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 1995-2005

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
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
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

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 9.1

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 1995-2006

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
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
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

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 2005

Demographic Characteristic	Persons Served[1]	Services: Number in Thousands	Services: Per Person Served[1]	Submitted Charges: Amount in Thousands	Submitted Charges: Per Person Served[1]
Total	33,434,580	1,766,256	52.8	$236,285,951	$7,067
Sex					
Male	14,068,320	735,060	52.2	104,619,226	7,437
Female	19,366,260	1,031,196	53.2	131,666,725	6,799
Age					
Under 65 Years	5,046,320	266,273	52.8	37,782,640	7,487
65-74 Years	13,318,420	627,274	47.1	86,712,635	6,511
75-84 Years	10,590,700	619,443	58.5	82,302,220	7,771
85 Years or Over	4,479,140	253,267	56.5	29,488,455	6,584
Race[3]					
White	28,225,200	1,475,667	52.3	197,406,599	6,994
Other	5,053,700	283,722	56.1	37,967,710	7,513
Type of Entitlement[4]					
Aged	28,129,680	1,460,270	51.9	192,457,893	6,842
Disabled	4,958,700	242,138	48.8	33,281,982	6,712
ESRD	346,200	63,848	184.4	10,546,075	30,462

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 2005

Demographic Characteristic	Allowed Charges: Amount in Thousands	Allowed Charges: Per Person Served[1]	Allowed Charges: Assigned in Thousands	Allowed Charges: Percent of Charges Assigned	Program Payments: Amount in Thousands	Program Payments: Per Person Served[2]	Balance Billing: Amount in Thousands	Balance Billing: Per Person with Liability
Total	$108,052,939	$3,232	$107,224,850	99.2	$83,747,781	$2,561	$61,459	$28
Sex								
Male	47,358,789	3,366	47,014,293	99.3	36,720,026	2,685	26,117	30
Female	60,694,150	3,134	60,210,557	99.2	47,027,755	2,472	35,342	27
Age								
Under 65 Years	17,386,378	3,445	17,337,683	99.7	13,230,237	2,727	3,416	30
65-74 Years	38,445,266	2,887	38,110,156	99.1	29,722,960	2,291	24,780	27
75-84 Years	37,747,467	3,564	37,413,488	99.1	29,511,814	2,823	25,040	29
85 Years or Over	14,473,828	3,231	14,363,523	99.2	11,282,771	2,553	8,222	27
Race[3]								
White	89,884,587	3,185	89,096,352	99.1	69,590,176	2,518	58,544	28
Other	17,754,196	3,513	17,717,216	99.8	13,838,405	2,818	2,706	25
Type of Entitlement[4]								
Aged	88,037,902	3,130	87,264,508	99.1	68,415,363	2,479	57,559	28
Disabled	15,527,248	3,131	15,478,345	99.7	11,737,537	2,465	3,436	30
ESRD	4,487,790	12,963	4,481,997	99.9	3,594,881	10,467	464	44

[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 9.2

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Demographic Characteristics: Calendar Year 2006

Demographic Characteristic	Persons Served[1]	Number in Services Thousands	Per Person Served[1]	Amount Submitted Charges in Thousands	Per Person Served[1]
Total	32,981,880	1,766,733	53.6	$248,447,505	$7,533
Sex					
Male	13,927,080	739,037	53.1	110,004,903	7,899
Female	19,054,800	1,027,697	53.9	138,442,602	7,265
Age					
Under 65 Years	5,073,060	269,339	53.1	39,885,768	7,862
65-74 Years	13,091,600	624,450	47.7	91,089,094	6,958
75-84 Years	10,280,000	610,886	59.4	85,323,345	8,300
85 Years or Over	4,537,220	262,058	57.8	32,149,298	7,086
Race[3]					
White	27,849,940	1,481,015	53.2	207,845,955	7,463
Other	4,995,300	279,495	56.0	39,731,980	7,954
Type of Entitlement[4]					
Aged	27,640,980	1,455,737	52.7	201,974,009	7,307
Disabled	4,987,460	242,914	48.7	34,966,946	7,011
ESRD	353,440	68,082	192.6	11,506,550	32,556

See footnotes at end of table.

Table 9.2—Continued

Physician and Supplier Services, by Demographic Characteristics: Calendar Year 2006

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare

Demographic Characteristic	Allowed Charges: Amount in Thousands	Allowed Charges: Per Person Served[1]	Assigned: Amount in Thousands	Assigned: Percent of Charges Assigned	Program Payments: Amount in Thousands	Program Payments: Per Person Served[2]	Balance Billing: Amount in Thousands	Balance Billing: Per Person with Liability
Total	$110,135,017	$3,339	$109,387,656	99.3	$85,218,098	$2,647	$56,350	$29
Sex								
Male	48,278,815	3,467	47,967,708	99.4	37,375,233	2,767	23,895	31
Female	61,856,202	3,246	61,419,947	99.3	47,842,865	2,561	32,455	28
Age								
Under 65 Years	17,671,797	3,483	17,631,116	99.8	13,441,428	2,765	2,998	31
65-74 Years	39,153,438	2,991	38,851,049	99.2	30,212,832	2,374	22,611	28
75-84 Years	37,978,545	3,694	37,679,565	99.2	29,633,897	2,925	22,782	30
85 Years or Over	15,331,238	3,379	15,225,926	99.3	11,929,941	2,668	7,959	28
Race[3]								
White	91,810,049	3,297	91,096,468	99.2	70,965,578	2,608	53,845	29
Other	17,941,457	3,592	17,909,891	99.8	13,957,518	2,881	2,328	25
Medicare Status[4]								
Aged	89,643,967	3,243	88,941,640	99.2	69,523,607	2,569	53,022	29
Disabled	15,657,143	3,139	15,616,065	99.7	11,824,491	2,479	3,019	30
ESRD	4,833,907	13,677	4,829,951	99.9	3,870,000	11,028	310	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 2005

		Services		Submitted Charges	
Type of Service	Persons Served [1]	Number in Thousands	Per Person Served [1]	Amount in Thousands	Per Person Served [1]
Total	33,434,580	1,766,256	52.8	$236,285,951	$7,067
Medical Care	32,362,980	677,242	20.9	69,835,987	2,158
Surgery	19,921,840	104,184	5.2	47,725,325	2,396
Consultation	13,366,280	33,032	2.5	7,071,186	529
Diagnostic X-Ray	22,747,600	145,953	6.4	24,429,264	1,074
Diagnostic Laboratory	27,632,860	499,817	18.1	28,717,418	1,039
Radiation Therapy	1,126,820	11,464	10.2	4,900,321	4,349
Anesthesia	6,536,220	12,671	1.9	8,926,015	1,366
Assistance at Surgery	937,520	1,627	1.7	1,917,076	2,045
Other Medical Services	363,340	4,615	12.7	2,148,893	5,914
Ambulatory Surgical Center	2,969,360	5,032	1.7	8,514,909	2,868
Renal Supplies in the Home	10,280	164	15.9	246,521	23,981
ESRD Capitation Payment	316,060	2,742	8.7	1,394,856	4,413
Psychological Therapy	2,868,380	20,107	7.0	2,049,263	714
Occupational Therapy	13,080	174	13.3	6,056	463
Pneumococcal Vaccine	12,974,880	28,127	2.2	519,531	40
Physical Therapy	75,020	2,352	31.4	86,596	1,154
Durable Medical Equipment [4]	9,730,680	135,621	13.9	16,423,527	1,688
Other [5]	NA	81,332	NA	11,373,207	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.

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 2005

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
$108,052,939	$3,232	$107,224,850	99.2	$83,747,781	$2,561	$61,459	$28
40,334,751	1,246	39,937,670	99.0	30,350,996	982	28,537	19
16,191,996	813	16,078,707	99.3	12,672,337	646	9,337	31
4,356,511	326	4,324,754	99.3	3,354,221	253	2,719	20
9,870,682	434	9,809,861	99.4	7,699,146	349	5,182	22
10,344,552	374	10,305,355	99.6	8,845,056	323	3,283	11
1,675,460	1,487	1,665,661	99.4	1,331,349	1,186	877	141
1,833,918	281	1,829,981	99.8	1,449,102	222	347	18
229,249	245	228,581	99.7	181,909	194	59	25
1,060,196	2,918	1,060,082	99.9	839,308	2,321	7	7
2,635,006	887	2,634,830	99.9	2,079,667	701	16	53
75,562	7,350	75,562	99.9	60,102	5,869	0	0
785,378	2,485	785,302	99.9	620,271	1,968	7	114
1,414,317	493	1,382,521	97.8	661,041	245	2,307	38
3,994	305	3,950	98.9	3,107	242	1	13
397,050	31	395,640	99.6	396,317	31	35	2
65,924	879	65,308	99.1	51,013	691	30	38
10,031,193	1,031	9,901,457	98.7	7,835,707	817	8,145	15
6,747,200	NA	6,739,628	99.9	5,317,132	NA	570	NA

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 2006

Type of Service	Persons Served[1]	Services: Number in Thousands	Services: Per Person Served[1]	Submitted Charges: Amount in Thousands	Submitted Charges: Per Person Served[1]
Total	32,981,880	1,766,733	53.6	$248,447,505	$7,533
Medical Care	31,864,300	660,150	20.7	72,926,539	2,289
Surgery	19,705,240	106,040	5.4	49,232,372	2,498
Consultation	13,113,900	30,180	2.3	7,008,079	534
Diagnostic X-Ray	22,320,600	146,640	6.6	26,113,218	1,170
Diagnostic Laboratory	27,282,900	515,453	18.9	30,685,283	1,125
Radiation Therapy	1,182,920	11,975	10.1	5,410,555	4,574
Anesthesia	6,472,160	12,604	1.9	9,323,681	1,441
Assistance at Surgery	909,720	1,597	1.8	2,028,799	2,230
Other Medical Services	1,303,320	9,693	7.4	2,154,879	1,653
Ambulatory Surgical Center	3,076,200	5,368	1.7	9,563,829	3,109
Renal Supplies in the Home	2,940	79	26.8	76,272	25,943
ESRD Capitation Payment	322,620	2,800	8.7	1,450,348	4,496
Psychological Therapy	2,845,140	20,531	7.2	2,134,219	750
Occupational Therapy	10,920	77	7.0	2,343	215
Pneumococcal Vaccine	13,286,560	28,190	2.1	575,043	43
Physical Therapy	380	(6)	1.0	45	119
Durable Medical Equipment[4]	9,955,940	134,938	13.6	17,498,189	1,758
Other[5]	NA	80,418	NA	12,263,812	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.

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 2006

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
$110,135,017	$3,339	$109,387,656	99.3	$85,218,098	$2,647	$56,350	$29
40,471,055	1,270	40,109,297	99.1	30,360,479	1,003	26,558	19
16,382,235	831	16,276,482	99.4	12,799,324	661	8,736	32
4,217,762	322	4,187,432	99.3	3,231,718	249	2,609	20
10,281,616	461	10,225,652	99.5	8,005,581	370	4,740	24
10,898,328	399	10,859,115	99.6	9,304,255	344	3,332	12
1,835,008	1,551	1,827,062	99.6	1,460,248	1,240	710	126
1,785,729	276	1,782,368	99.8	1,411,605	219	295	17
222,513	245	222,047	99.8	176,491	194	41	22
1,041,355	799	1,041,299	99.9	822,688	638	5	6
2,751,439	894	2,751,300	99.9	2,170,798	706	9	56
35,113	11,943	35,113	99.9	27,617	9,394	0	0
801,903	2,486	801,767	99.9	632,358	1,963	12	122
1,436,999	505	1,409,439	98.1	667,997	250	2,031	37
861	79	861	99.9	674	62	0	0
428,583	32	427,333	99.7	427,942	32	37	1
36	95	36	99.9	27	76	0	0
10,363,615	1,041	10,257,593	99.0	8,068,911	825	6,670	15
7,180,867	NA	7,173,460	99.9	5,649,385	NA	565	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 2005

Place of Service	Persons Served[1]	Services: Number in Thousands	Services: Per Person Served[1]	Submitted Charges: Amount in Thousands	Submitted Charges: Per Person Served[1]
Total	33,434,580	1,766,256	52.8	$236,285,951	$7,067
Office	31,136,700	885,970	28.5	94,478,128	3,034
Home	10,831,060	149,234	13.8	18,826,749	1,738
Inpatient Hospital	8,550,880	216,105	25.3	48,906,109	5,719
Outpatient Hospital [4]	18,145,800	102,008	5.6	26,253,342	1,447
Emergency Room Hospital [4]	10,570,100	41,397	3.9	7,994,429	756
Ambulatory Surgical Center	3,321,580	13,123	4.0	14,759,984	4,444
Skilled Nursing Care Facility	2,182,640	23,972	11.0	2,057,100	942
Nursing Home	1,968,320	28,276	14.4	1,618,636	822
Hospice	5,920	17	2.9	1,759	297
Ambulance [5]	4,530,360	59,143	13.1	7,095,125	1,566
Independent Laboratory	17,323,500	220,807	12.7	10,768,975	622
All Other [6]	NA	26,204	NA	3,525,615	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 2005

	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	$108,052,939	100.0	$3,232	$107,224,850	99.2	$83,747,781	100.0	$2,561
Office	52,001,116	48.1	1,670	51,412,939	98.9	39,347,804	47.0	1,304
Home	11,455,593	10.6	1,058	11,324,848	98.9	8,950,315	10.7	837
Inpatient Hospital	17,881,062	16.5	2,091	17,817,275	99.6	14,151,681	16.9	1,663
Outpatient Hospital [4]	7,596,136	7.0	419	7,568,304	99.6	5,892,587	7.0	332
Emergency Room Hospital [4]	2,672,449	2.5	253	2,670,397	99.9	2,065,930	2.5	199
Ambulatory Surgical Center	4,467,000	4.1	1,345	4,457,272	99.8	3,522,637	4.2	1,062
Skilled Nursing Care Facility	1,426,408	1.3	654	1,424,565	99.9	1,076,591	1.3	502
Nursing Home	1,081,811	1.0	550	1,081,135	99.9	786,840	0.9	406
Hospice	1,155	(7)	195	1,155	99.9	901	(7)	155
Ambulance [5]	4,247,094	3.9	937	4,246,914	99.9	3,367,255	4.0	744
Independent Laboratory	3,239,497	3.0	187	3,238,863	99.9	3,060,513	3.7	177
All Other [6]	1,983,618	1.8	NA	1,981,183	99.9	1,524,727	1.8	NA

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

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

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

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

[5]Excludes air or water services.

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

[7]Less than 0.05 percent.

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

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

Table 9.4

Persons Served, Services, Submitted and Allowed Charges, Program Payments for Medicare Physician and Supplier Services, by Place of Service: Calendar Year 2006

Place of Service	Persons Served[1]	Services: Number in Thousands	Services: Per Person Served[1]	Submitted Charges: Amount in Thousands	Submitted Charges: Per Person Served[1]
Total	32,981,880	1,766,733	53.6	$248,447,505	$7,533
Office	30,646,240	878,148	28.7	100,031,539	3,264
Home	10,887,340	152,428	14.0	20,080,599	1,844
Inpatient Hospital	8,282,900	211,718	25.6	49,525,664	5,979
Outpatient Hospital [4]	17,761,380	102,963	5.8	26,891,595	1,514
Emergency Room Hospital [4]	10,260,760	41,433	4.0	8,521,976	831
Ambulatory Surgical Center	3,413,800	14,260	4.2	16,412,618	4,808
Skilled Nursing Care Facility	2,117,900	23,368	11.0	2,127,694	1,005
Nursing Home	1,967,040	29,214	14.9	1,721,913	875
Hospice	4,880	17	3.5	1,674	343
Ambulance [5]	4,506,520	56,390	12.5	7,556,010	1,677
Independent Laboratory	17,284,800	231,277	13.4	11,715,197	678
All Other [6]	NA	25,517	NA	3,861,026	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 2006

	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	$110,135,017	100.0	$3,339	$109,387,656	99.3	$85,218,098	100.0	$2,647
Office	53,010,407	48.1	1,730	52,468,510	99.0	40,004,446	46.9	1,350
Home	11,942,328	10.8	1,097	11,836,706	99.1	9,301,635	10.9	868
Inpatient Hospital	17,579,478	16.0	2,122	17,524,052	99.7	13,910,460	16.3	1,686
Outpatient Hospital [4]	7,548,224	6.9	425	7,521,712	99.6	5,841,499	6.9	336
Emergency Room Hospital [4]	2,692,012	2.4	262	2,689,817	99.9	2,077,207	2.4	206
Ambulatory Surgical Center	4,697,530	4.3	1,376	4,688,372	99.8	3,704,157	4.3	1,086
Skilled Nursing Care Facility	1,462,857	1.3	691	1,461,420	99.9	1,103,796	1.3	528
Nursing Home	1,145,993	1.0	583	1,145,423	99.9	837,664	1.0	431
Hospice	986	(7)	202	986	99.9	763	(7)	160
Ambulance [5]	4,468,303	4.1	992	4,467,759	99.9	3,540,261	4.2	786
Independent Laboratory	3,458,631	3.1	200	3,458,133	99.9	3,260,511	3.8	189
All Other [6]	2,128,268	1.9	NA	2,124,766	99.8	1,635,699	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 2005

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	33,434,580	1,766,256	100.0	52.8	$236,285,951	100.0	$7,067
Total Physicians	32,918,180	1,198,998	67.9	36.4	177,043,517	74.9	5,378
General Practice	3,149,500	25,291	1.4	8.0	2,254,503	1.0	716
General Surgery	4,467,340	15,951	0.9	3.6	6,179,373	2.6	1,383
Allergy and Immunology	424,380	12,517	0.7	29.5	298,600	0.1	704
Otology, Laryngology, Rhinology	3,031,640	14,923	0.8	4.9	1,898,725	0.8	626
Anesthesiology	5,837,780	15,045	0.9	2.6	7,769,080	3.3	1,331
Cardiology	11,830,220	115,460	6.5	9.8	19,127,314	8.1	1,617
Dermatology	5,523,040	38,295	2.2	6.9	3,264,726	1.4	591
Family Practice	14,083,760	129,677	7.3	9.2	8,665,354	3.7	615
Gastroenterology	4,656,280	16,177	0.9	3.5	4,896,425	2.1	1,052
Internal Medicine	18,464,540	215,334	12.2	11.7	18,969,304	8.0	1,027
Manipulative Therapy	126,340	926	(5)	7.3	78,680	(5)	623
Neurology	3,383,280	17,286	1.0	5.1	2,663,353	1.1	787
Neurologiclal Surgery	781,860	2,675	0.2	3.4	2,321,540	1.0	2,969
Obstetrics and Gynecology	2,613,120	8,795	0.5	3.4	1,387,438	0.6	531
Ophthalmology	11,725,500	43,458	2.5	3.7	10,937,031	4.6	933
Oral Surgery (Dentists Only)	93,920	211	(5)	2.2	48,662	(5)	518
Orthopedic Surgery	5,438,240	35,978	2.0	6.6	9,690,187	4.1	1,782
Pathology	6,203,200	21,565	1.2	3.5	2,609,716	1.1	421
Plastic and Reconstructive Surgery	491,400	1,740	0.1	3.5	797,666	0.3	1,623
Physical Medicine and Rehabilitation	1,447,780	15,283	0.9	10.6	1,592,024	0.7	1,100
Psychiatry	2,301,820	17,011	1.0	7.4	1,869,036	0.8	812
Colorectal Surgery (Proctology)	275,680	720	(5)	2.6	300,180	0.1	1,089
Pulmonary Disease	3,095,640	23,838	1.3	7.7	2,920,766	1.2	944
Diagnostic Radiology	20,692,960	105,592	6.0	5.1	15,954,919	6.8	771
Thoracic Surgery	521,340	1,650	0.1	3.2	1,448,227	0.6	2,778
Urology	4,519,820	29,831	1.7	6.6	5,611,556	2.4	1,242
Chiropractic	2,212,800	23,867	1.4	10.8	975,910	0.4	441
Nuclear Medicine	537,660	1,428	0.1	2.7	325,434	0.1	605
Pediatric Medicine	328,280	1,963	0.1	6.0	207,541	0.1	632
Geriatric Medicine	406,660	2,444	0.1	6.0	224,294	0.1	552
Nephrology	1,569,020	18,147	1.0	11.6	3,371,926	1.4	2,149
Optometrist	5,359,360	11,402	0.6	2.1	911,798	0.4	170
Infectious Disease	873,040	8,720	0.5	10.0	903,714	0.4	1,035
Endocrinology	1,174,880	8,241	0.5	7.0	622,935	0.3	530
Podiatry	6,204,220	33,851	1.9	5.5	2,463,907	1.0	397

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 2005

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
$108,052,939	100.0	$3,232	$107,224,850	99.2	$83,747,781	100.0	$2,561	$61,459	$28
80,266,450	74.3	2,438	79,568,807	99.1	61,602,469	73.6	1,926	53,209	31
1,424,956	1.3	452	1,411,534	99.1	1,084,195	1.3	359	864	18
2,331,263	2.2	522	2,321,178	99.6	1,818,919	2.2	417	844	33
190,705	0.2	449	187,136	98.1	144,509	0.2	351	276	27
916,788	0.8	302	910,007	99.3	693,382	0.8	238	568	16
1,735,936	1.6	297	1,729,656	99.6	1,364,420	1.6	235	552	24
8,093,530	7.5	684	8,057,655	99.6	6,285,305	7.5	543	3,001	33
2,166,929	2.0	392	2,129,517	98.3	1,638,242	2.0	308	3,118	20
5,286,478	4.9	375	5,232,289	99.0	3,869,609	4.6	287	4,332	19
1,779,164	1.6	382	1,765,113	99.2	1,374,324	1.6	300	1,188	28
10,908,473	10.1	591	10,789,406	98.9	8,281,747	9.9	461	10,049	24
47,165	(5)	373	45,783	97.1	36,085	(5)	294	90	26
1,455,327	1.3	430	1,443,995	99.2	1,117,681	1.3	338	987	29
594,278	0.5	760	590,516	99.4	466,074	0.6	611	328	49
638,380	0.6	244	627,922	98.4	486,528	0.6	191	795	14
5,305,649	4.9	452	5,260,123	99.1	3,997,522	4.8	359	3,745	21
25,983	(5)	277	24,118	92.8	20,097	(5)	221	107	19
3,450,628	3.2	635	3,432,966	99.5	2,667,349	3.2	505	1,486	39
962,396	0.9	155	955,722	99.3	761,331	0.9	124	570	19
287,799	0.3	586	285,157	99.1	224,797	0.3	470	205	36
853,126	0.8	589	849,766	99.6	667,692	0.8	468	281	25
1,182,837	1.1	514	1,149,339	97.2	746,783	0.9	336	2,420	43
120,507	0.1	437	118,971	98.7	93,213	0.1	344	135	41
1,646,718	1.5	532	1,639,941	99.6	1,284,178	1.5	422	596	27
5,779,443	5.3	279	5,730,706	99.2	4,514,927	5.4	224	4,186	42
448,080	0.4	859	445,683	99.5	354,153	0.4	690	210	75
2,540,068	2.4	562	2,528,675	99.6	1,967,242	2.3	442	993	29
785,655	0.7	355	684,047	87.1	584,543	0.7	276	4,945	16
146,171	0.1	272	143,221	98.0	115,091	0.1	218	263	43
115,043	0.1	350	114,792	99.8	88,752	0.1	280	11	18
141,558	0.1	348	140,259	99.1	106,915	0.1	269	117	28
1,735,496	1.6	1,106	1,731,906	99.8	1,362,911	1.6	880	318	26
735,751	0.7	137	724,530	98.5	516,626	0.6	106	264	7
493,570	0.5	565	491,673	99.6	388,557	0.5	450	167	23
371,155	0.3	316	362,578	97.7	287,192	0.3	249	727	20
1,664,011	1.5	268	1,654,226	99.4	1,250,075	1.5	207	539	13

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 2005

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	1,338,580	13,908	0.8	10.4	$1,662,577	0.7	$1,242
Vascular Surgery	1,230,560	3,845	0.2	3.1	1,588,787	0.7	1,291
Cardiac Surgery	376,780	1,308	0.1	3.5	1,305,853	0.6	3,466
Hematology/Oncology	1,659,740	66,473	3.8	40.1	10,731,243	4.5	6,466
Medical Oncology	708,120	26,950	1.5	38.1	4,569,907	1.9	6,454
Radiation Oncology	886,080	10,769	0.6	12.2	4,301,069	1.8	4,854
Emergency Medicine	8,910,560	23,356	1.3	2.6	5,800,297	2.5	651
All Other Physician [6]	NA	17,097	1.0	NA	3,521,940	1.5	NA
Group Practice	328,400	2,194	0.1	6.7	178,345	0.1	543
Total Non-Physician	13,655,100	117,082	6.6	8.6	18,647,015	7.9	1,366
Total Suppliers	22,953,760	447,982	25.4	19.5	40,417,073	17.1	1,761

[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 2005

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
$962,792	0.9	$719	$948,874	98.6	$741,969	0.9	$565	$1,200	$26
582,619	0.5	473	581,398	99.8	456,676	0.5	377	108	48
391,844	0.4	1,040	387,928	99.0	309,555	0.4	831	349	91
4,989,711	4.6	3,006	4,984,889	99.9	3,953,146	4.7	2,411	424	39
2,015,638	1.9	2,846	2,014,640	99.9	1,598,794	1.9	2,287	89	27
1,502,096	1.4	1,695	1,492,397	99.4	1,190,534	1.4	1,389	870	169
2,093,424	1.9	235	2,091,594	99.9	1,620,114	1.9	186	151	12
1,367,310	1.3	NA	1,356,981	99.2	1,070,715	1.3	NA	741	NA
64,116	0.1	195	63,578	99.2	52,403	0.1	163	42	12
7,138,717	6.6	523	7,118,244	99.7	5,390,031	6.4	402	1,180	12
20,583,657	19.0	897	20,474,221	99.5	16,702,878	19.9	731	7,028	17

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 2006

Physician/Supplier Specialty[1]	Persons Served[2]	Services			Submitted Charges		
		Number in Thousands	Percent	Per Person Served[2]	Amount in Thousands	Percent	Per Person Served[2]
Total All Specialties	32,981,880	1,766,733	100.0	53.6	$248,447,505	100.0	$7,533
Total Physicians	32,416,740	1,191,690	67.5	36.8	184,539,158	74.3	5,693
General Practice	2,780,860	21,042	1.2	7.6	1,948,874	0.8	701
General Surgery	4,289,360	15,138	0.9	3.5	6,195,433	2.5	1,444
Allergy and Immunology	417,840	12,008	0.7	28.7	292,237	0.1	699
Otology, Laryngology, Rhinolog	3,008,480	14,895	0.8	5.0	1,978,618	0.8	658
Anesthesiology	5,739,820	15,044	0.9	2.6	8,145,127	3.3	1,419
Cardiology	11,808,340	116,161	6.6	9.8	19,726,022	7.9	1,671
Dermatology	5,577,780	39,223	2.2	7.0	3,487,838	1.4	625
Family Practice	13,882,800	126,064	7.1	9.1	8,800,366	3.5	634
Gastroenterology	4,621,340	15,922	0.9	3.4	5,022,747	2.0	1,087
Internal Medicine	18,092,080	208,700	11.8	11.5	18,988,803	7.6	1,050
Manipulative Therapy	135,420	956	0.1	7.1	93,644	(5)	692
Neurology	3,361,840	17,149	1.0	5.1	2,784,477	1.1	828
Neurologiclal Surgery	773,840	2,596	0.1	3.4	2,363,669	1.0	3,054
Obstetrics and Gynecology	2,531,720	8,218	0.5	3.2	1,378,949	0.6	545
Ophthalmology	11,496,360	44,080	2.5	3.8	11,228,093	4.5	977
Oral Surgery (Dentists Only)	88,940	191	(5)	2.1	47,740	(5)	537
Orthopedic Surgery	5,413,500	35,537	2.0	6.6	10,029,138	4.0	1,853
Pathology	6,061,940	22,317	1.3	3.7	2,771,952	1.1	457
Plastic and Reconstructive Surgery	462,820	1,645	0.1	3.6	770,522	0.3	1,665
Physical Medicine and Rehabilitatio	1,435,300	14,073	0.8	9.8	1,642,091	0.7	1,144
Psychiatry	2,247,840	16,370	0.9	7.3	1,847,477	0.7	822
Colorectal Surgery (Proctology	277,900	738	(5)	2.7	321,476	0.1	1,157
Pulmonary Disease	3,079,520	23,709	1.3	7.7	3,020,580	1.2	981
Diagnostic Radiology	20,297,860	105,604	6.0	5.2	16,714,470	6.7	823
Thoracic Surgery	501,120	1,579	0.1	3.2	1,457,549	0.6	2,909
Urology	4,531,660	30,330	1.7	6.7	5,824,258	2.3	1,285
Chiropractic	2,206,120	24,430	1.4	11.1	1,015,964	0.4	461
Nuclear Medicine	512,580	1,329	0.1	2.6	328,539	0.1	641
Pediatric Medicine	285,600	1,862	0.1	6.5	181,751	0.1	636
Geriatric Medicine	416,940	2,544	0.1	6.1	253,145	0.1	607
Nephrology	1,660,900	18,844	1.1	11.3	3,728,067	1.5	2,245
Optometrist	5,391,780	11,619	0.7	2.2	969,747	0.4	180
Infectious Disease	879,120	8,467	0.5	9.6	959,678	0.4	1,092
Endocrinology	1,211,160	8,405	0.5	6.9	671,685	0.3	555
Podiatry	6,194,740	34,540	2.0	5.6	2,583,360	1.0	417

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 2006

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
$110,135,017	100.0	$3,339	$109,387,656	99.3	$85,218,098	100.0	$2,647	$56,350	$29
81,204,476	73.7	2,505	80,564,185	99.2	62,201,315	73.0	1,979	49,538	32
1,157,121	1.1	416	1,145,815	99.0	872,409	1.0	327	750	18
2,250,751	2.0	525	2,242,171	99.6	1,753,070	2.1	417	718	33
186,084	0.2	445	182,925	98.3	139,893	0.2	344	240	26
930,389	0.8	309	923,703	99.3	700,615	0.8	240	557	18
1,709,715	1.6	298	1,704,283	99.7	1,343,988	1.6	235	476	23
8,267,675	7.5	700	8,232,048	99.6	6,412,646	7.5	553	2,988	35
2,263,021	2.1	406	2,225,727	98.4	1,704,625	2.0	317	3,109	21
5,204,798	4.7	375	5,158,101	99.1	3,785,759	4.4	284	3,778	19
1,777,522	1.6	385	1,763,439	99.2	1,369,817	1.6	300	1,195	29
10,669,545	9.7	590	10,561,977	99.0	8,077,566	9.5	459	9,148	24
52,207	(5)	386	50,659	97.0	39,869	(5)	301	110	36
1,474,062	1.3	438	1,462,788	99.2	1,128,745	1.3	343	992	31
588,412	0.5	760	584,283	99.3	460,613	0.5	606	365	57
613,732	0.6	242	604,797	98.5	464,931	0.5	188	686	14
5,466,893	5.0	476	5,425,370	99.2	4,110,319	4.8	375	3,411	21
25,066	(5)	282	23,361	93.2	19,353	(5)	225	91	19
3,457,149	3.1	639	3,438,956	99.5	2,665,462	3.1	504	1,547	44
996,208	0.9	164	989,434	99.3	787,233	0.9	131	590	20
272,435	0.2	589	270,330	99.2	212,773	0.2	469	175	34
833,054	0.8	580	829,750	99.6	649,643	0.8	457	288	26
1,138,772	1.0	507	1,109,299	97.4	712,749	0.8	329	2,177	41
124,898	0.1	449	123,568	98.9	96,267	0.1	351	119	41
1,647,027	1.5	535	1,641,023	99.6	1,282,675	1.5	422	525	25
5,907,101	5.4	291	5,861,416	99.2	4,605,421	5.4	233	3,881	47
439,681	0.4	877	438,001	99.6	347,092	0.4	701	147	74
2,558,613	2.3	565	2,548,520	99.6	1,976,110	2.3	442	871	30
798,774	0.7	362	702,670	88.0	588,734	0.7	280	5,140	17
144,214	0.1	281	141,240	97.9	113,318	0.1	225	260	40
96,340	0.1	337	96,110	99.8	73,839	0.1	267	7	15
154,747	0.1	371	153,419	99.1	116,648	0.1	286	119	28
1,852,093	1.7	1,115	1,848,795	99.8	1,453,948	1.7	885	286	24
765,646	0.7	142	756,357	98.8	530,842	0.6	108	222	7
501,691	0.5	571	499,798	99.6	394,423	0.5	452	164	24
383,629	0.3	317	375,235	97.8	295,944	0.3	249	715	20
1,710,223	1.6	276	1,701,438	99.5	1,279,267	1.5	212	514	14

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 2006

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	1,320,340	13,936	0.8	10.6	$1,842,500	0.7	$1,395
Vascular Surgery	1,238,160	3,947	0.2	3.2	1,725,415	0.7	1,394
Cardiac Surgery	375,260	1,303	0.1	3.5	1,312,490	0.5	3,498
Hematology/Oncology	1,758,700	70,765	4.0	40.2	12,221,669	4.9	6,949
Medical Oncology	751,580	27,497	1.6	36.6	4,867,132	2.0	6,476
Radiation Oncology	870,400	10,828	0.6	12.4	4,725,690	1.9	5,429
Emergency Medicine	8,757,340	23,688	1.3	2.7	6,234,868	2.5	712
All Other Physician [6]	NA	18,397	1.0	NA	4,035,308	1.6	NA
Group Practice	257,220	1,900	0.1	7.4	156,934	0.1	610
Total Non-Physician	13,749,820	112,945	6.4	8.2	20,237,346	8.1	1,472
Total Suppliers	22,800,240	460,198	26.0	20.2	43,514,067	17.5	1,908

[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 2006

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
$1,041,959	0.9	$789	$1,030,534	98.9	$801,479	0.9	$619	$957	$25
609,426	0.6	492	608,620	99.9	477,167	0.6	390	71	37
375,990	0.3	1,002	372,779	99.1	296,883	0.3	800	288	56
5,413,810	4.9	3,078	5,409,736	99.9	4,292,451	5.0	2,466	349	33
2,080,058	1.9	2,768	2,079,160	99.9	1,651,134	1.9	2,221	81	28
1,626,100	1.5	1,868	1,618,524	99.5	1,290,987	1.5	1,528	680	158
2,121,437	1.9	242	2,119,164	99.9	1,637,912	1.9	191	190	13
1,516,408	1.4	NA	1,508,862	99.5	1,186,696	1.4	NA	561	NA
53,327	(5)	207	52,593	98.6	43,619	0.1	173	59	11
7,266,974	6.6	529	7,250,163	99.8	5,466,408	6.4	404	1,005	11
21,610,240	19.6	948	21,520,715	99.6	17,506,756	20.5	772	5,749	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 2005

Area of Residence	Persons Served [1] Number	Persons Served [1] Per 1,000 Enrollees [2]	Services Number in Thousands	Services Per Person Served [1]	Submitted Charges Amount in Thousands	Submitted Charges Per Person Served [1]
All Areas [5]	33,434,580	986	1,766,256	53	$236,285,951	$7,067
United States [6]	33,051,860	986	1,746,018	53	234,849,490	7,105
Northeast	6,206,440	983	347,487	56	44,915,872	7,237
Midwest	8,396,440	999	399,858	48	54,166,507	6,451
South	13,060,800	991	717,008	55	98,767,610	7,562
West	5,388,180	963	281,664	52	36,999,501	6,867
New England	1,744,780	983	84,413	48	11,315,947	6,486
Connecticut	458,880	998	24,903	54	3,426,272	7,467
Maine	210,560	952	8,230	39	1,038,031	4,930
Massachusetts	721,940	987	36,022	50	4,838,486	6,702
New Hampshire	166,340	954	6,770	41	935,621	5,625
Rhode Island	98,360	996	5,377	55	612,991	6,232
Vermont	88,700	980	3,112	35	464,546	5,237
Middle Atlantic	4,461,660	982	263,074	59	33,599,925	7,531
New Jersey	1,030,840	986	65,980	64	8,675,138	8,416
New York	1,987,380	980	124,206	63	14,905,366	7,500
Pennsylvania	1,443,440	983	72,888	51	10,019,421	6,941
East North Central	5,827,160	994	287,484	49	39,853,129	6,839
Illinois	1,466,800	981	74,211	51	10,704,755	7,298
Indiana	827,140	992	38,297	46	5,744,567	6,945
Michigan	1,369,240	987	71,640	52	9,014,683	6,584
Ohio	1,449,380	1,013	72,230	50	9,686,163	6,683
Wisconsin	714,600	1,003	31,105	44	4,702,960	6,581
West North Central	2,569,280	1,009	112,374	44	14,313,378	5,571
Iowa	448,260	1,015	18,227	41	2,195,661	4,898
Kansas	363,980	991	17,863	49	2,289,741	6,291
Minnesota	562,780	1,045	21,496	38	2,761,143	4,906
Missouri	744,680	996	35,408	48	4,796,114	6,441
Nebraska	238,400	1,011	10,803	45	1,336,680	5,607
North Dakota	97,660	1,006	3,707	38	459,493	4,705
South Dakota	113,520	962	4,869	43	474,547	4,180
South Atlantic	7,015,120	993	391,770	56	54,028,532	7,702
Delaware	120,200	1,004	6,478	54	913,846	7,603
District of Columbia	55,520	963	2,541	46	358,867	6,464
Florida	2,322,160	999	156,944	68	21,759,343	9,370
Georgia	949,520	989	47,646	50	6,891,116	7,257
Maryland	601,920	991	31,432	52	4,604,831	7,650
North Carolina	1,153,240	1,003	58,696	51	7,804,886	6,768
South Carolina	605,160	985	31,188	52	4,368,131	7,218
Virginia	899,120	988	42,725	48	5,465,362	6,079
West Virginia	308,280	969	14,119	46	1,862,151	6,040

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 2005

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
$108,052,939	100.0	$3,232	99.2	$83,747,781	100.0	$2,561	$61,459	$28
107,032,734	99.1	3,238	99.2	82,957,186	99.1	2,566	61,411	28
21,561,294	20.0	3,474	99.2	16,725,032	20.0	2,749	11,298	28
23,794,763	22.0	2,834	99.1	18,356,089	21.9	2,238	15,517	28
43,940,027	40.7	3,364	99.4	34,110,065	40.7	2,667	20,738	26
17,736,650	16.4	3,292	99.0	13,765,999	16.4	2,618	13,858	34
5,113,236	4.7	2,931	99.6	3,933,668	4.7	2,302	1,632	25
1,543,700	1.4	3,364	99.2	1,194,482	1.4	2,645	1,017	33
478,233	0.4	2,271	99.7	365,688	0.4	1,789	83	15
2,203,378	2.0	3,052	99.9	1,693,220	2.0	2,388	202	15
407,485	0.4	2,450	99.3	311,730	0.4	1,924	180	21
288,412	0.3	2,932	99.9	222,624	0.3	2,324	19	14
192,028	0.2	2,165	99.0	145,925	0.2	1,699	131	26
16,448,057	15.2	3,687	99.1	12,791,364	15.3	2,924	9,666	29
4,267,796	3.9	4,140	98.7	3,332,180	4.0	3,289	4,333	29
7,663,479	7.1	3,856	99.0	5,961,630	7.1	3,055	4,746	31
4,516,782	4.2	3,129	99.7	3,497,555	4.2	2,481	586	17
17,391,738	16.1	2,985	99.3	13,429,372	16.0	2,356	8,737	26
4,505,491	4.2	3,072	98.9	3,480,439	4.2	2,422	3,842	30
2,370,122	2.2	2,865	99.2	1,824,166	2.2	2,267	1,162	21
4,502,570	4.2	3,288	99.6	3,486,270	4.2	2,598	1,469	30
4,316,254	4.0	2,978	99.7	3,335,716	4.0	2,352	723	17
1,697,300	1.6	2,375	98.8	1,302,781	1.6	1,869	1,541	28
6,403,025	5.9	2,492	98.6	4,926,718	5.9	1,967	6,780	31
1,010,405	0.9	2,254	97.7	772,433	0.9	1,771	1,849	45
1,034,107	1.0	2,841	99.3	799,715	1.0	2,248	445	21
1,215,382	1.1	2,160	99.3	930,233	1.1	1,702	565	21
2,067,303	1.9	2,776	99.2	1,596,548	1.9	2,191	1,128	21
611,645	0.6	2,566	97.5	470,909	0.6	2,027	1,224	33
215,197	0.2	2,204	97.7	165,479	0.2	1,740	409	52
248,986	0.2	2,193	94.5	191,401	0.2	1,736	1,161	42
24,765,138	22.9	3,530	99.3	19,256,686	23.0	2,798	14,261	30
415,218	0.4	3,454	99.5	322,339	0.4	2,747	128	19
165,208	0.2	2,976	98.3	127,969	0.2	2,343	219	40
10,803,190	10.0	4,652	99.1	8,472,657	10.1	3,708	7,411	45
2,902,587	2.7	3,057	99.3	2,245,211	2.7	2,414	1,499	24
2,108,238	2.0	3,503	99.2	1,633,311	2.0	2,765	1,275	27
3,293,260	3.0	2,856	99.3	2,540,386	3.0	2,244	1,836	21
1,826,912	1.7	3,019	99.4	1,412,369	1.7	2,385	821	20
2,444,824	2.3	2,719	99.5	1,881,009	2.2	2,135	874	19
805,702	0.7	2,614	99.7	621,434	0.7	2,070	197	19

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 2005

	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	2,480,820	992	127,420	51	$16,780,382	$6,764
Alabama	647,000	996	32,762	51	4,130,788	6,385
Kentucky	616,800	983	31,660	51	3,940,806	6,389
Mississippi	423,600	979	20,483	48	2,931,929	6,921
Tennessee	793,420	1,004	42,515	54	5,776,859	7,281
West South Central	3,564,860	984	197,819	56	27,958,696	7,843
Arkansas	430,920	961	22,307	52	2,728,028	6,331
Louisiana	512,920	1,007	26,739	52	3,803,201	7,415
Oklahoma	464,820	989	21,832	47	2,775,806	5,972
Texas	2,156,200	982	126,942	59	18,651,660	8,650
Mountain	1,819,420	980	82,459	45	11,378,802	6,254
Arizona	513,660	961	27,194	53	3,631,667	7,070
Colorado	354,260	1,016	15,899	45	2,218,420	6,262
Idaho	161,480	994	6,089	38	711,422	4,406
Montana	136,260	975	5,106	38	634,909	4,660
Nevada	184,260	970	9,961	54	1,586,750	8,611
New Mexico	193,780	941	7,541	39	1,152,078	5,945
Utah	209,000	1,005	7,989	38	1,082,661	5,180
Wyoming	66,720	1,000	2,679	40	360,894	5,409
Pacific	3,568,760	954	199,205	56	25,620,699	7,179
Alaska	42,780	895	1,488	35	290,824	6,798
California	2,451,620	940	152,836	62	19,472,282	7,943
Hawaii	115,320	1,065	4,777	41	548,292	4,755
Oregon	342,900	1,025	12,471	36	1,746,208	5,092
Washington	616,140	958	27,633	45	3,563,093	5,783
Outlying Areas [7]	382,720	934	20,238	53	1,436,461	3,753

[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.

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 9.6-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 2005

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
$7,310,577	6.8	$2,947	99.6	$5,640,881	6.7	$2,328	$1,962	$17
1,935,830	1.8	2,992	99.7	1,496,917	1.8	2,371	425	18
1,765,282	1.6	2,862	99.5	1,362,884	1.6	2,263	548	18
1,199,954	1.1	2,833	99.6	926,186	1.1	2,241	319	14
2,409,511	2.2	3,037	99.6	1,854,893	2.2	2,389	670	18
11,864,312	11.0	3,328	99.5	9,212,498	11.0	2,645	4,516	20
1,257,527	1.2	2,918	99.7	970,139	1.2	2,317	231	19
1,634,124	1.5	3,186	99.7	1,267,219	1.5	2,538	403	15
1,317,614	1.2	2,835	99.3	1,016,568	1.2	2,239	619	20
7,655,047	7.1	3,550	99.4	5,958,571	7.1	2,823	3,263	21
5,301,056	4.9	2,914	98.3	4,093,299	4.9	2,314	7,359	40
1,743,011	1.6	3,393	97.3	1,358,136	1.6	2,709	3,908	66
1,021,956	0.9	2,885	98.5	788,761	0.9	2,285	1,206	32
359,858	0.3	2,228	97.0	276,338	0.3	1,770	890	26
316,499	0.3	2,323	98.6	242,789	0.3	1,845	313	25
677,000	0.6	3,674	99.6	522,365	0.6	2,916	233	33
492,357	0.5	2,541	99.0	378,689	0.5	2,023	357	24
518,586	0.5	2,481	99.6	394,487	0.5	1,935	146	18
171,788	0.2	2,575	97.7	131,734	0.2	2,037	307	29
12,435,594	11.5	3,485	99.3	9,672,700	11.5	2,772	6,499	29
143,206	0.1	3,347	99.2	110,446	0.1	2,663	80	28
9,500,733	8.8	3,875	99.4	7,416,288	8.9	3,091	4,500	31
254,397	0.2	2,206	99.2	193,058	0.2	1,715	157	25
800,508	0.7	2,335	98.8	613,963	0.7	1,839	759	22
1,736,750	1.6	2,819	99.2	1,338,944	1.6	2,223	1,003	25
1,020,205	0.9	2,666	99.8	790,595	0.9	2,146	48	12

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 2006

	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]
All Areas[5]	32,981,880	1,002	1,766,733	54	$248,447,505	$7,533
United States[6]	32,720,640	1,002	1,753,951	54	247,494,912	7,564
Northeast	6,094,460	993	351,557	58	47,518,437	7,797
Midwest	8,294,520	1,015	404,131	49	57,195,161	6,896
South	12,998,800	1,008	732,227	56	104,390,450	8,031
West	5,332,860	976	266,035	50	38,390,864	7,199
New England	1,752,000	986	86,785	50	12,234,158	6,983
Connecticut	457,860	1,013	25,415	56	3,687,276	8,053
Maine	212,080	950	8,503	40	1,085,263	5,117
Massachusetts	725,820	989	37,478	52	5,265,641	7,255
New Hampshire	169,140	949	6,862	41	1,052,304	6,221
Rhode Island	97,080	995	5,445	56	655,284	6,750
Vermont	90,020	973	3,083	34	488,390	5,425
Middle Atlantic	4,342,460	996	264,772	61	35,284,278	8,125
New Jersey	1,034,180	991	68,695	66	9,427,599	9,116
New York	1,948,880	989	126,006	65	15,797,949	8,106
Pennsylvania	1,359,400	1,010	70,071	52	10,058,730	7,399
East North Central	5,778,420	1,011	292,393	51	42,373,512	7,333
Illinois	1,468,240	988	76,222	52	11,541,904	7,861
Indiana	822,100	1,012	39,198	48	6,049,824	7,359
Michigan	1,361,700	1,007	72,886	54	9,573,685	7,031
Ohio	1,445,760	1,031	74,570	52	10,384,319	7,183
Wisconsin	680,620	1,024	29,518	43	4,823,781	7,087
West North Central	2,516,100	1,026	111,738	44	14,821,648	5,891
Iowa	437,920	1,031	18,138	41	2,299,042	5,250
Kansas	359,820	998	17,776	49	2,341,731	6,508
Minnesota	521,740	1,070	20,075	39	2,741,799	5,255
Missouri	748,900	1,012	36,412	49	5,059,228	6,756
Nebraska	236,180	1,031	10,715	45	1,401,836	5,935
North Dakota	96,520	1,033	3,697	38	467,932	4,848
South Dakota	115,020	983	4,926	43	510,079	4,435
South Atlantic	6,981,120	1,014	402,242	58	56,980,862	8,162
Delaware	122,720	1,007	6,582	54	959,919	7,822
District of Columbia	56,400	985	2,826	50	404,162	7,166
Florida	2,277,120	1,018	161,024	71	22,699,695	9,969
Georgia	957,640	1,014	49,316	52	7,344,796	7,670
Maryland	607,400	996	32,939	54	4,933,101	8,122
North Carolina	1,144,760	1,021	59,188	52	8,139,192	7,110
South Carolina	604,360	1,002	32,052	53	4,674,260	7,734
Virginia	901,100	1,025	43,719	49	5,836,030	6,477
West Virginia	309,620	988	14,595	47	1,989,706	6,426

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 2006

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
$110,135,017	100.0	$3,339	99.3	$85,218,098	100.0	$2,647	$56,350	$29
109,471,651	99.4	3,346	99.3	84,704,906	99.4	2,652	56,308	29
22,114,354	20.1	3,629	99.3	17,130,405	20.1	2,874	10,393	29
24,482,996	22.2	2,952	99.2	18,849,332	22.1	2,332	14,090	29
45,186,472	41.0	3,476	99.5	35,025,767	41.1	2,756	18,691	26
17,687,829	16.1	3,317	99.1	13,699,401	16.1	2,638	13,135	36
5,350,823	4.9	3,054	99.6	4,107,102	4.8	2,398	1,402	25
1,605,675	1.5	3,507	99.3	1,239,706	1.5	2,756	896	33
495,243	0.4	2,335	99.8	377,401	0.4	1,838	59	16
2,312,087	2.1	3,185	99.9	1,773,280	2.1	2,493	189	17
442,810	0.4	2,618	99.5	338,277	0.4	2,054	156	18
301,827	0.3	3,109	99.9	232,679	0.3	2,458	15	14
193,181	0.2	2,146	99.3	145,759	0.2	1,674	88	20
16,763,531	15.2	3,860	99.2	13,023,303	15.3	3,065	8,990	29
4,473,438	4.1	4,326	98.8	3,490,869	4.1	3,437	4,034	30
7,879,400	7.2	4,043	99.1	6,123,288	7.2	3,206	4,427	32
4,410,692	4.0	3,245	99.8	3,409,146	4.0	2,578	529	17
17,982,425	16.3	3,112	99.4	13,855,761	16.3	2,458	7,728	26
4,722,855	4.3	3,217	99.0	3,641,684	4.3	2,538	3,435	30
2,415,879	2.2	2,939	99.4	1,856,167	2.2	2,322	1,000	21
4,714,151	4.3	3,462	99.6	3,642,159	4.3	2,737	1,317	29
4,481,310	4.1	3,100	99.7	3,455,957	4.1	2,450	617	15
1,648,229	1.5	2,422	98.9	1,259,794	1.5	1,902	1,360	29
6,500,571	5.9	2,584	98.7	4,993,572	5.9	2,044	6,362	33
1,029,128	0.9	2,350	97.6	786,747	0.9	1,857	2,012	54
1,037,477	0.9	2,883	99.3	799,437	0.9	2,279	479	26
1,181,924	1.1	2,265	99.3	903,667	1.1	1,788	520	23
2,151,163	2.0	2,872	99.3	1,659,137	1.9	2,276	1,029	21
626,252	0.6	2,652	98.2	480,375	0.6	2,092	924	33
211,451	0.2	2,191	98.3	162,310	0.2	1,734	314	46
263,177	0.2	2,288	95.1	201,898	0.2	1,812	1,085	37
25,468,903	23.1	3,648	99.4	19,768,044	23.2	2,891	12,716	30
422,384	0.4	3,442	99.6	326,798	0.4	2,713	123	21
185,574	0.2	3,290	98.4	143,799	0.2	2,603	237	41
10,899,925	9.9	4,787	99.3	8,535,999	10.0	3,817	6,325	44
3,023,639	2.7	3,157	99.4	2,333,924	2.7	2,495	1,383	25
2,236,983	2.0	3,683	99.3	1,731,274	2.0	2,898	1,249	27
3,379,265	3.1	2,952	99.4	2,600,321	3.1	2,322	1,600	22
1,904,291	1.7	3,151	99.5	1,471,819	1.7	2,488	760	21
2,571,463	2.3	2,854	99.5	1,974,189	2.3	2,239	857	20
845,380	0.8	2,730	99.7	649,920	0.8	2,167	182	20

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 2006

	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	2,453,980	1,007	129,494	53	$17,624,469	$7,182
Alabama	642,700	1,010	33,322	52	4,307,069	6,702
Kentucky	615,440	1,005	32,692	53	4,174,582	6,783
Mississippi	419,060	987	20,682	49	3,068,924	7,323
Tennessee	776,780	1,017	42,799	55	6,073,893	7,819
West South Central	3,563,700	999	200,492	56	29,785,120	8,358
Arkansas	431,140	990	22,025	51	2,839,724	6,587
Louisiana	501,060	1,001	25,681	51	3,943,516	7,870
Oklahoma	468,200	1,003	22,303	48	2,971,389	6,346
Texas	2,163,300	999	130,483	60	20,030,490	9,259
Mountain	1,768,480	1,005	80,608	46	11,813,573	6,680
Arizona	478,720	993	25,234	53	3,572,481	7,463
Colorado	355,200	1,033	16,339	46	2,391,567	6,733
Idaho	159,040	1,021	5,922	37	746,023	4,691
Montana	133,700	1,007	5,064	38	660,274	4,938
Nevada	184,820	961	10,209	55	1,737,460	9,401
New Mexico	194,080	969	7,773	40	1,238,890	6,383
Utah	196,180	1,053	7,483	38	1,090,472	5,559
Wyoming	66,740	1,012	2,584	39	376,405	5,640
Pacific	3,564,380	962	185,428	52	26,577,291	7,456
Alaska	44,280	892	1,546	35	314,799	7,109
California	2,456,660	948	139,889	57	20,227,575	8,234
Hawaii	113,900	1,091	4,548	40	543,584	4,772
Oregon	326,740	1,040	11,833	36	1,721,452	5,269
Washington	622,800	965	27,611	44	3,769,881	6,053
Outlying Areas[7]	261,240	1,078	12,782	49	952,593	3,646

[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.

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 9.6—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 2006

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
$7,500,637	6.8	$3,057	99.7	$5,782,974	6.8	$2,413	$1,788	$17
1,984,458	1.8	3,088	99.7	1,532,177	1.8	2,439	358	18
1,839,321	1.7	2,989	99.6	1,418,326	1.7	2,359	511	17
1,206,314	1.1	2,879	99.7	929,885	1.1	2,277	298	14
2,470,544	2.2	3,180	99.6	1,902,585	2.2	2,507	621	19
12,216,932	11.1	3,428	99.5	9,474,749	11.1	2,729	4,187	20
1,271,152	1.2	2,948	99.8	979,013	1.1	2,344	215	20
1,635,320	1.5	3,264	99.7	1,265,402	1.5	2,603	383	19
1,356,319	1.2	2,897	99.4	1,045,860	1.2	2,298	644	21
7,954,140	7.2	3,677	99.5	6,184,474	7.3	2,926	2,945	21
5,301,084	4.8	2,998	98.3	4,090,117	4.8	2,386	7,159	45
1,666,706	1.5	3,482	97.2	1,296,308	1.5	2,779	3,951	73
1,062,787	1.0	2,992	98.6	822,027	1.0	2,375	1,178	37
358,696	0.3	2,255	97.1	273,886	0.3	1,785	864	29
311,353	0.3	2,329	98.8	237,525	0.3	1,852	280	27
714,635	0.6	3,867	99.6	552,766	0.6	3,081	199	30
516,524	0.5	2,661	99.1	397,270	0.5	2,125	322	27
500,441	0.5	2,551	99.7	380,167	0.4	2,006	95	16
169,943	0.2	2,546	98.0	130,168	0.2	2,037	271	26
12,386,744	11.2	3,475	99.4	9,609,284	11.3	2,762	5,975	30
112,615	0.1	2,543	99.4	86,164	0.1	2,033	58	22
9,482,179	8.6	3,860	99.4	7,376,929	8.7	3,073	4,189	32
248,476	0.2	2,182	99.2	188,607	0.2	1,699	136	27
765,235	0.7	2,342	99.0	586,164	0.7	1,855	614	24
1,778,239	1.6	2,855	99.3	1,371,421	1.6	2,254	979	28
663,367	0.6	2,539	99.8	513,192	0.6	2,089	42	14

Table 9.7

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 2005

BETOS Classification	BETOS Codes	Persons Served [1]	Services		
			Number in Thousands	Percent	Per Served [1]
Total All BETOS Groups	Total	33,434,580	1,766,256	100.0	53
Office Visits - Established	M1B	29,142,720	217,394	12.3	7
Other Drugs	O1E	6,795,160	77,699	4.4	11
Hospital Visit - Subsequent	M2B	7,164,180	98,608	5.6	14
Ambulance	O1A	4,545,160	58,475	3.3	13
Consultations	M6	13,266,500	31,886	1.8	2
Minor Procedures - Other (MFS)	P6C	9,348,520	112,435	6.4	12
Other Durable Medical Equipment	D1E	6,604,780	68,112	3.9	10
Oxygen and Supplies	D1C	1,436,300	20,271	1.1	14
Chemotherapy	O1D	558,680	18,673	1.1	33
Specialist - Ophthalmology	M5C	13,424,160	33,934	1.9	3
Eye Procedure - Cataract Removal/Lens Insertion	P4B	1,362,420	3,513	0.2	3
Lab Tests, Other (Non-MFS)	T1H	20,079,020	182,642	10.3	9
Standard Imaging - Nuclear Medicine	I1E	4,726,420	17,992	1.0	4
Emergency Room Visit	M3	9,894,520	19,004	1.1	2
Advanced Imaging - MRI: Other	I2D	3,062,700	4,710	0.3	2
Anesthesia	P0	6,539,340	12,764	0.7	2
Lab Tests, Other (MFS)	T1G	8,453,040	31,202	1.8	4
Echography - Heart	I3C	5,989,660	22,800	1.3	4
Advanced Imaging - CAT: Other	I2B	5,664,760	14,640	0.8	3
Other Tests - Other	T2D	6,516,140	42,944	2.4	7
All Other BETOS Groups		NA	676,558	38.3	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 the Medicare fee schedule. MRI is Magnetic Resonance Imaging. CAT is Computerized Axial Tomography. NA is not applicable. The leading BETOS codes are based on amount of allowed charges for 2005. 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 9.7–Continued

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 2005

Allowed Charges			Program Payments		
Amount in Thousands	Percent	Per Person Served [1]	Amount in Thousands	Percent	Per Person Served [2]
$108,052,939	100.0	$3,232	$83,747,781	100.0	$2,561
12,628,193	11.7	433	8,840,296	10.6	322
6,477,158	6.0	953	5,107,865	6.1	782
5,772,803	5.3	806	4,579,920	5.5	642
4,484,222	4.2	987	3,555,421	4.2	783
4,282,539	4.0	323	3,295,821	3.9	250
4,224,590	3.9	452	3,320,858	4.0	365
2,951,777	2.7	447	2,280,289	2.7	351
2,673,801	2.5	1,862	2,092,834	2.5	1,458
2,643,791	2.4	4,732	2,094,008	2.5	3,768
2,464,610	2.3	184	1,755,823	2.1	140
2,397,437	2.2	1,760	1,897,486	2.3	1,394
2,359,471	2.2	118	2,352,975	2.8	117
2,259,955	2.1	478	1,781,821	2.1	379
1,968,363	1.8	199	1,519,506	1.8	157
1,861,419	1.7	608	1,466,401	1.8	482
1,841,176	1.7	282	1,452,720	1.7	223
1,779,064	1.6	210	1,397,841	1.7	168
1,654,448	1.5	276	1,298,439	1.6	219
1,634,202	1.5	288	1,282,456	1.5	228
1,615,641	1.5	248	1,258,132	1.5	197
40,078,279	37.1	NA	31,116,869	37.2	NA

Table 9.7

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 2006

BETOS Classification	BETOS Codes	Persons Served[1]	Services		
			Number in Thousands	Percent	Per Person Served[1]
Total All BETOS Groups	Total	32,981,880	1,766,733	100.0	54
Office Visits - Established	M1B	28,700,020	214,936	12.2	7
Other Drugs	O1E	7,385,860	83,081	4.7	11
Hospital Visit - Subsequent	M2B	6,979,760	98,092	5.6	14
Ambulance	O1A	4,521,480	56,501	3.2	12
Consultations	M6	13,033,760	29,009	1.6	2
Minor Procedures - Other (MFS)	P6C	9,379,140	92,781	5.3	10
Other Durable Medical Equipment	D1E	6,724,880	67,462	3.8	10
Oxygen and Supplies	D1C	1,491,560	20,878	1.2	14
Specialist - Ophthalmology	M5C	13,352,920	35,015	2.0	3
Lab Tests, Other (Non-MFS)	T1H	19,993,320	188,984	10.7	9
Chemotherapy	O1D	529,780	16,525	0.9	31
Eye Procedure - Cataract Removal/Lens Insertion	P4B	1,310,720	3,465	0.2	3
Standard Imaging - Nuclear Medicine	I1E	4,977,500	18,883	1.1	4
Advanced Imaging - MRI: Other	I2D	3,221,780	5,086	0.3	2
Emergency Room Visit	M3	9,510,840	18,469	1.0	2
Lab Tests, Other (MFS)	T1G	8,380,800	37,326	2.1	4
Anesthesia	P0	6,457,820	12,647	0.7	2
Other Tests - Other	T2D	6,698,680	38,699	2.2	6
Echography - Heart	I3C	6,111,120	23,383	1.3	4
Orthotic Devices	D1F	3,326,600	25,272	1.4	8
All Other BETOS Groups		NA	680,239	38.5	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 the Medicare fee schedule. MRI is Magnetic Resonance Imaging. CAT is Computerized Axial Tomography. NA is not applicable. The leading BETOS codes are based on amount of allowed charges for 2006. 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 9.7—Continued

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 2006

Allowed Charges			Program Payments		
Amount in Thousands	Percent	Per Person Served[1]	Amount in Thousands	Percent	Per Person Served[2]
$110,135,017	100.0	$3,339	$85,218,098	100.0	$2,647
12,662,787	11.5	441	8,816,517	10.3	327
7,152,605	6.5	968	5,641,713	6.6	793
5,795,495	5.3	830	4,597,674	5.4	660
4,739,944	4.3	1,048	3,756,429	4.4	831
4,145,934	3.8	318	3,174,964	3.7	246
3,222,456	2.9	344	2,513,026	2.9	276
2,956,573	2.7	440	2,269,584	2.7	345
2,745,556	2.5	1,841	2,138,759	2.5	1,435
2,531,829	2.3	190	1,789,861	2.1	143
2,519,978	2.3	126	2,513,581	2.9	126
2,396,573	2.2	4,524	1,900,335	2.2	3,605
2,380,615	2.2	1,816	1,883,963	2.2	1,438
2,376,550	2.2	477	1,874,345	2.2	378
2,109,414	1.9	655	1,662,108	2.0	518
1,943,019	1.8	204	1,496,890	1.8	161
1,894,089	1.7	226	1,485,646	1.7	180
1,790,040	1.6	277	1,412,811	1.7	219
1,761,725	1.6	263	1,368,783	1.6	208
1,730,829	1.6	283	1,356,772	1.6	224
1,709,996	1.6	514	1,340,317	1.6	408
41,569,010	37.7	NA	32,224,020	37.8	NA

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 2005

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	---	1,766,256	$236,285,951	$108,052,939	99.2	$83,747,781
Leading Diagnoses [2]	---	1,041,401	125,194,298	58,626,388	99.2	45,379,922
Infectious and Parasitic Diseases (MDC 1)	001-139	21,749	1,955,444	1,142,520	99.5	881,713
Dermatophytosis	110	9,236	508,386	368,207	99.5	269,832
Neoplasm (MDC 2)	140-239	148,749	32,189,591	13,654,209	99.4	10,779,093
Malignant Neoplasm of Colon	153	11,052	2,174,002	1,006,043	99.8	798,671
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	19,136	3,377,893	1,362,654	99.7	1,081,337
Other Malignant Neoplasm of Skin	173	7,769	2,147,868	1,208,272	99.1	946,019
Malignant Neoplasm of Female Breast	174	17,907	3,145,512	1,343,615	98.8	1,061,611
Malignant Neoplasm of Prostate	185	15,822	4,240,662	1,676,532	99.6	1,325,473
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	197,285	11,314,886	5,678,533	98.9	4,484,421
Thyroiditis	244	13,148	683,063	287,605	98.8	242,709
Diabetes Mellitus	250	108,182	5,756,128	3,356,659	98.8	2,597,482
Disorders of Lipoid Metabolism	272	50,882	2,377,804	928,641	98.8	761,263
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	8,209	698,103	335,122	99.7	267,242
Diseases of the Blood and Blood-Forming Organs (MDC 4)	280-289	51,825	6,600,464	3,001,455	99.9	2,425,206
Other and Unspecified Anemias	285	26,709	3,661,787	1,531,782	99.9	1,239,856
Mental Disorders (MDC 5)	290-319	39,880	4,252,206	2,668,568	98.7	1,643,572
Schizophrenic Disorders	295	6,946	640,763	389,051	99.7	240,036
Affective Psychoses	296	11,920	1,303,263	844,982	97.9	482,511
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	91,479	21,433,804	10,061,860	99.2	7,647,066
Other Retinal Disorders	362	11,334	2,477,373	1,429,097	99.6	1,096,565
Glaucoma	365	14,588	1,698,353	1,003,447	99.0	729,480
Cataract	366	17,255	9,633,604	3,709,233	99.3	2,846,688

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 2005

Principal ICD-9-CM [1] Diagnosis Within MDC	ICD-9-CM Code	Services in Thousands	Submitted Charges in Thousands	Allowed Charges Amount in Thousands	Allowed Charges Percent of Charges Assigned	Program Payments in Thousands
Diseases of the Circulatory System (MDC 7)	390-459	258,386	$37,098,129	$16,476,363	99.3	$12,740,271
Essential Hypertension	401	67,326	4,379,198	2,455,714	98.5	1,795,091
Acute Myocardial Infarction	410	3,906	833,685	325,570	99.7	256,893
Other Acute and Subacute Forms of Ischemic Heart Disease	411	3,401	962,537	332,926	99.8	261,771
Angina Pectoris	413	5,142	1,083,269	457,357	99.7	356,327
Other Forms of Chronic Ischemic Heart Disease	414	36,839	7,909,623	3,160,368	99.5	2,451,635
Other Diseases of Endocardium	424	9,498	2,137,117	796,558	99.2	623,302
Cardiac Dysrhythmias	427	39,378	3,941,817	1,746,837	99.4	1,360,304
Heart Failure	428	26,858	3,412,702	1,694,343	99.6	1,335,497
Ill-Defined Descriptions and Complications of Heart Disease	429	4,645	452,441	193,423	99.2	149,319
Acute, But Ill-Defined, Cerebrovascular Disease	436	7,695	990,206	595,353	99.6	466,172
Diseases of the Respiratory System (MDC 8)	460-519	141,691	15,560,991	7,930,022	99.6	6,109,662
Acute Bronchitis and Bronchiolitis	466	5,660	396,688	240,999	98.5	163,959
Allergic Rhinitis	477	22,764	405,439	272,455	98.5	203,500
Pneumonia, Organism Unspecified	486	10,428	1,180,322	607,994	99.7	474,450
Asthma	493	10,910	986,502	512,775	99.5	391,490
Other Diseases of Lung	518	13,450	2,165,646	1,057,748	99.7	836,656
Diseases of the Digestive System (MDC 9)	520-579	41,542	10,220,895	3,842,033	99.4	2,992,834
Diseases of the Genitourinary System (MDC 10)	580-629	83,509	12,220,423	5,373,136	99.5	4,241,024
Chronic Renal Failure	585	20,146	3,847,810	1,772,564	99.9	1,413,997
Calculus of Kidney and Ureter	592	2,396	600,000	182,215	99.4	142,204
Other Disorders of Urethra and Urinary Tract	599	20,941	1,602,105	759,129	99.5	604,104
Hyperplasia of Prostate	600	5,223	940,547	497,449	99.5	381,920
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	57,875	4,805,236	2,856,868	98.9	2,162,156
Other Dermatoses	702	23,990	1,227,473	771,781	98.3	572,950
Chronic Ulcer of Skin	707	8,518	1,352,775	750,013	99.7	589,222

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 2005

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	219,267	$29,349,992	$12,724,389	98.6	$9,818,583
Rheumatoid Arthritis and Ofher Inflammatory Polyarthrophathies	714	9,237	1,407,701	784,250	99.3	612,610
Osteoarthrosis and Allied Disorders	715	30,967	5,690,583	2,316,666	99.0	1,790,344
Other and Unspecified Arthropathies	716	3,664	405,041	213,380	98.6	163,033
Other and Unspecified Disorders of Joint	719	35,555	2,745,161	1,389,544	99.5	1,071,056
Other and Unspecified Disorders of Back	724	37,444	5,577,110	2,232,650	99.1	1,729,750
Peripheral Enthesopathies and Allied Syndromes	726	12,964	1,193,159	533,486	99.3	406,559
Other Disorders of Soft Tissues	729	14,089	1,322,985	667,814	99.2	511,683
Non-Allopathic Lesions, Not Elsewhere Classified	739	19,507	820,882	650,184	87.7	484,979
Congenital Anomalies (MDC 14)	740-759	2,413	545,751	219,484	99.0	170,007
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	216,741	28,276,939	13,272,410	99.6	10,364,127
General Symptoms	780	49,704	6,375,284	3,180,013	99.6	2,496,488
Symptoms Involving Respiratory System and Other Chest Sympto	786	61,822	8,033,480	3,697,689	99.7	2,872,104
Symptoms Involving Digestive System	787	16,663	2,166,930	1,028,665	99.7	807,391
Symptoms Involving Urinary System	788	11,885	1,095,875	522,476	99.2	408,249
Sudden Death, Cause Unknown	798	16	4,869	2,456	99.9	1,863
Other Ill-Defined and Unknown Causes of Morbidity and Mortality	799	4,198	733,235	377,511	99.9	296,931
Injury and Poisoning (MDC 17)	800-999	58,884	11,212,924	4,671,026	99.4	3,650,748
Fracture of Neck of Femur	820	4,715	1,453,066	542,578	99.7	429,443
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	V01-V82	133,339	9,008,717	4,348,649	98.6	3,533,875
Need for Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	V04	24,580	438,377	333,881	99.6	331,184
Special Investigations and Examinations	V72	5,183	398,097	188,631	98.9	148,718

[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.

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 2006

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	---	1,766,733	$248,447,505	$110,135,017	99.3	$85,218,098
Leading Diagnoses [2]	---	1,043,587	131,328,778	59,923,914	99.3	46,302,382
Infectious and Parasitic Diseases (MDC 1)	001-139	21,885	1,930,417	1,081,493	99.5	829,539
Dermatophytosis	110	9,659	535,325	381,409	99.5	278,139
Neoplasm (MDC 2)	140-239	152,845	34,178,312	14,051,893	99.5	11,094,543
Malignant Neoplasm of Colon	153	10,632	2,275,556	1,032,378	99.9	820,608
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	18,836	3,555,310	1,364,401	99.8	1,083,374
Other Malignant Neoplasm of Skin	173	8,849	2,309,525	1,278,014	99.2	1,000,844
Malignant Neoplasm of Female Breast	174	19,763	3,533,853	1,481,523	99.1	1,173,760
Malignant Neoplasm of Prostate	185	16,225	4,539,751	1,744,665	99.6	1,379,847
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	204,707	12,113,916	5,911,110	99.1	4,651,152
Thyroiditis	244	13,142	712,570	293,045	98.9	246,779
Diabetes Mellitus	250	115,571	6,352,807	3,569,664	99.1	2,753,254
Disorders of Lipoid Metabolism	272	51,029	2,518,896	961,743	98.9	784,408
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	7,931	706,899	325,995	99.7	259,609
Diseases of the Blood and Blood-Forming Organs (MDC 4)	280-289	53,852	6,967,556	2,888,821	99.9	2,336,533
Other and Unspecified Anemias	285	27,950	4,141,225	1,606,805	99.9	1,300,800
Mental Disorders (MDC 5)	290-319	40,402	4,419,062	2,721,226	98.8	1,673,238
Schizophrenic Disorders	295	6,842	635,977	380,888	99.7	231,992
Affective Psychoses	296	12,050	1,351,796	853,418	98.2	484,561
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	94,390	22,604,771	10,460,065	99.3	7,932,646
Other Retinal Disorders	362	12,587	2,809,559	1,654,711	99.7	1,270,461
Glaucoma	365	14,622	1,765,743	1,020,911	99.1	736,699
Cataract	366	16,972	9,771,774	3,655,488	99.4	2,798,382

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 2006

Principal ICD-9-CM [1] Diagnosis Within MDC	ICD-9-CM Code	Services in Thousands	Submitted Charges in Thousands	Allowed Charges Amount in Thousands	Allowed Charges Percent of Charges Assigned	Program Payments in Thousands
Diseases of the Circulatory System (MDC 7)	390-459	254,560	$38,087,708	$16,564,465	99.4	$12,781,089
Essential Hypertensior	401	67,473	4,592,080	2,485,373	98.6	1,807,823
Acute Myocardial Infarctior	410	3,624	835,817	320,478	99.7	252,767
Other Acute and Subacute Forms of Ischemic Heart Disease	411	2,938	869,839	299,663	99.9	235,510
Angina Pectoris	413	4,709	1,051,437	434,308	99.7	338,785
Other Forms of Chronic Ischemic Heart Disease	414	35,910	7,913,134	3,142,678	99.5	2,432,495
Other Diseases of Endocardium	424	9,825	2,259,887	835,069	99.3	652,443
Cardiac Dysrhythmias	427	39,868	4,059,134	1,766,532	99.3	1,373,197
Heart Failure	428	24,995	3,337,208	1,624,483	99.7	1,278,185
Ill-Defined Descriptions and Complications of Heart Disease	429	4,284	440,392	186,071	99.2	143,198
Acute, But Ill-Defined, Cerebrovascular Disease	436	6,680	893,411	530,353	99.6	414,569
Diseases of the Respiratory System (MDC 8)	460-519	130,964	16,018,370	7,816,485	99.6	6,018,862
Acute Bronchitis and Bronchiolitis	466	5,042	362,964	211,460	98.7	144,180
Allergic Rhinitis	477	18,151	388,696	252,654	98.7	186,818
Pneumonia, Organism Unspecified	486	9,685	1,152,003	575,012	99.7	448,949
Asthma	493	10,139	1,042,153	512,864	99.6	390,870
Other Diseases of Lung	518	13,565	2,350,293	1,105,316	99.8	873,515
Diseases of the Digestive System (MDC 9)	520-579	41,555	10,692,928	3,871,054	99.5	3,011,471
Diseases of the Genitourinary System (MDC 10	580-629	85,825	13,086,208	5,566,226	99.6	4,389,301
Chronic Renal Failure	585	21,894	4,199,191	1,889,913	99.9	1,504,583
Calculus of Kidney and Urete	592	2,488	630,338	185,367	99.6	144,279
Other Disorders of Urethra and Urinary Trac	599	21,653	1,766,915	802,685	99.6	637,968
Hyperplasia of Prostate	600	5,740	1,022,257	520,107	99.5	398,225
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	60,185	5,067,414	2,919,500	99.0	2,200,327
Other Dermatoses	702	25,296	1,305,696	801,012	98.3	589,833
Chronic Ulcer of Skin	707	8,925	1,426,105	759,684	99.8	596,404

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 2006

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	214,037	$31,339,918	$13,043,015	98.7	$10,035,081
Rheumatoid Arthritis and Ofher Inflammatory Polyarthrophathies	714	9,235	1,565,990	858,453	99.5	669,540
Osteoarthrosis and Allied Disorders	715	32,793	6,066,472	2,449,623	99.1	1,893,174
Other and Unspecified Arthropathies	716	3,207	403,670	207,579	98.8	158,536
Other and Unspecified Disorders of Joint	719	33,391	2,816,210	1,371,271	99.6	1,050,241
Other and Unspecified Disorders of Back	724	36,143	5,977,386	2,279,463	99.2	1,762,436
Peripheral Enthesopathies and Allied Syndromes	726	12,247	1,236,623	518,105	99.3	392,500
Other Disorders of Soft Tissues	729	13,150	1,353,968	649,565	99.3	494,808
Non-Allopathic Lesions, Not Elsewhere Classified	739	20,126	858,326	667,441	88.4	492,544
Congenital Anomalies (MDC 14)	740-759	2,288	532,048	207,475	99.1	160,234
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	216,993	29,741,172	13,600,560	99.6	10,598,552
General Symptoms	780	50,085	6,685,720	3,280,849	99.7	2,567,855
Symptoms Involving Respiratory System and Other Chest Symptoms	786	59,714	8,303,299	3,748,484	99.7	2,908,222
Symptoms Involving Digestive System	787	16,727	2,242,672	998,857	99.6	782,102
Symptoms Involving Urinary System	788	11,977	1,169,490	531,758	99.2	414,180
Sudden Death, Cause Unknown	798	14	3,882	2,163	99.9	1,611
Other Ill-Defined and Unknown Causes of Morbidity and Mortali	799	4,196	791,832	402,669	99.9	315,637
Injury and Poisoning (MDC 17	800-999	53,926	11,723,863	4,705,637	99.5	3,673,191
Fracture of Neck of Femu	820	4,471	1,492,971	538,178	99.7	425,497
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	V01-V82	136,853	9,707,393	4,600,422	98.8	3,733,474
Need for Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	V04	24,566	484,756	358,354	99.7	355,342
Special Investigations and Examinations	V72	6,001	459,995	214,960	99.0	170,042

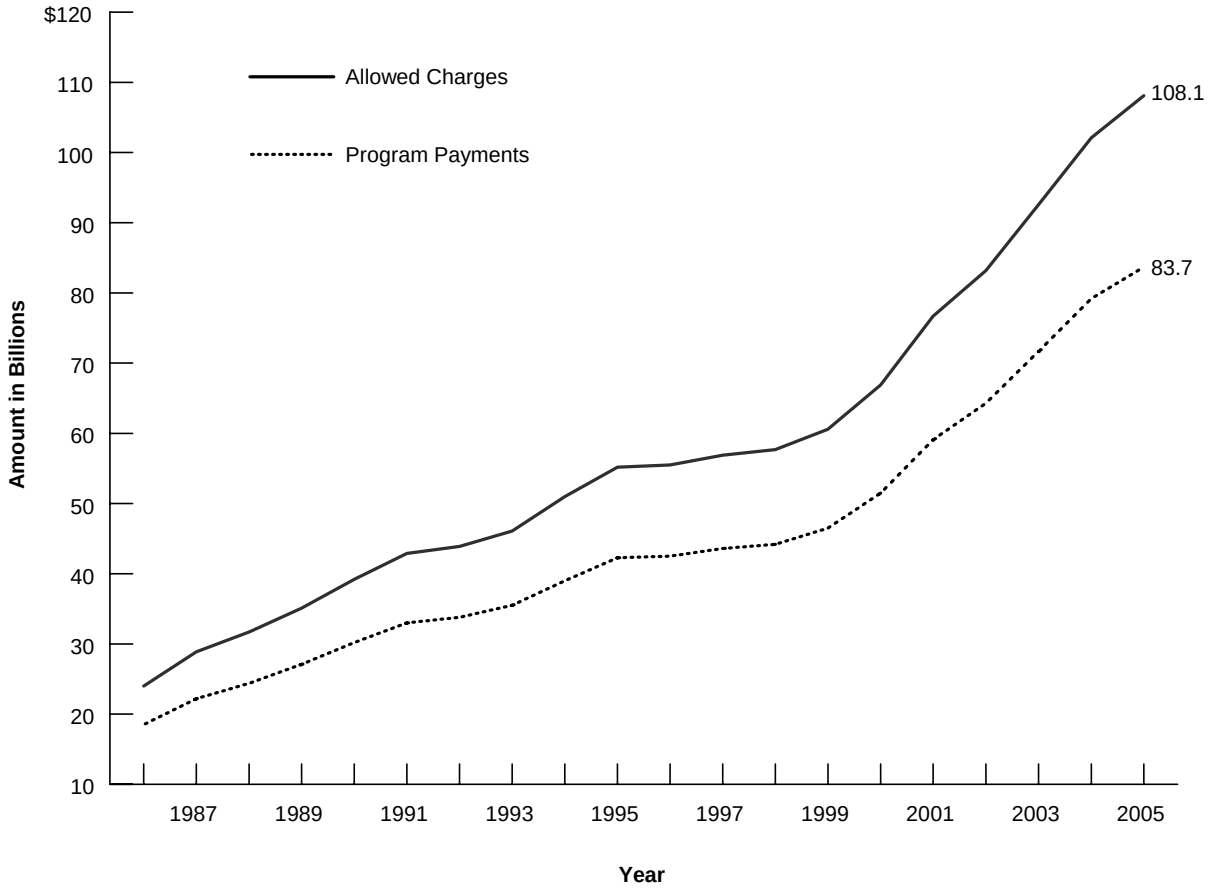
[1]ICD-9-CM is International Classification of Diseases, 9th Revision, Clinical Modification. Only the first listed or principal diagnosis has been used.

[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.

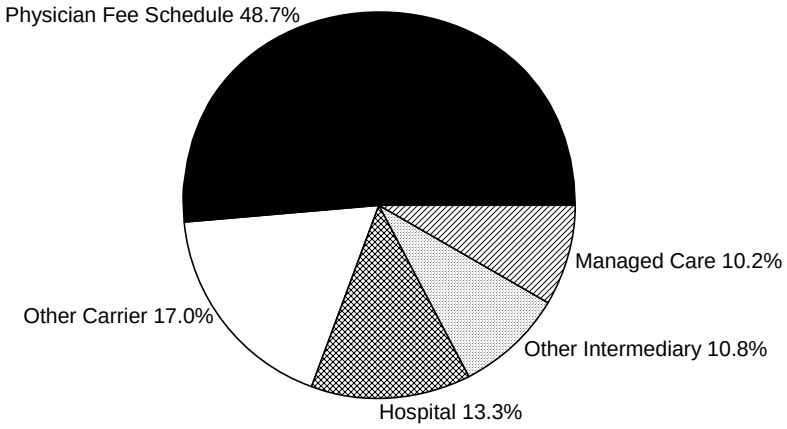
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Figure 9.1
Trends in Medicare Physician and Supplier Allowed Charges and Program Payments: Calendar Years 1986-2005



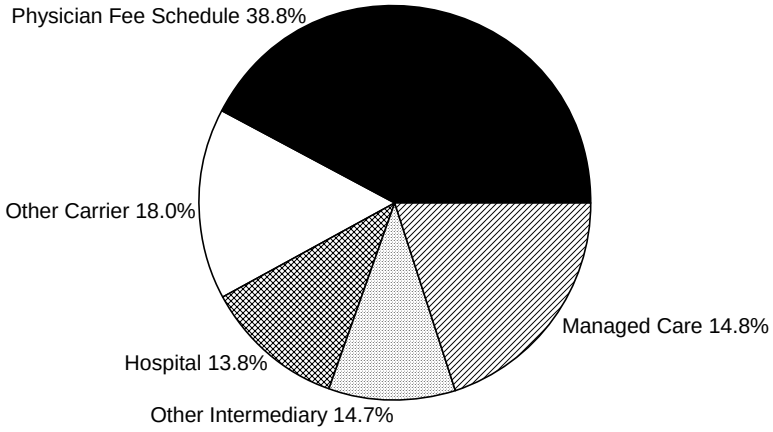
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Figure 9.2
Distribution of Medicare Supplementary Medical Insurance Benefit Payments, by Type of Provider: Calendar Years 1995 and 2005



1995

(Total Benefit Payments = $65.0 Billion)



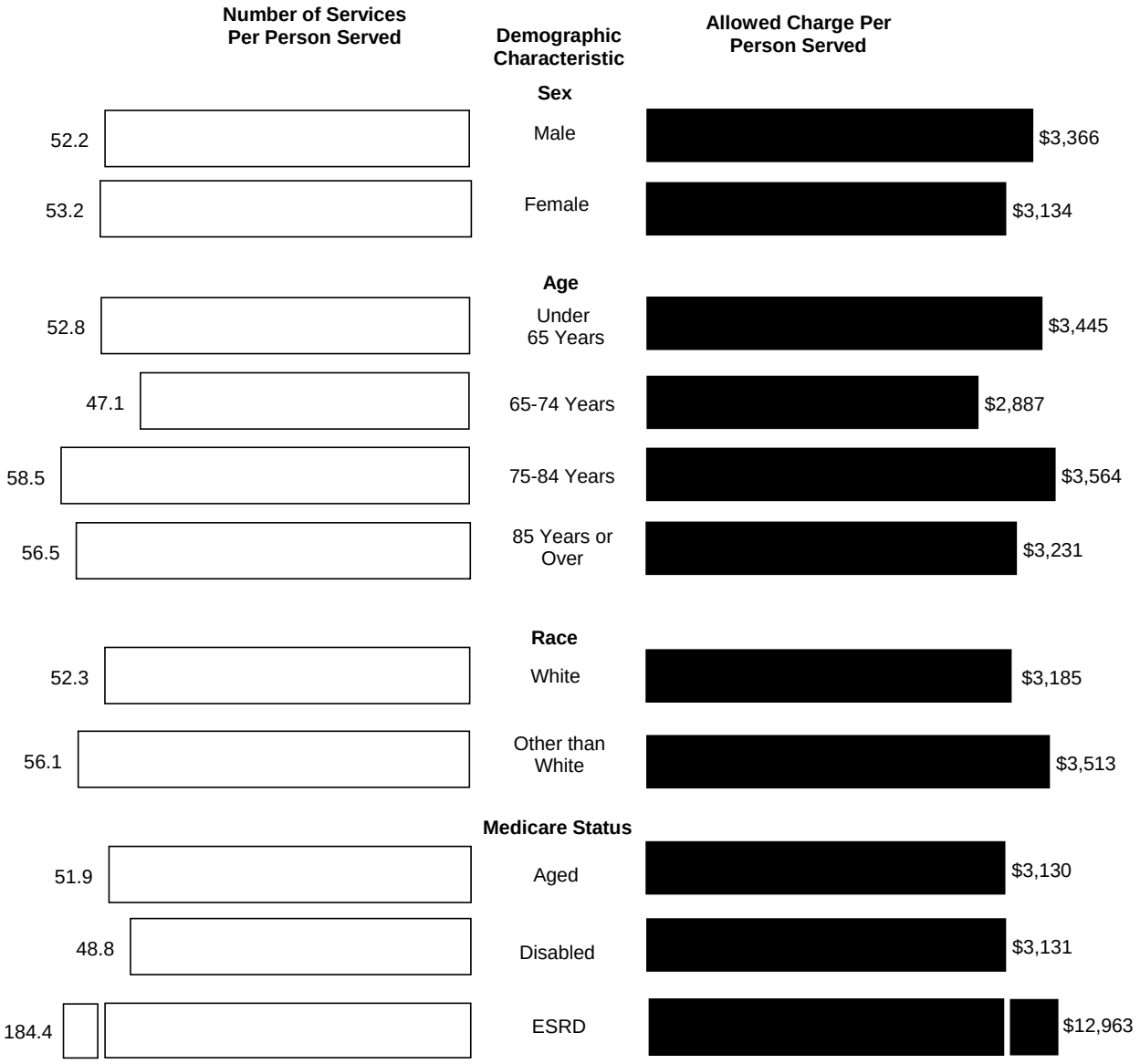
2005

(Total Benefit Payments = $149.1 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.

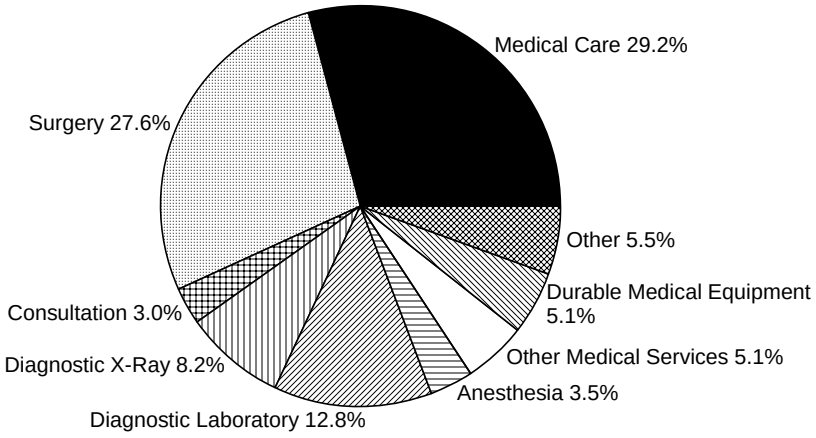
Figure 9.3
Number of Medicare Physician and Supplier Services, and Allowed Charges per Person Served, by Selected Demographic Characteristics: Calendar Year 2005



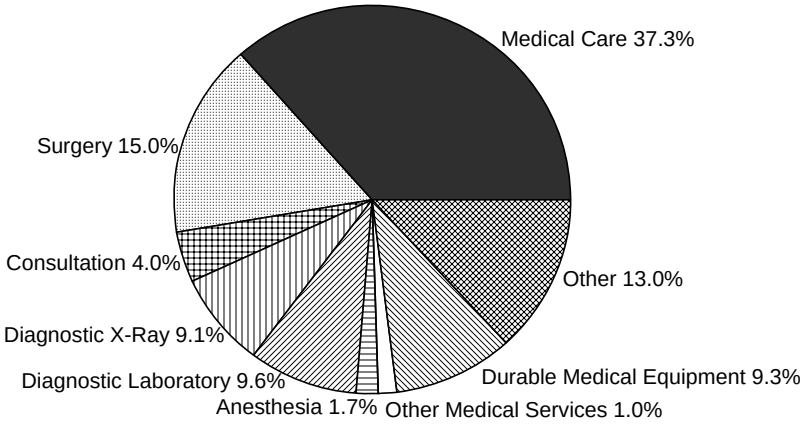
NOTE: ESRD is end stage renal disease.

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 2005



1990
(Total Allowed Charges = $37.4 Billion)

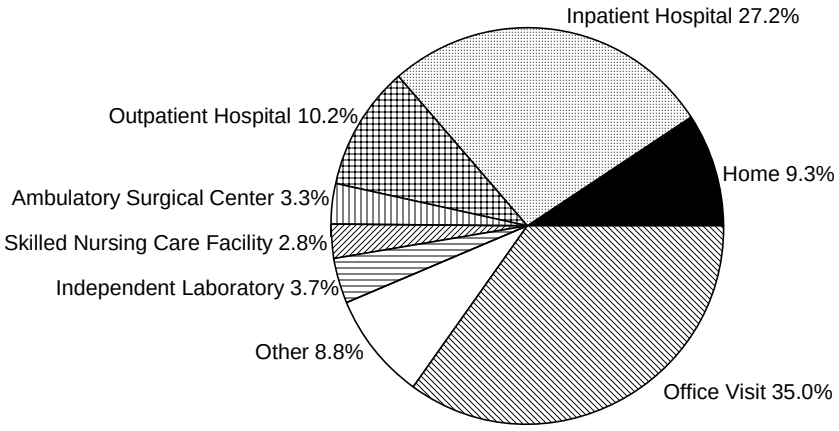


2005
(Total Allowed Charges = $108.1 Billion)

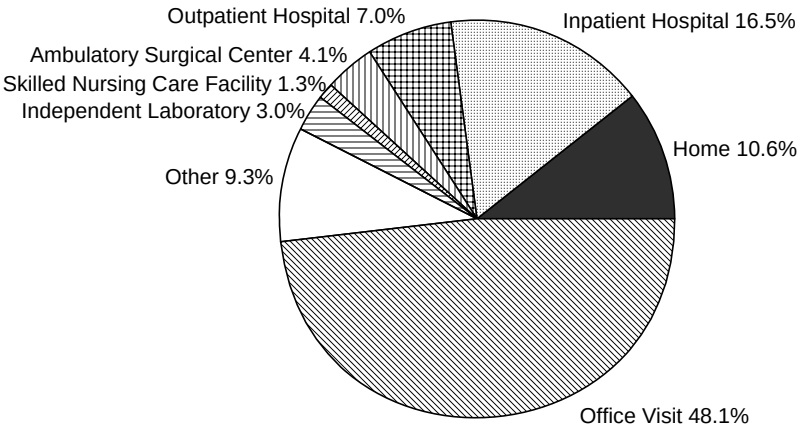
NOTE: Other includes ambulatory surgery center services, therapeutic radiology, psychological therapy assistance at surgery, monthly capitation dialysis services, etc.

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 2005



1995
(Total Allowed Charges = $55.2 Billion)

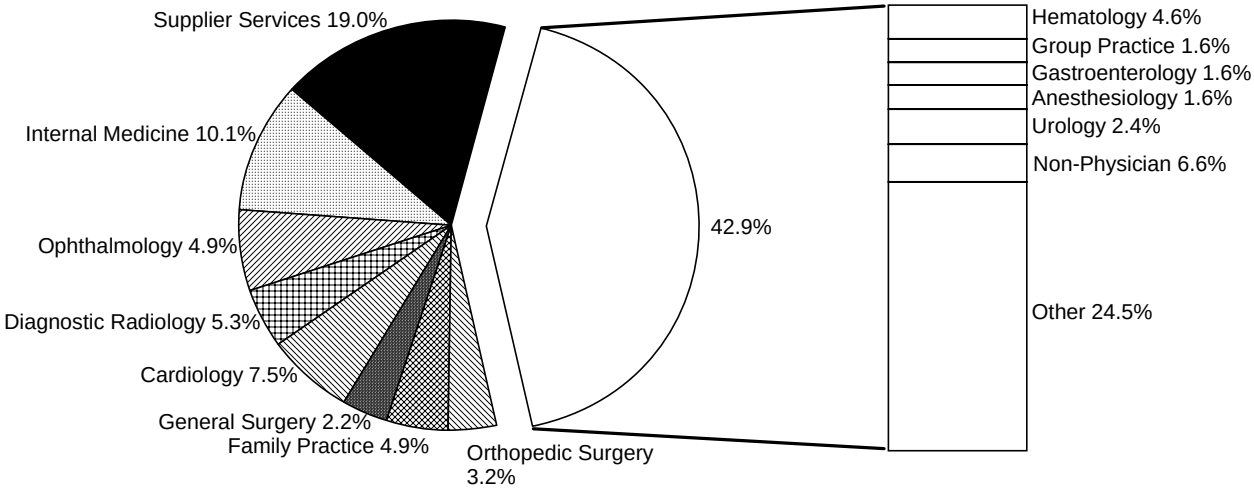


2005
(Total Allowed Charges = $108.1 Billion)

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 2005

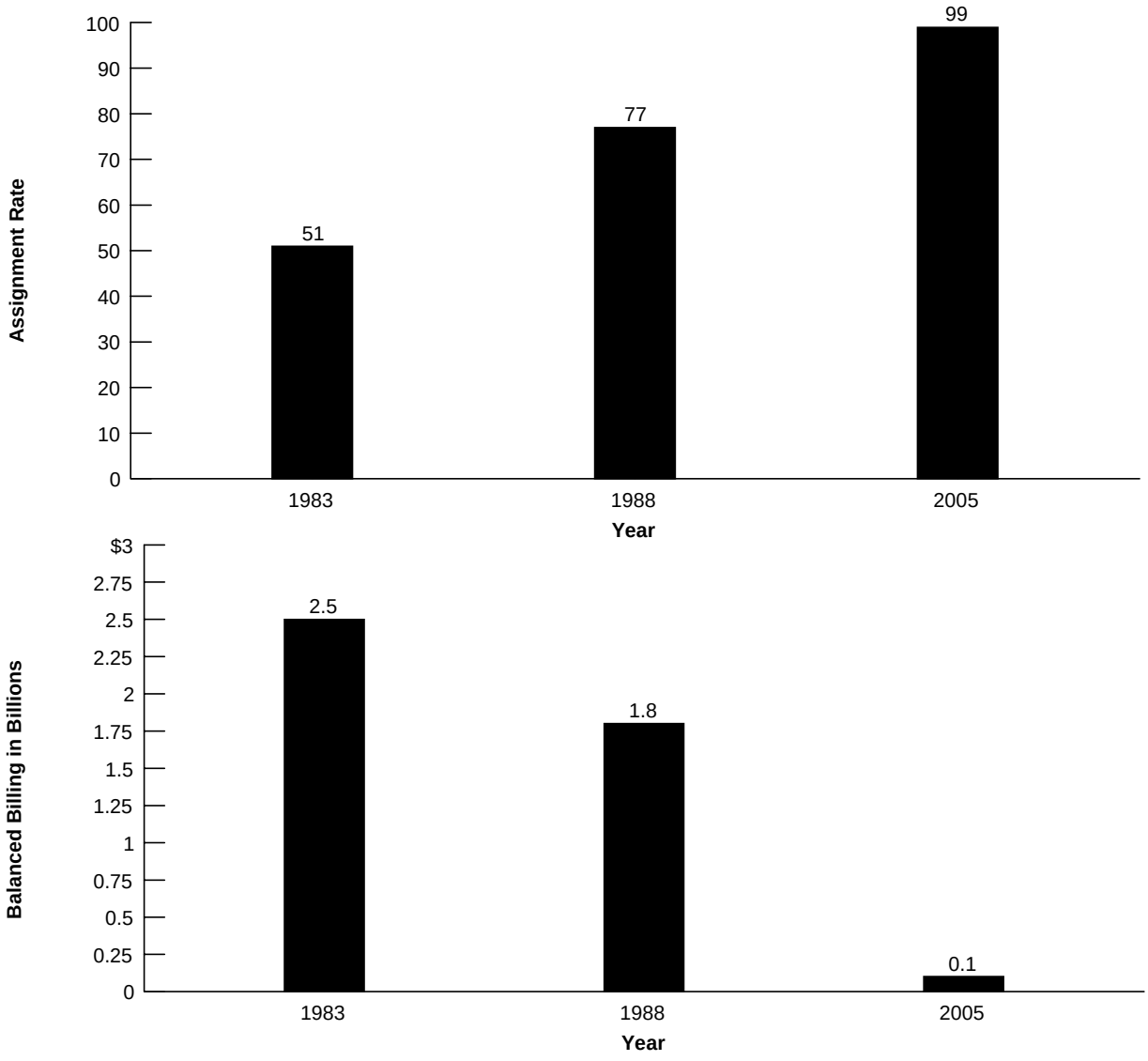


(Total Allowed Charges=$108.1 Billion)

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.

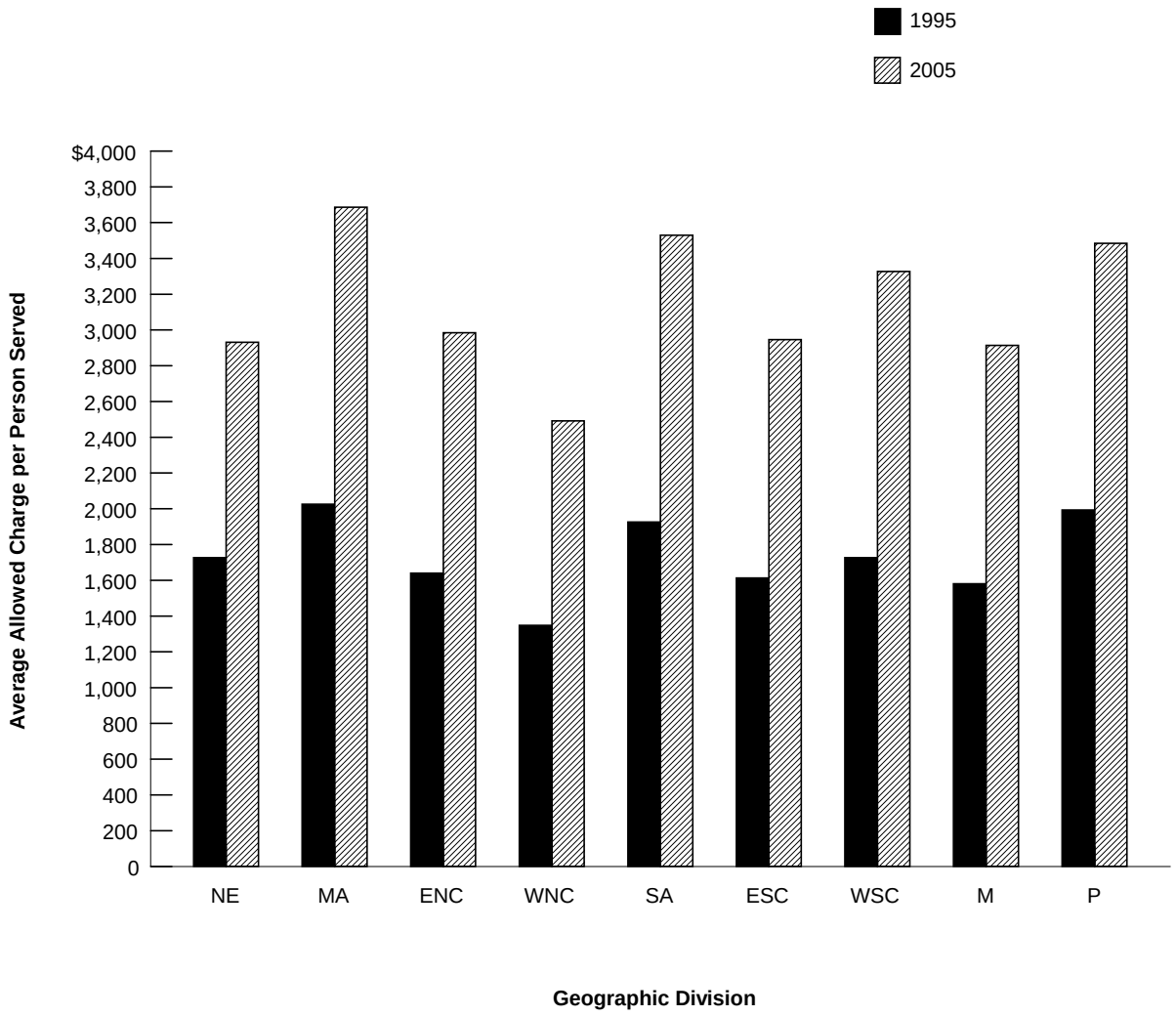
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Figure 9.7
Trends in Medicare Assignment Rates and Amount of Balanced Billing: Selected Calendar Years 1983, 1988, and 2005



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.

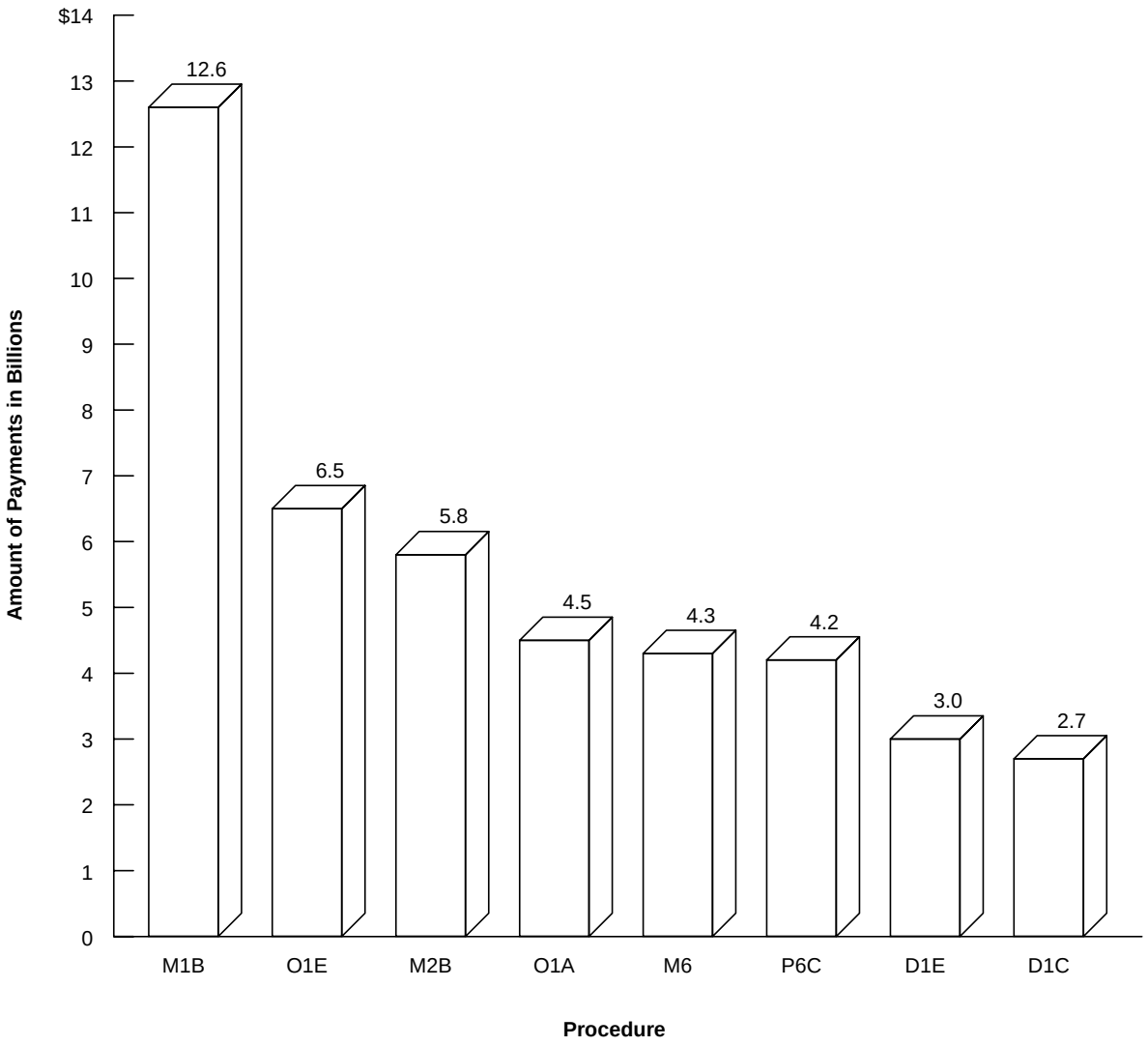
Figure 9.8
Average Allowed Charge per Person Served for Medicare Physician and Supplier Services, by Geographic Division: Calendar Years 1995 and 2005



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.

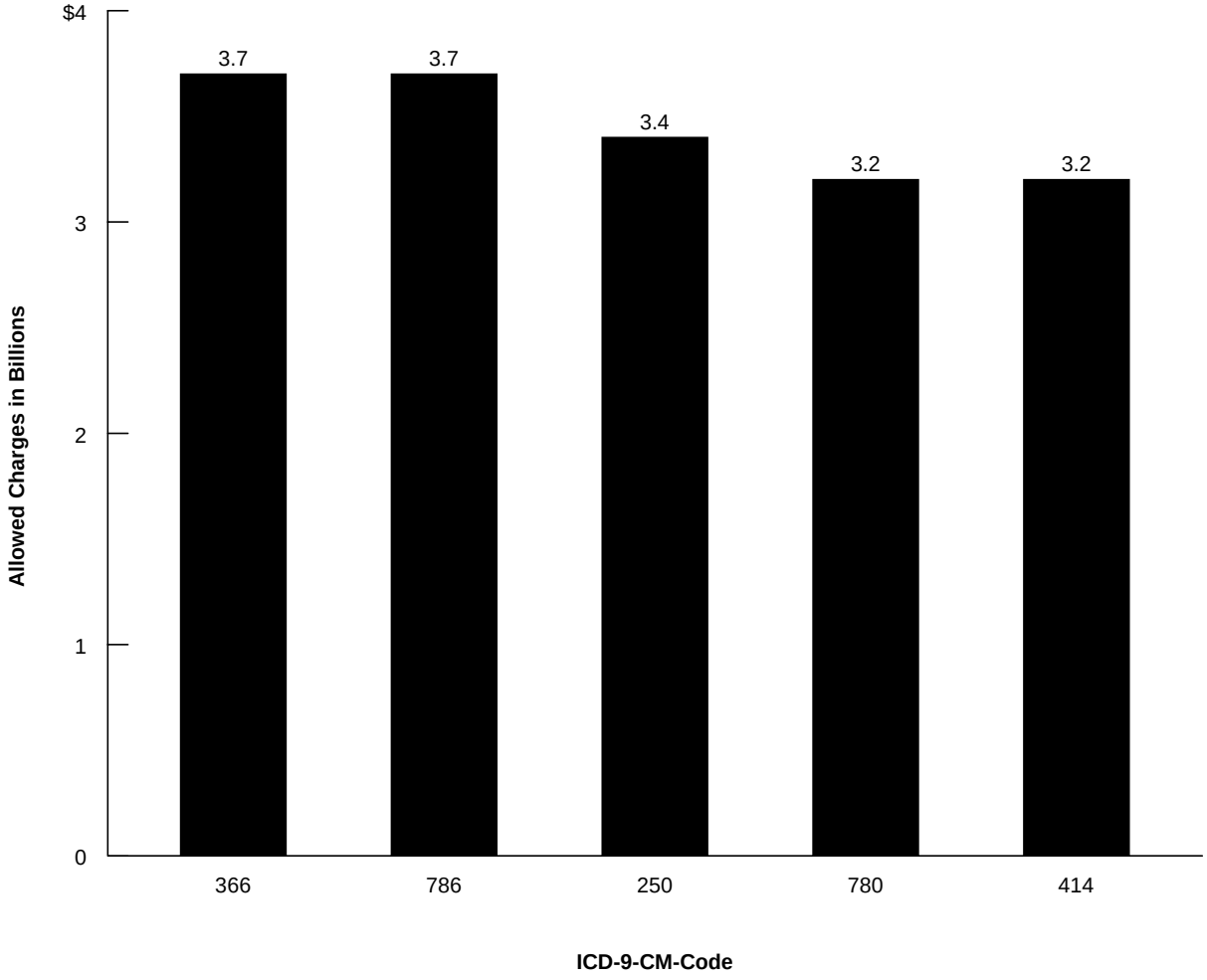
Figure 9.9
Leading Medicare Physician and Supplier BETOS Procedures, Based on Allowed Charges: Calendar Year 2005



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; D1C--Oxygen and Supplies.

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 2005



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