Table 9.3

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

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

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

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

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

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

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

[6]Less than 500.

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

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

Table 9.3--Continued

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

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