Table 55

Medicare Supplementary Medical Insurance Disbursements for Benefits, by Type of Provider: Selected Calendar Years 1970-2000

Type of Provider	1970	1975	1980	1985	1990
			Dollars in Millions		
Total, Old Format[1]	$1,975	$4,273	$10,635	$22,947	$42,468
Physicians and Suppliers[2]	1,790	3,416	8,187	17,312	29,609
Outpatient Facilities[3]	114	643	1,897	4,319	8,482
Managed Care[4]	26	80	203	720	2,827
Home Health Agencies[5]	34	95	234	38	74
Independent Laboratories	11	39	114	558	1,476
Total, New Format[1,6]	---	---	---	---	---
Physician Fee Schedule	---	---	---	---	---
Durable Medical Equipment	---	---	---	---	---
Carrier Laboratories	---	---	---	---	---
Other Carrier	---	---	---	---	---
Hospital	---	---	---	---	---
Home Health Agencies[5]	---	---	---	---	---
Intermediary Laboratories	---	---	---	---	---
Other Intermediary	---	---	---	---	---
Managed Care	---	---	---	---	---
			Percent Distribution		
Total, Old Format[1]	100.0	100.0	100.0	100.0	100.0
Physicians and Suppliers[2]	90.6	79.9	77.0	75.4	69.7
Outpatient Facilities[3]	5.8	15.0	17.8	18.8	20.0
Managed Care[4]	1.3	1.9	1.9	3.1	6.7
Home Health Agencies[5]	1.7	2.2	2.2	0.2	0.2
Independent Laboratories	0.6	0.9	1.1	2.4	3.5
Total, New Format[1, 6]	---	---	---	---	---
Physician Fee Schedule	---	---	---	---	---
Durable Medical Equipment	---	---	---	---	---
Carrier Laboratories	---	---	---	---	---
Other Carrier	---	---	---	---	---
Hospital	---	---	---	---	---
Home Health Agencies[5]	---	---	---	---	---
Intermediary Laboratories	---	---	---	---	---
Other Intermediary	---	---	---	---	---
Managed Care	---	---	---	---	---

[1]Represents disbursements accrued on a cash-flow basis. Excludes disbursements for program administration and the net cost of private health insurance, government public health activities, and research and construction.

[2]Excludes disbursements for health maintenance organizations, competitive medical plans, and other prepaid health plans.

[3]Includes disbursements for hospital outpatient facilities, end stage renal disease freestanding facilities, rural health clinics, and outpatient rehabilitation facilities.

[4]Includes disbursements for health maintenance organizations, competitive medical plans, and other prepaid health plans.

[5]As a result of the 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 agency services, associated with a hospital or skilled nursing facility stay after the first 100 visits, be transferred from Part A (HI) to Part B (SMI).

[6]Costs for Peer Review Organization activity, from 1991-2000, are excluded from the totals.

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 1970-2000

1995	1996	1997	1998	1999	2000
		Dollars in Millions			
$64,972	$68,599	$72,757	---	---	---
40,474	41,238	42,411	---	---	---
15,625	16,456	17,416	---	---	---
6,608	8,847	10,980	---	---	---
200	219	228	---	---	---
2,065	1,839	1,722	---	---	---
$64,970	$68,584	$72,741	$76,644	$81,287	$90,552
31,660	31,631	31,898	32,449	33,354	36,961
3,689	3,825	4,236	4,037	4,280	4,719
2,807	2,550	2,385	2,087	2,078	2,229
4,530	5,059	5,586	5,940	6,451	7,407
8,666	8,614	9,358	8,713	8,794	8,494
229	241	239	155	1,173	4,354
1,448	1,355	1,503	1,542	1,680	1,780
5,331	5,749	6,575	6,382	5,775	6,250
6,610	9,558	10,962	15,338	17,702	18,358
100.0	100.0	100.0	---	---	---
62.3	60.1	58.3	---	---	---
24.0	24.0	23.9	---	---	---
10.2	12.9	15.1	---	---	---
0.3	0.3	0.3	---	---	---
3.2	2.7	2.4	---	---	---
100.0	100.0	100.0	100.0	100.0	100.0
48.7	46.1	43.9	42.3	41.0	40.8
5.7	5.6	5.8	5.3	5.3	5.2
4.3	3.7	3.3	2.7	2.6	2.5
7.0	7.4	7.7	7.8	7.9	8.2
13.3	12.6	12.9	11.4	10.8	9.4
0.4	0.4	0.3	0.2	1.4	4.8
2.2	2.0	2.1	2.0	2.1	2.0
8.2	8.4	9.0	8.3	7.1	6.9
10.2	13.9	15.1	20.0	21.8	20.3

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 2000

Demographic Characteristic	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	29,644,740	1,252,280	42.2	$127,853,210	$4,313
Sex					
Male	12,156,400	513,981	42.3	55,945,720	4,602
Female	17,488,340	738,299	42.2	71,907,490	4,112
Age					
Under 65 Years	3,802,820	161,138	42.4	17,070,425	4,489
65-74 Years	12,048,380	455,444	37.8	47,460,553	3,939
75-84 Years	9,817,500	454,739	46.3	46,654,362	4,752
85 Years or Over	3,976,040	180,959	45.5	16,667,870	4,192
Race[4]					
White	25,370,200	1,060,449	41.8	108,009,901	4,257
Other	3,323,500	147,417	44.4	15,445,594	4,647
Medicare Status[5]					
Aged	25,697,820	1,075,631	41.9	109,042,287	4,243
Disabled	3,728,280	144,506	38.8	14,878,546	3,991
End Stage Renal Disease	218,640	32,143	147.0	3,932,377	17,986

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 2000

	Allowed Charges				Program Payments		Balance Billing	
Demographic Characteristic	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[3]
Total	$66,911,902	$2,257	$65,852,124	98.4	$51,456,747	$1,789	$72,884	$24
Sex								
Male	29,015,917	2,387	28,578,541	98.5	22,351,370	1,910	30,772	26
Female	37,895,985	2,167	37,273,583	98.4	29,105,377	1,706	42,111	23
Age								
Under 65 Years	8,907,361	2,342	8,849,301	99.3	6,699,568	1,861	3,741	26
65-74 Years	24,097,507	2,000	23,667,641	98.2	18,488,040	1,589	28,923	23
75-84 Years	24,536,458	2,499	24,110,508	98.3	19,026,169	1,977	29,692	25
85 Years or Over	9,370,575	2,357	9,224,674	98.4	7,242,970	1,855	10,528	25
Race[4]								
White	56,485,475	2,226	55,471,662	98.2	43,395,961	1,760	69,859	24
Other	8,013,467	2,411	7,979,099	99.6	6,190,716	1,941	2,263	19
Medicare Status[5]								
Aged	57,136,468	2,223	56,139,253	98.3	44,069,429	1,761	68,819	24
Disabled	7,860,714	2,108	7,804,183	99.3	5,859,802	1,663	3,612	25
End Stage Renal Disease	1,914,720	8,757	1,908,688	99.7	1,527,516	7,090	452	49

[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 balanced 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 2000

		Services		Submitted Charges	
Type of Service	Persons Served[1]	Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	29,644,740	1,252,280	42.2	$127,853,210	$4,313
Medical Care	28,628,020	461,610	16.1	35,172,322	1,229
Surgery	16,550,740	80,303	4.9	30,499,244	1,843
Consultation	10,321,540	25,127	2.4	4,249,406	412
Diagnostic X-Ray	19,239,200	102,315	5.3	11,635,749	605
Diagnostic Laboratory	23,723,160	367,890	15.5	15,546,019	655
Radiation Therapy	849,620	9,632	11.3	2,545,192	2,996
Anesthesia	5,065,880	9,719	1.9	5,276,427	1,042
Assistance at Surgery	762,920	1,176	1.5	1,004,045	1,316
Other Medical Services	887,980	8,031	9.0	1,109,449	1,249
Ambulatory Surgical Center	1,610,640	2,442	1.5	3,321,610	2,062
Renal Supplies in the Home	43,200	616	14.3	268,847	6,223
ESRD Capitation Payment	237,460	2,211	9.3	764,597	3,220
Psychological Therapy	2,331,380	15,910	6.8	1,375,764	590
Occupational Therapy	20,620	684	33.2	21,149	1,026
Pneumococcal Vaccine	10,242,300	21,021	2.1	186,982	18
Physical Therapy	474,000	17,948	37.9	541,905	1,143
Durable Medical Equipment[5]	6,411,720	85,665	13.4	8,742,131	1,363
Other[6]	---	39,980	---	5,592,372	---

[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]Excludes persons with no balanced billing in calendar year.

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

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

NOTES: Medicare charges and program payments represent fee-for-service utilization only. Numbers may not add to total because of rounding. BETOS is Berenson-Eggers Type of Service System for classifying HCPCS. ESRD is end stage renal disease. --- 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 2000

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[4]
$66,911,902	$2,257	$65,852,124	98.4	$51,456,747	$1,789	$72,884	$24
24,524,158	857	24,035,514	98.0	18,155,469	674	32,989	17
11,883,271	718	11,750,918	98.9	9,295,982	574	10,577	26
2,997,661	290	2,967,055	99.0	2,311,808	226	2,457	15
4,975,745	259	4,933,410	99.1	3,851,388	208	3,508	12
6,099,535	257	6,059,731	99.3	5,228,207	222	3,239	8
923,622	1,087	918,580	99.5	733,932	869	442	75
1,453,834	287	1,448,212	99.6	1,151,128	228	483	19
192,912	253	191,361	99.2	153,323	201	134	21
622,875	701	617,739	99.2	495,731	559	284	73
1,371,497	852	1,371,468	99.9	1,088,036	676	1	32
172,063	3,983	172,056	99.9	136,739	3,173	1	4
464,329	1,955	464,122	99.9	365,430	1,544	18	63
1,047,365	449	1,009,607	96.4	486,630	225	2,361	33
15,361	745	15,320	99.7	12,150	597	3	19
102,745	10	99,530	96.9	102,617	10	184	1
398,605	841	392,926	98.6	314,457	668	241	38
5,906,694	921	5,762,814	97.6	4,615,041	731	7,091	14
3,759,630	---	3,641,761	96.9	2,958,679	---	8,871	---

Table 58

Persons Served, Services, Submitted and Allowed Charges, Program Payments for Medicare Physician and Supplier Services, by Place of Service: Calendar Year 2000

		Services		Submitted Charges	
Place of Service	Persons Served[1]	Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	29,644,740	1,252,280	42.2	$127,853,210	$4,313
Office	27,434,660	606,196	22.1	43,965,931	1,603
Home	6,930,140	97,140	14.0	10,149,453	1,465
Inpatient Hospital	7,812,920	180,128	23.1	33,863,882	4,334
Outpatient Hospital[4]	15,550,400	77,159	5.0	16,823,603	1,082
Emergency Room Hospital[4]	8,894,760	29,511	3.3	3,983,736	448
Ambulatory Surgical Center	1,913,280	7,111	3.7	6,186,424	3,233
Skilled Nursing Care Facility	2,155,660	27,058	12.6	1,894,897	879
Nursing Home	1,684,380	18,733	11.1	898,567	533
Hospice	8,800	22	2.5	1,906	217
Ambulance[5]	3,471,860	25,024	7.2	3,320,861	957
Independent Laboratory	13,915,460	160,204	11.5	5,086,064	365
All Other[6]	---	23,994	---	1,677,886	---

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 2000

	Allowed Charges					Program Payments			Balance Billing	
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]	Amount in Thousands	Per Person with Liability[4]
Total	$66,911,902	100.0	$2,257	$65,852,124	98.4	$51,456,747	100.0	$1,789	$76,730	$23
Office	28,445,007	42.5	1,037	27,790,121	97.7	21,062,249	40.9	800	43,892	18
Home	6,844,321	10.2	988	6,672,161	97.5	5,344,258	10.4	784	7,719	12
Inpatient Hospital	14,672,898	21.9	1,878	14,583,173	99.4	11,613,941	22.6	1,496	8,108	48
Outpatient Hospital[4]	5,731,494	8.6	369	5,695,346	99.4	4,461,483	8.7	295	3,330	23
Emergency Room Hospital[4]	1,760,666	2.6	198	1,758,403	99.9	1,357,164	2.6	156	189	8
Ambulatory Surgical Center	2,401,145	3.6	1,255	2,391,484	99.6	1,901,598	3.7	996	838	39
Skilled Nursing Care Facility	1,376,729	2.1	639	1,373,094	99.7	1,028,728	2.0	487	337	18
Nursing Home	643,800	1.0	382	642,553	99.8	463,563	0.9	282	127	13
Hospice	1,138	(7)	129	1,138	100.0	888	(7)	103	(8)	5
Ambulance[5]	2,203,041	3.3	635	2,121,885	96.3	1,743,537	3.4	503	6,483	30
Independent Laboratory	1,789,521	2.7	129	1,788,784	99.9	1,701,251	3.3	122	104	9
All Other[6]	1,042,142	1.6	---	1,033,982	99.2	778,087	1.5	---	76,730	---

[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. 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. --- 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 2000

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	29,644,740	1,252,280	100.0	42.2	$127,853,210	100.0	$4,313
Total, Physicians	29,010,720	869,489	69.4	30.0	96,964,513	75.8	3,342
General Practice	3,176,640	21,099	1.7	6.6	1,300,154	1.0	409
General Surgery	4,027,440	14,218	1.1	3.5	4,491,369	3.5	1,115
Allergy and Immunology	324,600	11,125	0.9	34.3	181,054	0.1	558
Otology, Laryngology, Rhinology	2,593,900	11,711	0.9	4.5	1,143,386	0.9	441
Anesthesiology	4,699,000	11,373	0.9	2.4	4,682,198	3.7	996
Cardiology	8,744,700	78,051	6.2	8.9	10,520,673	8.2	1,203
Dermatology	4,433,100	27,635	2.2	6.2	1,754,996	1.4	396
Family Practice	10,996,320	94,633	7.6	8.6	4,818,110	3.8	438
Gastroenterology	3,466,540	13,616	1.1	3.9	2,979,551	2.3	860
Internal Medicine	14,979,780	162,923	13.0	10.9	10,774,181	8.4	719
Manipulative Therapy	76,880	571	(5)	7.4	34,773	(5)	452
Neurology	2,637,540	12,196	1.0	4.6	1,423,701	1.1	540
Neurologiclal Surgery	564,500	1,727	0.1	3.1	1,211,284	0.9	2,146
Obstetrics and Gynecology	2,295,120	6,263	0.5	2.7	819,801	0.6	357
Ophthalmology	10,360,780	32,682	2.6	3.2	7,337,517	5.7	708
Oral Surgery (Dentists Only)	87,180	173	(5)	2.0	33,017	(5)	379
Orthopedic Surgery	4,214,180	23,749	1.9	5.6	5,336,713	4.2	1,266
Pathology	5,267,940	16,107	1.3	3.1	1,610,313	1.3	306
Plastic and Reconstructive Surgery	452,100	1,520	0.1	3.4	539,613	0.4	1,194
Physical Medicine and Rehabilitation	983,540	10,518	0.8	10.7	805,231	0.6	819
Psychiatry	1,866,360	15,193	1.2	8.1	1,382,404	1.1	741
Colorectal Surgery (Proctology)	222,780	567	(5)	2.5	188,033	0.1	844
Pulmonary Disease	2,245,040	18,357	1.5	8.2	1,703,092	1.3	759
Diagnostic Radiology	17,112,860	74,888	6.0	4.4	8,596,066	6.7	502
Thoracic Surgery	520,900	1,576	0.1	3.0	1,332,294	1.0	2,558
Urology	3,863,420	24,242	1.9	6.3	3,654,081	2.9	946
Chiropractic	1,645,140	14,309	1.1	8.7	487,300	0.4	296
Nuclear Medicine	419,040	985	0.1	2.4	166,874	0.1	398
Pediatric Medicine	239,660	1,458	0.1	6.1	85,513	0.1	357
Geriatric Medicine	260,720	1,712	0.1	6.6	112,443	0.1	431
Nephrology	948,420	19,914	1.6	21.0	1,724,398	1.3	1,818
Optometrist	4,117,820	11,725	0.9	2.8	480,274	0.4	117
Infectious Disease	547,440	5,116	0.4	9.3	440,267	0.3	804
Endocrinology	766,380	5,928	0.5	7.7	340,074	0.3	444
Podiatry	5,117,780	23,988	1.9	4.7	1,443,631	1.1	282

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 2000

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
$66,911,902	100.0	$2,257	$65,852,124	98.4	$51,456,747	100.0	$1,789	$72,884	$24
50,201,759	75.0	1,730	49,392,070	98.4	38,192,035	74.2	1,366	57,570	24
875,490	1.3	276	851,790	97.3	638,741	1.2	213	1,343	14
1,917,913	2.9	476	1,904,471	99.3	1,493,667	2.9	379	1,060	28
141,532	0.2	436	133,935	94.6	106,603	0.2	335	430	26
603,895	0.9	233	595,597	98.6	450,350	0.9	183	637	13
1,356,831	2.0	289	1,349,330	99.4	1,069,555	2.1	229	631	22
4,889,403	7.3	559	4,848,821	99.2	3,787,685	7.4	444	3,226	29
1,277,978	1.9	288	1,239,060	97.0	951,986	1.9	227	3,051	15
3,320,547	5.0	302	3,241,552	97.6	2,380,412	4.6	228	5,712	15
1,340,076	2.0	387	1,325,021	98.9	1,037,664	2.0	306	1,197	26
7,000,749	10.5	467	6,838,618	97.7	5,254,340	10.2	363	13,125	21
23,510	(5)	306	21,705	92.3	17,552	(5)	239	102	21
870,269	1.3	330	858,915	98.7	666,202	1.3	260	936	21
382,256	0.6	677	377,392	98.7	299,442	0.6	546	417	49
411,225	0.6	179	397,871	96.8	306,549	0.6	140	955	12
3,794,792	5.7	366	3,737,047	98.5	2,829,246	5.5	294	4,561	17
19,094	(5)	219	16,875	88.4	14,602	(5)	174	129	17
2,291,140	3.4	544	2,271,387	99.1	1,767,327	3.4	436	1,637	39
643,502	1.0	122	638,984	99.3	508,550	1.0	98	383	15
217,322	0.3	481	213,673	98.3	169,461	0.3	388	276	39
491,617	0.7	500	489,144	99.5	386,172	0.8	398	190	22
967,370	1.4	518	928,346	96.0	600,227	1.2	334	2,468	39
83,365	0.1	374	82,061	98.4	64,251	0.1	295	106	24
1,103,958	1.6	492	1,097,271	99.4	858,601	1.7	390	567	26
3,353,013	5.0	196	3,327,456	99.2	2,609,290	5.1	157	2,110	21
490,594	0.7	942	488,499	99.6	388,218	0.8	759	182	57
2,249,350	3.4	582	2,226,684	99.0	1,743,665	3.4	459	1,939	37
429,471	0.6	261	345,667	80.5	313,978	0.6	201	3,023	12
73,774	0.1	176	72,564	98.4	57,729	0.1	141	103	17
51,330	0.1	214	50,817	99.0	37,928	0.1	165	26	17
80,579	0.1	309	79,194	98.3	60,002	0.1	239	120	26
990,221	1.5	1,044	986,516	99.6	776,665	1.5	832	324	27
418,026	0.6	102	404,807	96.8	282,515	0.5	80	225	6
285,074	0.4	521	283,248	99.4	223,951	0.4	415	153	19
227,417	0.3	297	218,593	96.1	175,375	0.3	234	688	18
1,069,653	1.6	209	1,055,916	98.7	788,454	1.5	160	673	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 2000

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	998,980	10,035	0.8	10.0	$544,742	0.4	$545
Vascular Surgery	771,340	2,081	0.2	2.7	816,328	0.6	1,058
Cardiac Surgery	225,420	657	(5)	2.9	811,847	0.6	3,601
Hematology/Oncology	1,097,940	38,659	3.1	35.2	3,665,440	2.9	3,338
Medical Oncology	464,660	15,234	1.2	32.8	1,555,633	1.2	3,348
Radiation Oncology	579,000	7,956	0.6	13.7	1,995,191	1.6	3,446
Emergency Medicine	6,129,220	13,870	1.1	2.3	2,368,116	1.9	386
All Other Physician[6]	---	9,150	0.7	---	1,272,837	1.0	---
Group Practice	3,409,020	38,518	3.1	11.3	4,201,603	3.3	1,232
Total Non-Physician	6,529,000	41,498	3.3	6.4	6,934,037	5.4	1,062
Total Suppliers	18,761,420	300,082	24.0	16.0	18,982,576	14.8	1,012
Invalid Physician/Supplier Specialty Codes	2,604,100	2,693	0.2	1.0	770,478	0.6	296

[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. --- 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 2000

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
$372,890	0.6	$373	$355,277	95.3	$282,778	0.5	$290	$1,444	$23
339,679	0.5	440	338,090	99.5	266,159	0.5	353	133	35
297,060	0.4	1,318	293,595	98.8	235,412	0.5	1,062	311	173
2,143,987	3.2	1,953	2,134,513	99.6	1,702,653	3.3	1,575	717	60
855,468	1.3	1,841	848,064	99.1	678,175	1.3	1,485	644	104
747,065	1.1	1,290	742,388	99.4	591,837	1.2	1,060	410	90
1,099,638	1.6	179	1,097,997	99.9	847,551	1.6	142	134	10
603,640	0.9	---	583,253	96.6	470,511	0.9	---	1,070	---
2,096,352	3.1	615	2,093,944	99.9	1,603,097	3.1	486	189	21
3,155,606	4.7	483	3,134,032	99.3	2,344,950	4.6	367	1,091	9
11,072,379	16.5	590	10,847,182	98.0	9,013,103	17.5	482	13,977	21
385,803	0.6	148	384,893	99.8	303,560	0.6	126	56	22

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 2000

	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]	29,644,740	973	1,252,280	42.2	$127,853,210	$4,313
United States[5]	29,248,260	974	1,234,380	42.2	126,661,074	4,331
Northeast	5,817,900	971	259,629	44.6	26,798,981	4,606
Midwest	7,732,080	983	290,339	37.5	29,443,477	3,808
South	11,284,060	976	499,187	44.2	51,643,870	4,577
West	4,414,220	959	185,224	42.0	18,774,746	4,253
New England	1,542,180	972	60,701	39.4	6,453,180	4,184
Connecticut	381,440	990	16,024	42.0	1,753,643	4,597
Maine	196,320	961	6,725	34.3	713,884	3,636
Massachusetts	636,320	970	26,099	41.0	2,766,058	4,347
New Hampshire	148,100	955	5,018	33.9	506,357	3,419
Rhode Island	98,780	977	4,512	45.7	441,703	4,472
Vermont	81,220	962	2,323	28.6	271,534	3,343
Middle Atlantic	4,275,720	970	198,928	46.5	20,345,802	4,758
New Jersey	941,860	964	46,582	49.5	4,823,361	5,121
New York	1,958,740	964	94,191	48.1	9,125,939	4,659
Pennsylvania	1,375,120	984	58,155	42.3	6,396,501	4,652
East North Central	5,303,300	979	204,088	38.5	21,331,276	4,022
Illinois	1,310,060	969	50,303	38.4	5,390,764	4,115
Indiana	763,700	987	28,675	37.5	2,973,897	3,894
Michigan	1,227,380	974	50,329	41.0	5,054,754	4,118
Ohio	1,313,260	982	50,769	38.7	5,474,794	4,169
Wisconsin	688,900	989	24,012	34.9	2,437,068	3,538
West North Central	2,428,780	992	86,251	35.5	8,112,201	3,340
Iowa	442,460	999	15,746	35.6	1,376,994	3,112
Kansas	341,460	999	13,031	38.2	1,333,063	3,904
Minnesota	540,660	999	16,548	30.6	1,558,818	2,883
Missouri	668,840	976	25,366	37.9	2,542,018	3,801
Nebraska	231,020	990	8,226	35.6	737,143	3,191
North Dakota	96,040	995	3,360	35.0	286,564	2,984
South Dakota	108,300	959	3,975	36.7	277,601	2,563
South Atlantic	6,062,880	977	271,407	44.8	28,644,020	4,724
Delaware	102,060	982	4,309	42.2	497,952	4,879
District of Columbia	54,140	911	2,346	43.3	276,100	5,100
Florida	1,947,640	986	105,154	54.0	10,923,483	5,609
Georgia	806,300	974	32,920	40.8	3,553,662	4,407
Maryland	514,440	967	22,704	44.1	2,675,678	5,201
North Carolina	1,025,360	982	40,946	39.9	4,207,401	4,103
South Carolina	532,920	972	21,864	41.0	2,319,373	4,352
Virginia	790,780	971	30,399	38.4	3,061,865	3,872
West Virginia	289,240	963	10,764	37.2	1,128,505	3,902

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 2000

Allowed Charges				Program Payments			Balance Billing	
Amount in Thousands	Per-cent	Per Person Served[1]	Percent of Charges Assigned[2]	Amount in Thousands	Per-cent	Per Person Served[3]	Amount in Thousands	Per Person with Liablity
$66,911,902	100.0	$2,257	98	$51,456,747	100.0	$1,789	$72,884	$24
66,047,753	98.7	2,258	98	50,790,939	98.7	1,790	72,811	24
14,471,822	21.6	2,487	98	11,145,728	21.7	1,966	14,064	25
15,049,295	22.5	1,946	98	11,510,142	22.4	1,538	20,632	25
26,233,304	39.2	2,325	99	20,206,917	39.3	1,845	20,421	19
10,293,332	15.4	2,332	98	7,928,152	15.4	1,853	17,695	32
3,357,803	5.0	2,177	99	2,562,793	5.0	1,711	1,844	22
908,981	1.4	2,383	98	696,770	1.4	1,868	1,090	31
357,616	0.5	1,822	99	272,731	0.5	1,445	139	15
1,464,973	2.2	2,302	100	1,117,345	2.2	1,803	234	14
264,412	0.4	1,785	99	200,026	0.4	1,400	229	16
227,420	0.3	2,302	100	175,093	0.3	1,832	22	10
134,403	0.2	1,655	98	100,828	0.2	1,289	130	25
11,114,019	16.6	2,599	98	8,582,935	16.7	2,058	12,220	25
2,706,642	4.0	2,874	97	2,098,689	4.1	2,280	5,208	26
5,222,652	7.8	2,666	98	4,031,686	7.8	2,105	6,368	27
3,184,725	4.8	2,316	99	2,452,560	4.8	1,837	644	14
10,835,911	16.2	2,043	98	8,301,058	16.1	1,615	10,973	23
2,722,188	4.1	2,078	97	2,087,286	4.1	1,645	4,971	26
1,418,457	2.1	1,857	98	1,079,378	2.1	1,467	1,674	18
2,823,614	4.2	2,301	99	2,173,760	4.2	1,818	1,709	24
2,722,161	4.1	2,073	99	2,085,982	4.1	1,641	542	13
1,149,491	1.7	1,669	97	874,652	1.7	1,311	2,076	25
4,213,384	6.3	1,735	97	3,209,083	6.2	1,369	9,659	29
732,727	1.1	1,656	96	556,426	1.1	1,305	2,236	38
671,147	1.0	1,966	99	514,252	1.0	1,550	519	19
798,015	1.2	1,476	97	603,082	1.2	1,159	1,554	31
1,300,857	1.9	1,945	98	996,024	1.9	1,545	1,530	19
388,700	0.6	1,683	94	294,564	0.6	1,323	1,769	33
149,240	0.2	1,554	95	113,542	0.2	1,218	560	32
172,698	0.3	1,595	89	131,194	0.3	1,260	1,490	36
14,646,480	21.9	2,416	99	11,291,572	21.9	1,913	12,032	19
244,628	0.4	2,397	99	188,488	0.4	1,895	211	16
136,917	0.2	2,529	98	105,493	0.2	2,002	233	37
6,100,419	9.1	3,132	99	4,747,090	9.2	2,485	3,916	21
1,725,056	2.6	2,139	99	1,323,041	2.6	1,693	1,475	19
1,316,285	2.0	2,559	98	1,014,698	2.0	2,021	1,462	23
1,960,603	2.9	1,912	98	1,494,488	2.9	1,502	2,597	18
1,117,181	1.7	2,096	99	855,190	1.7	1,654	771	15
1,517,689	2.3	1,919	99	1,159,960	2.3	1,511	1,157	19
527,703	0.8	1,824	99	403,124	0.8	1,451	211	16

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 2000

	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	2,235,380	974	92,784	41.5	$9,381,048	$4,197
Alabama	582,100	977	24,366	41.9	2,501,620	4,298
Kentucky	543,440	974	22,608	41.6	2,155,021	3,966
Mississippi	383,080	966	14,915	38.9	1,584,087	4,135
Tennessee	726,760	977	30,896	42.5	3,140,320	4,321
West South Central	2,985,800	975	134,996	45.2	13,618,802	4,561
Arkansas	388,060	976	15,709	40.5	1,493,621	3,849
Louisiana	457,460	990	19,623	42.9	2,062,892	4,509
Oklahoma	420,660	974	15,898	37.8	1,516,750	3,606
Texas	1,719,620	971	83,766	48.7	8,545,539	4,969
Mountain	1,473,720	962	54,062	36.7	5,522,616	3,747
Arizona	378,740	942	16,125	42.6	1,593,821	4,208
Colorado	277,720	985	10,021	36.1	1,019,313	3,670
Idaho	145,220	999	4,543	31.3	381,680	2,628
Montana	126,480	968	3,948	31.2	388,265	3,070
Nevada	138,660	932	6,610	47.7	791,008	5,705
New Mexico	159,840	911	5,245	32.8	573,063	3,585
Utah	187,640	993	5,660	30.2	593,154	3,161
Wyoming	59,420	964	1,910	32.1	182,312	3,068
Pacific	2,940,500	958	131,162	44.6	13,252,130	4,507
Alaska	33,180	852	971	29.3	130,348	3,929
California	2,013,780	947	99,432	49.4	10,200,968	5,066
Hawaii	106,240	999	3,642	34.3	351,182	3,306
Oregon	290,860	999	9,039	31.1	865,285	2,975
Washington	496,440	963	18,078	36.4	1,704,347	3,433
Outlying Areas[6]	396,480	879	17,900	45.1	1,192,136	3,007

[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. 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 2000

Allowed Charges				Program Payments			Balance Billing	
Amount in Thousands	Per-cent	Per Person Served[1]	Percent of Charges Assigned[2]	Amount in Thousands	Per-cent	Per Person Served[3]	Amount in Thousands	Per Person with Liablity
$4,658,756	7.0	$2,084	99	$3,566,213	6.9	$1,650	$2,413	$15
1,286,579	1.9	2,210	99	988,420	1.9	1,750	410	14
1,062,201	1.6	1,955	99	812,037	1.6	1,554	660	16
776,595	1.2	2,027	99	595,267	1.2	1,615	484	13
1,533,381	2.3	2,110	99	1,170,489	2.3	1,660	859	16
6,928,068	10.4	2,320	99	5,349,132	10.4	1,854	5,976	18
781,724	1.2	2,014	99	599,631	1.2	1,604	435	20
1,058,214	1.6	2,313	99	816,817	1.6	1,861	592	15
845,762	1.3	2,011	98	649,096	1.3	1,593	907	20
4,242,368	6.3	2,467	99	3,283,588	6.4	1,972	4,042	19
2,986,527	4.5	2,027	96	2,286,851	4.4	1,608	8,376	34
897,890	1.3	2,371	95	694,194	1.3	1,884	3,448	53
545,066	0.8	1,963	97	417,340	0.8	1,555	1,159	28
232,051	0.3	1,598	90	176,337	0.3	1,264	1,798	32
219,874	0.3	1,738	97	167,290	0.3	1,381	461	24
374,374	0.6	2,700	99	287,238	0.6	2,149	205	27
293,417	0.4	1,836	97	224,310	0.4	1,468	539	25
320,886	0.5	1,710	99	241,885	0.5	1,330	252	18
102,968	0.2	1,733	94	78,257	0.2	1,396	514	25
7,306,805	10.9	2,485	98	5,641,301	11.0	1,975	9,319	30
60,128	0.1	1,812	97	45,822	0.1	1,447	129	25
5,621,663	8.4	2,792	99	4,358,871	8.5	2,224	5,705	32
180,404	0.3	1,698	98	134,791	0.3	1,303	185	26
487,346	0.7	1,676	96	371,215	0.7	1,323	1,551	30
957,265	1.4	1,928	98	730,602	1.4	1,518	1,749	27
864,149	1.3	2,180	100	665,808	1.3	1,739	72	10

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 2000

Area of Residence	Assignment Rate [1]			Ratio of Submitted Charges to Allowed Charges		
	1983	1988	2000	1983	1988	2000
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	1.94
Alaska	0.46	0.71	0.97	1.33	1.82	2.17
Arizona	0.34	0.70	0.95	1.30	1.58	1.78
Arkansas	0.58	0.82	0.99	1.32	1.85	1.91
California	0.53	0.79	0.99	1.28	1.74	1.81
Colorado	0.42	0.66	0.97	1.37	1.67	1.87
Connecticut	0.44	0.74	0.98	1.31	1.86	1.93
Delaware	0.75	0.80	0.99	1.28	2.05	2.04
District of Columbia	0.76	0.86	0.98	1.33	2.07	2.02
Florida	0.34	0.76	0.99	1.29	1.72	1.79
Georgia	0.55	0.75	0.99	1.30	1.89	2.06
Hawaii	0.42	0.75	0.98	1.34	2.02	1.95
Idaho	0.22	0.40	0.90	1.32	1.43	1.64
Illinois	0.36	0.67	0.97	1.29	1.65	1.98
Indiana	0.28	0.87	0.98	1.33	1.85	2.10
Iowa	0.33	0.63	0.96	1.34	1.66	1.88
Kansas	0.48	0.82	0.99	1.30	1.82	1.99
Kentucky	0.39	0.89	0.99	1.29	1.84	2.03
Louisiana	0.37	0.79	0.99	1.37	1.80	1.95
Maine	0.73	0.84	0.99	1.28	1.90	2.00
Maryland	0.72	0.87	0.98	1.30	1.98	2.03
Massachusetts	0.85	0.93	0.99	1.28	1.92	1.89
Michigan	0.79	0.93	0.99	1.32	1.77	1.79
Minnesota	0.27	0.53	0.97	1.30	1.66	1.95
Mississippi	0.58	0.72	0.99	1.37	1.85	2.04
Missouri	0.44	0.76	0.98	1.28	1.72	1.95
Montana	0.19	0.53	0.97	1.27	1.42	1.77
Nebraska	0.19	0.54	0.94	1.28	1.59	1.90
Nevada	0.61	0.86	0.99	1.30	1.92	2.11
New Hampshire	0.51	0.69	0.99	1.32	1.86	1.92
New Jersey	0.58	0.70	0.97	1.34	1.67	1.78
New Mexico	0.41	0.70	0.97	1.34	1.68	1.95
New York	0.62	0.89	0.98	1.37	1.71	1.75
North Carolina	0.49	0.75	0.98	1.31	1.95	2.15
North Dakota	0.29	0.47	0.95	1.27	1.80	1.92

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 2000

Area of Residence	Assignment Rate [1]			Ratio of Submitted Charges to Allowed Charges		
	1983	1988	2000	1983	1988	2000
Ohio	0.34	0.73	0.99	1.32	1.82	2.01
Oklahoma	0.30	0.63	0.98	1.37	1.65	1.79
Oregon	0.25	0.57	0.96	1.28	1.55	1.78
Pennsylvania	0.76	0.88	0.99	1.28	1.94	2.01
Rhode Island	0.90	0.90	0.99	1.39	2.05	1.94
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	1.61
Tennessee	0.46	0.75	0.99	1.34	1.85	2.05
Texas	0.53	0.75	0.99	1.37	1.75	2.01
Utah	0.45	0.73	0.99	1.27	1.67	1.85
Vermont	0.58	0.78	0.98	1.31	2.01	2.02
Virginia	0.56	0.73	0.99	1.31	1.91	2.02
Washington	0.30	0.57	0.98	1.27	1.54	1.78
West Virginia	0.51	0.81	0.99	1.39	1.96	2.14
Wisconsin	0.32	0.61	0.97	1.25	1.67	2.12
Wyoming	0.26	0.46	0.94	1.32	1.50	1.77

[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.

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 2000

BETOS Classification	BETOS Codes	Persons Served[1]	Services		
			Number in Thousands	Percent	Per Person Served[1]
Total, All BETOS Groups	Total	29,644,740	1,252,280	100.0	42
Office Visits - Established	M1B	25,445,560	176,027	14.1	7
Hospital Visit - Subsequent	M2B	6,230,400	82,043	6.6	13
Consultations	M6	10,210,020	24,182	1.9	2
Chemotherapy	O1D	497,460	16,335	1.3	33
Ambulance	O1A	3,476,320	23,916	1.9	7
Other Drugs	O1E	4,827,920	44,767	3.6	9
Eye Procedure - Cataract Removal/Lens Insertion	P4B	1,231,180	6,963	0.6	6
Specialist - Ophthalmology	M5C	10,895,140	21,793	1.7	2
Lab Tests, Other (Non-MFS)	T1H	16,869,140	146,910	11.7	9
Anesthesia	P0	5,067,980	9,801	0.8	2
Emergency Room Visit	M3	8,254,060	15,127	1.2	2
Minor Procedures - Other (MFS)	P6C	5,427,680	44,960	3.6	8
Major Procedure, Cardiovascular-Other	P2F	2,010,200	4,699	0.4	2
Specialist - Psychiatry	M5B	1,972,960	17,227	1.4	9
Hospital Visit - Initial	M2A	5,429,300	9,097	0.7	2
Minor Procedures - Skin	P6A	7,166,600	19,138	1.5	3
Office Visits - New	M1A	8,945,720	12,090	1.0	1
Echography - Heart	I3C	4,077,920	14,108	1.1	3
Nursing Home Visit	M4B	2,549,420	19,812	1.6	8
Durable Medical Equipment[3]	D1A-D1F	9,376,260	85,582	6.8	9
All Other BETOS Groups	---	---	457,703	36.5	---

[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]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. --- is not applicable. The leading BETOS codes are based on amount of allowed charges for 2000. 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 2000

Allowed Charges			Program Payments		
Amount in Thousands	Percent	Per Person Served[1]	Amount in Thousands	Percent	Per Person Served[2]
$66,911,901	100.0	$2,257	$51,456,747	100.0	$1,789
8,551,700	12.8	336	5,855,454	11.4	249
4,481,506	6.7	719	3,556,408	6.9	573
2,943,719	4.4	288	2,268,902	4.4	224
2,295,208	3.4	4,614	1,820,422	3.5	3,672
2,216,779	3.3	638	1,754,279	3.4	505
1,973,758	2.9	409	1,562,021	3.0	340
1,886,410	2.8	1,532	1,498,040	2.9	1,218
1,462,999	2.2	134	1,008,048	2.0	103
1,459,908	2.2	87	1,455,488	2.8	86
1,459,611	2.2	288	1,154,053	2.2	228
1,377,910	2.1	167	1,061,703	2.1	132
1,277,649	1.9	235	995,388	1.9	190
1,242,010	1.9	618	985,596	1.9	492
1,204,071	1.8	610	648,532	1.3	341
1,176,865	1.8	217	916,920	1.8	169
1,097,938	1.6	153	812,268	1.6	119
1,068,586	1.6	119	730,456	1.4	89
1,010,326	1.5	248	793,124	1.5	196
984,887	1.5	386	721,901	1.4	290
5,898,683	8.8	629	4,608,847	9.0	---
21,841,378	32.6	---	17,248,897	33.5	---

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 2000

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	---	1,252,280	$127,853,210	$66,911,901	98.4	$51,456,747
Leading Diagnoses[2]	---	735,655	60,084,123	36,653,261	98.4	28,162,227
Infectious and Parasitic Diseases (MDC 1)	001-139	17,070	1,186,557	769,057	98.8	582,880
Dermatophytosis	110	7,059	349,404	276,288	98.8	198,332
Neoplasm (MDC 2)	140-239	106,308	15,957,760	8,131,986	98.8	6,410,026
Malignant Neoplasm of Colon	153	7,523	788,580	375,614	99.3	299,026
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	12,989	1,683,205	847,615	99.4	671,835
Other Malignant Neoplasm of Skin	173	5,924	1,187,222	689,945	98.3	537,575
Malignant Neoplasm of Female Breast	174	13,668	1,558,957	780,028	97.8	617,033
Malignant Neoplasm of Prostate	185	12,941	2,604,009	1,620,097	99.1	1,279,754
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	130,312	5,721,358	3,271,747	97.1	2,576,763
Thyroiditis	244	10,332	419,977	207,892	98.1	175,130
Diabetes Mellitus	250	67,779	2,846,728	1,859,401	96.1	1,428,051
Disorders of Lipoid Metabolism	272	34,353	1,140,215	500,003	98.0	411,871
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	6,434	433,311	252,502	99.2	200,742
Diseases of the Blood and Blood-Forming Organs (MDC 4)	280-289	35,566	2,260,533	1,222,693	99.3	996,834
Other and Unspecified Anemias	285	17,039	1,175,615	627,701	99.3	513,348
Mental Disorders (MDC 5)	290-319	32,200	2,900,489	2,019,338	97.8	1,244,909
Schizophrenic Disorders	295	5,695	442,554	300,854	99.3	183,663
Affective Psychoses	296	9,467	891,515	630,392	96.8	369,905
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	70,844	13,275,507	6,836,542	98.6	5,146,080
Other Retinal Disorders	362	6,913	1,266,103	817,075	99.2	618,316
Glaucoma	365	8,873	893,086	590,423	98.2	417,733
Cataract	366	19,334	6,795,934	2,905,234	98.8	2,219,693

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 2000

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	206,016	$23,852,352	$11,813,413	98.7	$9,083,697
Essential Hypertension	401	46,608	2,293,459	1,519,511	96.9	1,073,152
Acute Myocardial Infarction	410	4,561	736,786	332,734	98.8	262,521
Other Acute and Subacute Forms of Ischemic Heart Disease	411	4,424	1,037,102	405,320	99.3	319,024
Angina Pectoris	413	4,987	776,931	361,526	99.1	280,003
Other Forms of Chronic Ischemic Heart Disease	414	28,956	5,108,469	2,230,179	98.9	1,726,481
Other Diseases of Endocardium	424	6,676	1,308,695	539,562	98.8	421,924
Cardiac Dysrhythmias	427	28,909	2,404,226	1,231,262	98.7	956,361
Heart Failure	428	25,314	2,330,471	1,326,072	99.2	1,039,209
Ill-Defined Descriptions and Complications of Heart Disease	429	5,033	384,668	182,092	98.5	139,599
Acute, But Ill-Defined, Cerebrovascular Disease	436	9,380	1,058,453	674,377	99.0	527,501
Diseases of the Respiratory System (MDC 8)	460-519	103,357	9,037,354	5,475,832	99.1	4,201,781
Acute Bronchitis and Bronchiolitis	466	4,450	252,700	177,763	97.3	119,860
Allergic Rhinitis	477	15,441	231,505	181,964	96.3	132,892
Pneumonia, Organism Unspecified	486	8,845	768,698	464,992	99.1	361,201
Asthma	493	7,550	497,347	324,661	98.7	245,621
Other Diseases of Lung	518	9,739	1,130,888	630,253	99.4	498,412
Diseases of the Digestive System (MDC 9)	520-579	34,257	6,304,336	2,798,048	98.9	2,175,289
Diseases of the Genitourinary System (MDC 10)	580-629	69,998	6,997,380	3,490,600	99.1	2,728,850
Chronic Renal Failure	585	21,186	2,261,992	1,174,360	99.9	935,592
Calculus of Kidney and Ureter	592	1,439	294,742	108,794	99.2	84,968
Other Disorders of Urethra and Urinary Tract	599	15,400	886,158	475,408	99.0	375,912
Hyperplasia of Prostate	600	6,898	586,277	294,255	98.7	226,375
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	41,869	2,722,459	1,802,135	98.0	1,343,341
Other Dermatoses	702	16,740	687,501	493,851	96.9	361,582
Chronic Ulcer of Skin	707	5,905	738,429	425,008	99.5	331,980

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 2000

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	121,704	$12,580,387	$6,379,183	97.4	$4,875,487
Rheumatoid Arthritis and Ofher Inflammatory Polyarthrophathies	714	7,169	404,671	251,154	96.8	194,087
Osteoarthrosis and Allied Disorders	715	19,782	2,798,015	1,376,251	98.2	1,055,428
Other and Unspecified Arthropathies	716	3,314	253,116	153,363	97.7	114,512
Other and Unspecified Disorders of Joint	719	16,341	1,106,786	600,207	98.5	457,518
Other and Unspecified Disorders of Back	724	17,435	2,292,575	1,034,972	98.2	796,763
Peripheral Enthesopathies and Allied Syndromes	726	8,038	529,439	311,173	98.4	233,454
Other Disorders of Soft Tissues	729	8,511	628,806	344,961	98.2	260,823
Non-Allopathic Lesions, Not Elsewhere Classified	739	10,101	357,576	310,314	81.9	228,338
Congenital Anomalies (MDC 14)	740-759	2,263	352,770	166,167	98.6	128,373
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	136,816	13,834,990	7,183,315	98.8	5,579,385
General Symptoms	780	28,913	2,670,073	1,466,591	98.6	1,150,141
Symptoms Involving Respiratory System and Other Chest Symptoms	786	41,555	4,229,100	2,150,767	98.7	1,660,812
Symptoms Involving Digestive System	787	9,954	1,145,232	626,325	99.3	490,657
Symptoms Involving Urinary System	788	8,015	540,897	296,585	98.8	228,848
Sudden Death, Cause Unknown	798	12	2,178	1,193	98.7	903
Other Ill-Defined and Unknown Causes of Morbidity and Mortality	799	3,108	318,331	192,066	98.5	152,172
Injury and Poisoning (MDC 17)	800-999	44,816	6,542,461	3,193,483	98.6	2,484,124
Fracture of Neck of Femur	820	4,175	1,163,495	512,532	99.3	404,886
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	V01-V82	89,885	3,665,453	1,968,450	96.4	1,586,325
Need for Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	V04	17,674	148,458	81,327	96.9	80,528
Special Investigations and Examinations	V72	6,764	243,439	108,448	98.5	90,157

[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.