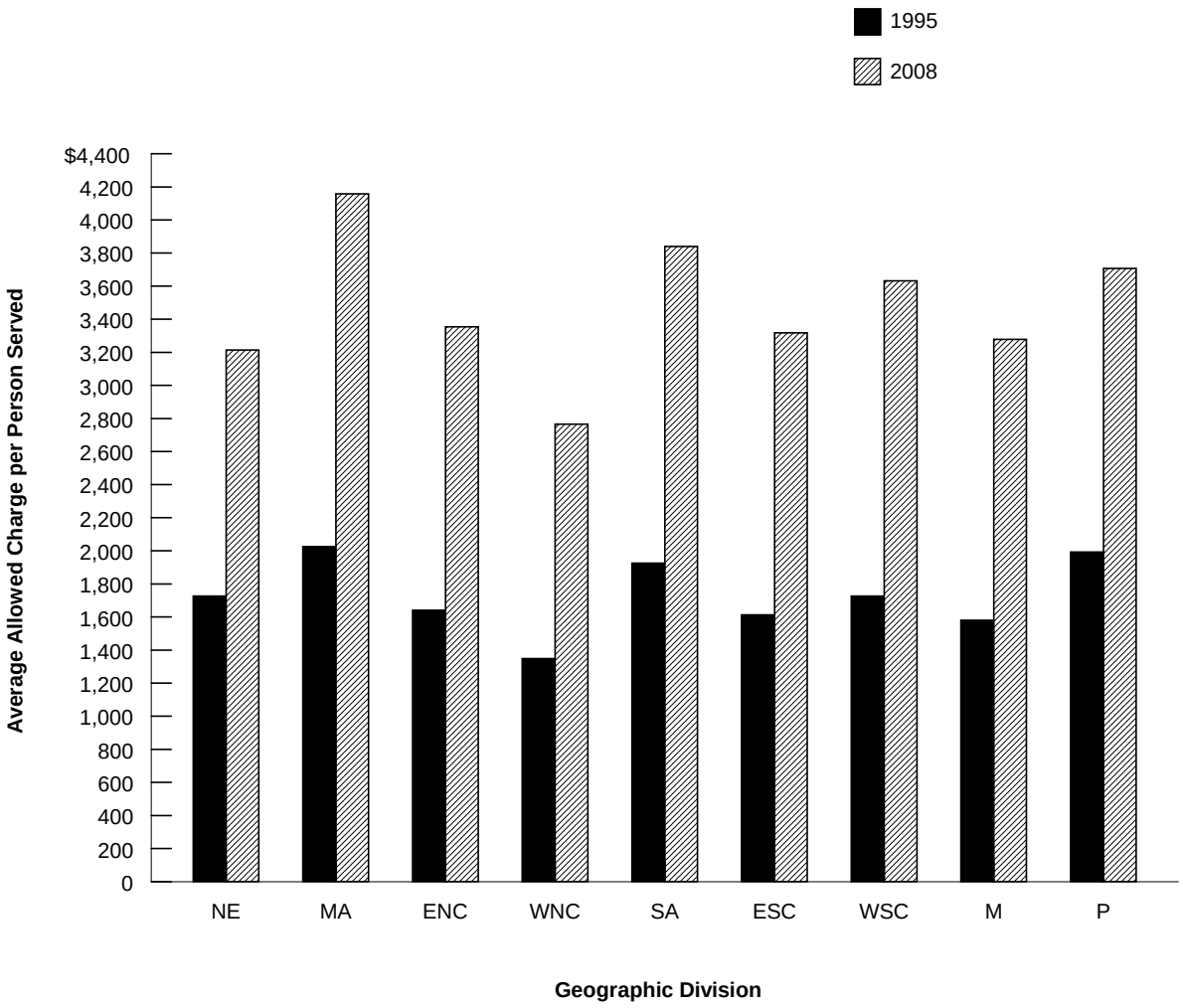
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Figure 9.7
Trends in Medicare Assignment Rates and Amount of Balanced Billing: Selected Calendar Years 1983, 1988, and 2008



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

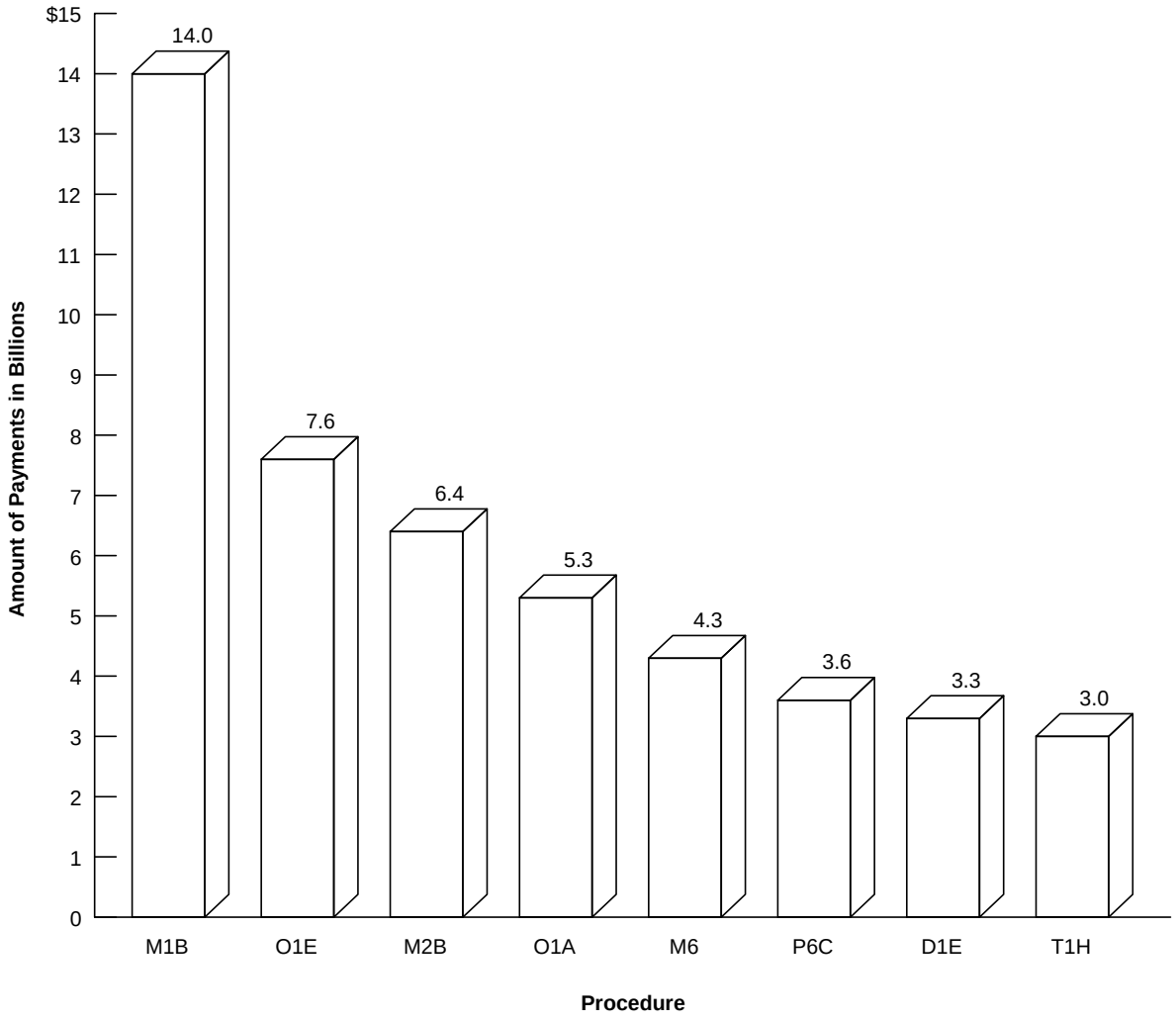
Figure 9.8
Average Allowed Charge per Person Served for Medicare Physician and Supplier Services, by Geographic Division: Calendar Years 1995 and 2008



NOTES: Average allowed charge per person with at least one covered service during the calendar year. NE is New England, MA is Middle Atlantic, ENC is East North Central, WNC is West North Central, SA is South Atlantic, ESC is East South Central, WSC is West South Central, M is Mountain, and P is Pacific.

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

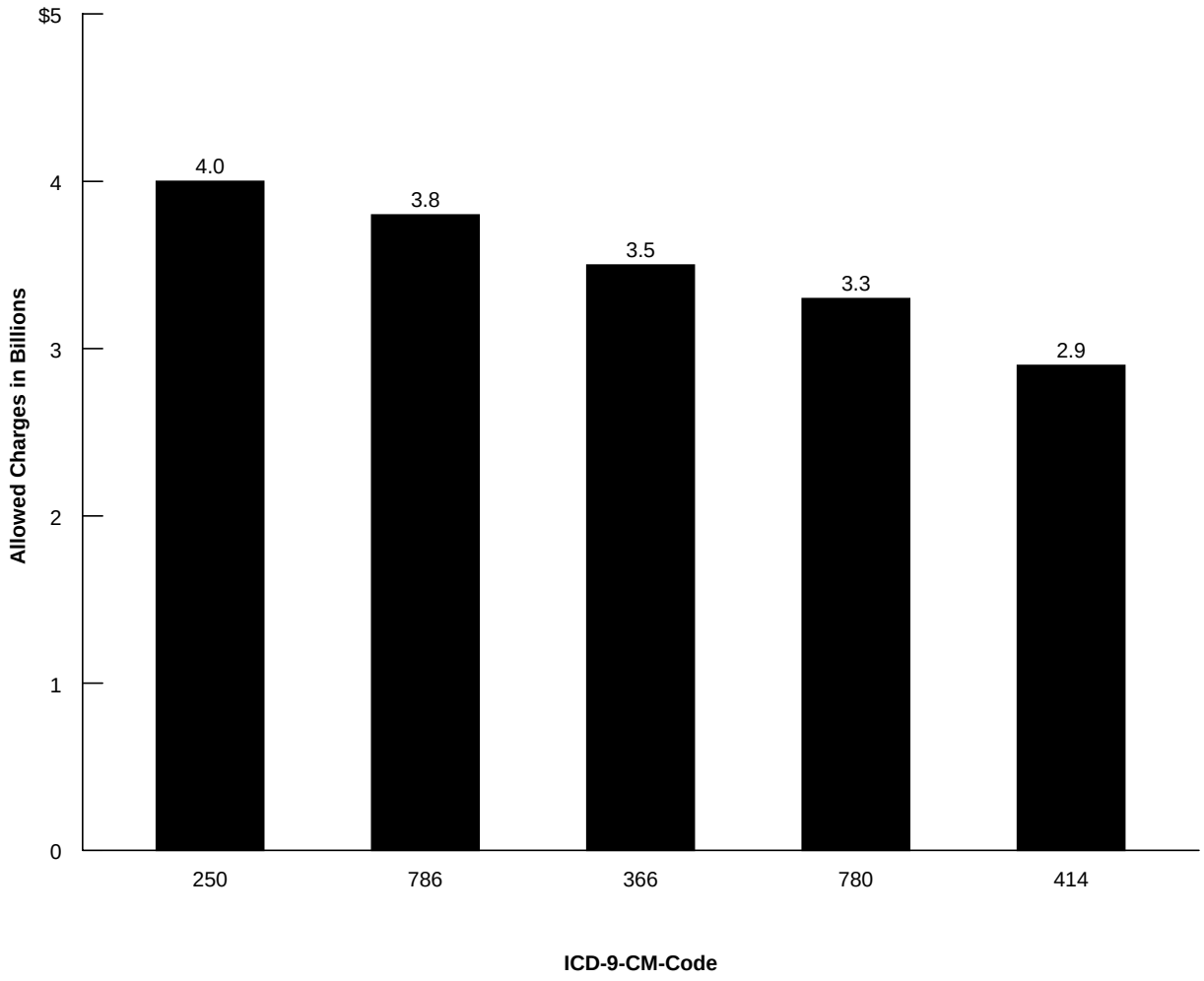
Figure 9.9
Leading Medicare Physician and Supplier BETOS Procedures, Based on Allowed Charges: Calendar Year 2008



NOTES: BETOS is the Berenson/Eggers Type of Service system for classifying HCPCS (Healthcare Common Procedure Coding System) codes. M1B--Office Visits, Established; O1E--Other Drugs; M2B--Hospital Visit, Subsequent; O1A--Ambulance; M6--Consultations; P6C--Minor Procedures, Other (Medicare Fee Schedule); D1E--Other Durable Medical Equipment; T1H--Lab Tests, Other (Non-Medicare Fee Schedule).

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

Figure 9.10
Leading Medicare Physician and Supplier Principal Diagnoses, Based on Allowed Charges: Calendar Year 2008



NOTE: Diagnoses have the following codes from the *International Classification of Diseases, 9th Revision, Clinical Modification:* diabetes mellitus, 250; symptoms involving respiratory system and other chest symptoms, 786; cataract, 366; general symptoms, 780; and other forms of chronic ischemic heart disease, 414.

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