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 1995-2009

Year	Persons Served[1]	Services Number in Thousands	Submitted Charges	Allowed Charges	Program Payments	Balanced Billing
			Amounts in Thousands			
Total						
1995	30,935,680	1,141,270	$96,407,229	$55,175,723	$42,276,746	$235,301
1996	30,675,540	1,130,934	100,648,030	55,500,815	42,514,806	121,195
1997	30,218,980	1,106,604	104,830,651	56,896,798	43,620,311	101,513
1998	29,539,140	1,162,469	108,718,353	57,656,483	44,171,579	82,958
1999	29,331,640	1,200,603	116,249,395	60,563,267	46,487,527	76,730
2000	29,644,740	1,252,280	127,853,210	66,911,902	51,456,747	72,884
2001	30,688,840	1,340,531	147,219,411	76,672,497	59,113,949	70,241
2002	31,754,480	1,481,154	169,663,267	83,181,299	64,253,710	64,359
2003	32,547,900	1,573,445	191,593,731	92,638,665	71,733,844	64,560
2004	32,961,620	1,662,332	215,840,889	102,067,747	79,178,272	63,625
2005	33,434,580	1,766,256	236,285,951	108,052,939	83,747,781	61,459
2006	32,981,880	1,766,733	248,447,505	110,135,017	85,218,098	56,350
2007	32,224,600	1,766,037	259,930,435	110,633,862	85,628,319	51,039
2008	31,826,820	1,798,520	274,355,179	113,804,294	88,112,583	46,980
2009	31,646,640	1,826,304	287,934,772	117,586,191	91,115,719	46,083
Aged						
1995	27,649,460	1,012,890	84,940,078	48,786,706	37,475,087	222,718
1996	27,251,260	998,001	88,225,320	48,760,710	37,448,311	115,555
1997	26,739,000	973,626	91,714,021	49,843,717	38,311,260	96,496
1998	25,965,040	1,019,731	94,762,267	50,281,005	38,634,165	78,838
1999	25,668,380	1,049,891	100,988,074	52,642,997	40,532,735	72,794
2000	25,841,920	1,091,142	110,782,785	58,004,541	44,757,179	69,143
2001	26,660,980	1,164,112	127,081,467	66,214,834	51,234,552	66,700
2002	27,464,140	1,279,875	145,779,008	71,524,366	55,443,808	61,169
2003	27,998,940	1,350,638	163,233,484	78,920,043	61,323,439	61,133
2004	28,164,840	1,418,663	182,463,880	86,306,236	67,186,296	60,135
2005	28,388,260	1,499,983	198,503,311	90,666,561	70,517,544	58,043
2006	27,908,820	1,497,394	208,561,737	92,463,220	71,776,670	53,352
2007	27,150,120	1,490,841	217,273,807	92,577,589	71,864,127	48,470
2008	26,685,820	1,510,700	228,017,745	94,678,189	73,511,787	44,672
2009	26,391,240	1,520,309	236,990,481	96,881,250	75,294,810	43,848
Disabled						
1995	3,286,220	128,380	11,467,151	6,389,017	4,801,659	12,583
1996	3,424,280	132,933	12,422,710	6,740,105	5,066,495	5,640
1997	3,479,980	132,978	13,116,630	7,053,081	5,309,051	5,017
1998	3,574,100	142,738	13,956,086	7,375,478	5,537,414	4,120
1999	3,663,260	150,712	15,261,321	7,920,270	5,954,792	3,936
2000	3,802,820	161,138	17,070,425	8,907,361	6,699,568	3,741
2001	4,027,860	176,419	20,137,944	10,457,663	7,879,397	3,541
2002	4,290,340	201,279	23,884,259	11,656,933	8,809,902	3,190
2003	4,548,960	222,807	28,360,247	13,718,622	10,410,405	3,427
2004	4,796,780	243,669	33,377,009	15,761,511	11,991,976	3,490
2005	5,046,320	266,273	37,782,640	17,386,378	13,230,237	3,416
2006	5,073,060	269,339	39,885,768	17,671,797	13,441,428	2,998
2007	5,074,480	275,197	42,656,629	18,056,273	13,764,192	2,569
2008	5,141,000	287,819	46,337,433	19,126,104	14,600,796	2,308
2009	5,255,400	305,995	50,944,291	20,704,940	15,820,910	2,234

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 Standard Analytical Files; 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 2009

Demographic Characteristic	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	31,646,640	1,826,304	57.7	$287,934,772	$9,098
Sex					
Male	13,497,760	765,296	56.7	127,142,620	9,420
Female	18,148,880	1,061,008	58.5	160,792,152	8,860
Age					
Under 65 Years	5,255,400	305,995	58.2	50,944,291	9,694
65-74 Years	12,685,480	652,738	51.5	106,903,449	8,427
75-84 Years	9,161,060	584,295	63.8	91,188,389	9,954
85 Years or Over	4,544,700	283,277	62.3	38,898,643	8,559
Race[3]					
White	26,641,120	1,521,964	57.1	239,618,286	8,994
Other	4,897,180	299,090	61.1	47,478,466	9,695
Type of Entitlement[4]					
Aged	26,111,000	1,472,925	56.4	228,398,030	8,747
Disabled	5,147,660	274,494	53.3	44,118,381	8,571
ESRD	387,980	78,885	203.3	15,418,361	39,740

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 2009

Demographic Characteristic	Allowed Charges				Program Payments		Balance Billing	
	Amount in Thousands	Per Person Served[1]	Assigned in Thousands	Percent of Charges Assigned	Amount in Thousands	Per Person Served[2]	Amount in Thousands	Per Person with Liability
Total	$117,586,191	$3,716	$116,989,449	99.5	$91,115,719	$2,944	$46,083	$31
Sex								
Male	51,468,829	3,813	51,217,439	99.5	39,873,437	3,039	19,776	33
Female	66,117,362	3,643	65,772,009	99.5	51,242,282	2,874	26,307	30
Age								
Under 65 Years	20,704,940	3,940	20,674,747	99.9	15,820,910	3,127	2,234	31
65-74 Years	41,984,305	3,310	41,738,353	99.4	32,430,181	2,624	18,938	30
75-84 Years	37,490,096	4,092	37,258,961	99.4	29,289,216	3,237	17,932	33
85 Years or Over	17,406,849	3,830	17,317,388	99.5	13,575,413	3,025	6,978	31
Race[3]								
White	97,671,699	3,666	97,101,756	99.4	75,598,983	2,899	44,039	31
Other	19,573,080	3,997	19,547,667	99.9	15,253,793	3,199	1,935	27
Type of Entitlement[4]								
Aged	93,524,903	3,582	92,962,054	99.4	72,611,904	2,835	43,553	31
Disabled	18,139,460	3,524	18,109,292	99.8	13,756,634	2,780	2,224	30
ESRD	5,921,827	15,263	5,918,102	99.9	4,747,181	12,311	305	40

[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 Standard Analytical Files; 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 2009

Type of Service	Persons Served [1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served [1]	Amount in Thousands	Per Person Served [1]
Total	31,646,640	1,826,304	57.7	$287,934,772	$9,098
Medical Care	30,662,140	686,403	22.4	87,798,482	2,863
Surgery	19,382,920	109,601	5.7	55,279,895	2,852
Consultation	12,695,900	29,503	2.3	7,855,997	619
Diagnostic X-Ray	21,583,480	146,652	6.8	27,856,889	1,291
Diagnostic Laboratory	26,516,500	530,344	20.0	35,877,544	1,353
Radiation Therapy	1,335,920	12,937	9.7	6,647,074	4,976
Anesthesia	6,804,420	13,752	2.0	11,321,892	1,664
Assistance at Surgery	901,260	1,706	1.9	2,528,860	2,806
Other Medical Services	1,158,680	7,746	6.7	1,526,163	1,317
Ambulatory Surgical Center	3,305,420	6,410	1.9	13,518,456	4,090
Renal Supplies in the Home	1,060	32	29.8	37,987	35,836
Psychological Therapy	3,059,140	21,438	7.0	2,488,431	813
Occupational Therapy	880	1	1.5	66	75
Pneumococcal Vaccine	12,861,000	27,760	2.2	635,338	49
Physical Therapy	20	(6)	1.0	3	170
Durable Medical Equipment [4]	10,257,080	140,726	13.7	18,055,102	1,760
Other [5]	NA	91,293	NA	16,506,593	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, and rental of DME.

[6]Less than 500.

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

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; 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 2009

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
$117,586,191	$3,716	$116,989,449	99.5	$91,115,719	$2,944	$46,083	$31
46,776,577	1,526	46,477,625	99.4	35,202,896	1,203	23,157	22
16,458,122	849	16,372,491	99.5	12,848,497	675	7,093	33
4,489,071	354	4,464,589	99.5	3,445,998	275	2,110	22
9,061,305	420	9,021,744	99.6	7,028,354	339	3,264	21
11,578,308	437	11,551,677	99.8	10,068,590	383	2,268	11
2,098,940	1,571	2,087,469	99.5	1,665,573	1,253	948	166
2,164,021	318	2,161,130	99.9	1,710,427	252	256	19
220,260	244	219,886	99.8	174,578	194	32	20
766,750	662	766,637	99.9	602,086	527	8	5
3,120,791	944	3,120,780	99.9	2,458,335	745	1	48
14,601	13,775	14,601	99.9	11,445	10,797	0	0
1,522,374	498	1,501,022	98.6	711,487	249	1,603	39
26	30	26	99.9	19	23	0	0
463,541	36	462,420	99.8	462,586	36	41	2
2	100	2	99.9	2	79	0	0
9,970,052	972	9,892,101	99.2	7,733,927	767	4,788	15
8,881,450	NA	8,875,249	99.9	6,990,919	NA	514	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 2009

Place of Service	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	31,646,640	1,826,304	57.7	$287,934,772	$9,098
Office	29,419,760	893,530	30.4	114,453,217	3,890
Home	10,389,380	158,276	15.2	21,986,835	2,116
Inpatient Hospital	7,765,860	195,932	25.2	53,310,062	6,865
Outpatient Hospital [4]	17,272,700	105,632	6.1	29,910,184	1,732
Emergency Room Hospital [4]	10,048,440	43,638	4.3	11,306,078	1,125
Ambulatory Surgical Center	3,610,080	17,643	4.9	22,224,185	6,156
Skilled Nursing Care Facility	2,027,140	24,321	12.0	2,373,683	1,171
Nursing Home	1,948,740	31,989	16.4	2,081,451	1,068
Hospice	7,380	23	3.2	2,711	367
Ambulance [5]	4,586,700	61,471	13.4	9,730,833	2,122
Independent Laboratory	17,522,640	263,075	15.0	15,771,182	900
All Other [6]	NA	30,774	NA	4,784,351	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 2009

	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	$117,586,191	100.0	$3,716	$116,989,449	99.5	$91,115,719	100.0	$2,944
Office	55,325,833	47.1	1,881	54,881,785	99.2	41,722,800	45.8	1,465
Home	12,244,617	10.4	1,179	12,165,767	99.4	9,502,150	10.4	930
Inpatient Hospital	18,381,806	15.6	2,367	18,342,338	99.8	14,548,514	16.0	1,883
Outpatient Hospital [4]	7,786,694	6.6	451	7,766,179	99.7	6,015,945	6.6	358
Emergency Room Hospital [4]	3,206,370	2.7	319	3,203,501	99.9	2,472,235	2.7	251
Ambulatory Surgical Center	5,315,015	4.5	1,472	5,307,285	99.9	4,185,843	4.6	1,161
Skilled Nursing Care Facility	1,575,151	1.3	777	1,574,489	99.9	1,185,031	1.3	594
Nursing Home	1,344,882	1.1	690	1,344,463	99.9	992,793	1.1	516
Hospice	1,490	(7)	202	1,487	99.8	1,127	(7)	156
Ambulance [5]	5,432,527	4.6	1,184	5,432,504	99.9	4,307,761	4.7	940
Independent Laboratory	4,631,535	3.9	264	4,631,116	99.9	4,370,188	4.8	250
All Other [6]	2,340,271	2.0	NA	2,338,535	99.9	1,811,332	2.0	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 Standard Analytical Files; 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 2009

Physician/Supplier Specialty [1]	Persons Served [2]	Services			Submitted Charges		
		Number in Thousands	Percent	Per Person Served [2]	Amount in Thousands	Percent	Per Person Served [2]
Total All Specialties	31,646,640	1,826,304	100.0	57.7	$287,934,772	100.0	$9,098
Total Physicians	31,078,720	1,170,858	64.1	37.7	206,933,966	71.9	6,658
General Practice	2,061,740	13,847	0.8	6.7	1,362,063	0.5	661
General Surgery	3,889,780	14,183	0.8	3.6	6,470,236	2.2	1,663
Allergy and Immunology	419,880	11,602	0.6	27.6	362,180	0.1	863
Otology, Laryngology, Rhinology	2,988,920	14,442	0.8	4.8	2,249,210	0.8	753
Anesthesiology	5,754,680	16,188	0.9	2.8	9,585,185	3.3	1,666
Cardiology	11,978,680	103,311	5.7	8.6	20,190,202	7.0	1,686
Dermatology	5,857,760	40,890	2.2	7.0	4,503,403	1.6	769
Family Practice	13,780,340	124,152	6.8	9.0	9,935,921	3.5	721
Gastroenterology	4,459,940	15,147	0.8	3.4	5,378,016	1.9	1,206
Internal Medicine	17,271,320	197,454	10.8	11.4	20,884,832	7.3	1,209
Manipulative Therapy	128,680	950	0.1	7.4	110,099	(6)	856
Neurology	3,421,560	17,550	1.0	5.1	3,342,023	1.2	977
Neurologiclal Surgery	793,820	2,818	0.2	3.5	2,883,663	1.0	3,633
Obstetrics and Gynecology	2,436,900	8,003	0.4	3.3	1,493,271	0.5	613
Ophthalmology	10,932,440	49,154	2.7	4.5	12,907,362	4.5	1,181
Oral Surgery (Dentists Only)	89,140	202	(6)	2.3	56,314	(6)	632
Orthopedic Surgery	5,392,560	36,487	2.0	6.8	11,658,295	4.0	2,162
Pathology	6,031,200	24,911	1.4	4.1	3,416,168	1.2	566
Plastic and Reconstructive Surgery	475,140	1,791	0.1	3.8	977,959	0.3	2,058
Physical Medicine and Rehabilitation	1,544,980	15,653	0.9	10.1	2,150,078	0.7	1,392
Psychiatry	2,199,760	15,712	0.9	7.1	1,930,341	0.7	878
Colorectal Surgery (Proctology)	279,620	763	(6)	2.7	367,883	0.1	1,316
Pulmonary Disease	3,115,380	22,909	1.3	7.4	3,414,532	1.2	1,096
Diagnostic Radiology	19,851,620	107,611	5.9	5.4	18,092,184	6.3	911
Thoracic Surgery	431,760	1,425	0.1	3.3	1,397,975	0.5	3,238
Urology	4,412,740	30,241	1.7	6.9	6,141,957	2.1	1,392
Chiropractic	2,089,620	22,776	1.2	10.9	1,004,700	0.3	481
Nuclear Medicine	476,800	1,151	0.1	2.4	350,225	0.1	735
Pediatric Medicine	267,720	1,522	0.1	5.7	154,349	0.1	577
Geriatric Medicine	462,600	2,731	0.1	5.9	321,165	0.1	694
Nephrology	1,875,900	20,336	1.1	10.8	4,533,256	1.6	2,417
Optometrist	5,477,520	12,467	0.7	2.3	1,172,192	0.4	214
Infectious Disease	959,640	9,075	0.5	9.5	1,213,887	0.4	1,265
Endocrinology	1,362,000	8,958	0.5	6.6	820,667	0.3	603
Podiatry	6,167,920	36,736	2.0	6.0	3,031,802	1.1	492

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 2009

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
$117,586,191	100.0	$3,716	$116,989,449	99.5	$91,115,719	100.0	$2,944	$46,083	$31
84,715,435	72.0	2,726	84,197,902	99.4	64,864,493	71.2	2,149	41,093	34
750,254	0.6	364	740,986	98.8	556,313	0.6	281	645	23
2,170,134	1.8	558	2,164,522	99.7	1,692,564	1.9	445	486	34
218,159	0.2	520	215,569	98.8	165,427	0.2	406	202	28
969,151	0.8	324	963,388	99.4	730,728	0.8	255	485	21
1,887,570	1.6	328	1,883,556	99.8	1,483,717	1.6	260	356	25
7,882,903	6.7	658	7,860,255	99.7	6,092,435	6.7	520	1,861	29
2,616,122	2.2	447	2,582,465	98.7	1,972,346	2.2	351	2,780	23
5,607,189	4.8	407	5,569,266	99.3	4,083,181	4.5	309	3,000	21
1,820,941	1.5	408	1,809,338	99.4	1,404,599	1.5	321	975	30
11,331,460	9.6	656	11,247,713	99.3	8,599,536	9.4	512	7,140	26
55,748	(6)	433	54,334	97.5	42,466	(6)	341	111	46
1,622,553	1.4	474	1,613,505	99.4	1,239,901	1.4	372	801	33
638,201	0.5	804	635,187	99.5	499,006	0.5	646	256	48
611,609	0.5	251	604,544	98.8	463,533	0.5	196	536	14
6,043,421	5.1	553	6,008,838	99.4	4,566,670	5.0	441	2,905	24
26,642	(6)	299	25,335	95.1	20,563	(6)	239	80	22
3,550,556	3.0	658	3,538,229	99.7	2,735,452	3.0	524	1,046	43
1,108,562	0.9	184	1,102,508	99.5	880,336	1.0	148	537	19
307,142	0.3	646	304,622	99.2	240,109	0.3	518	214	44
977,346	0.8	633	974,277	99.7	762,466	0.8	501	261	25
1,133,115	1.0	515	1,111,299	98.1	717,411	0.8	339	1,656	41
136,787	0.1	489	135,438	99.0	106,026	0.1	386	112	47
1,811,879	1.5	582	1,806,237	99.7	1,411,951	1.5	461	493	28
5,465,381	4.6	275	5,430,836	99.4	4,240,816	4.7	220	2,803	38
395,233	0.3	915	393,353	99.5	311,807	0.3	734	166	89
2,385,482	2.0	541	2,376,501	99.6	1,837,129	2.0	422	792	38
719,578	0.6	344	640,408	89.0	529,274	0.6	267	5,327	20
110,750	0.1	232	109,237	98.6	86,673	0.1	188	136	36
73,914	0.1	276	73,644	99.6	55,895	0.1	217	17	18
190,230	0.2	411	188,995	99.4	143,699	0.2	319	109	31
2,074,469	1.8	1,106	2,072,005	99.9	1,626,708	1.8	880	218	22
875,784	0.7	160	868,780	99.2	613,059	0.7	123	195	8
635,810	0.5	663	634,203	99.7	500,756	0.5	528	141	29
454,966	0.4	334	447,585	98.4	350,611	0.4	264	617	20
1,916,982	1.6	311	1,909,460	99.6	1,439,156	1.6	240	450	16

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 2009

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	1,318,340	13,930	0.8	10.6	$2,368,098	0.8	$1,796
Vascular Surgery	1,319,180	4,530	0.2	3.4	2,318,756	0.8	1,758
Cardiac Surgery	356,940	1,244	0.1	3.5	1,259,209	0.4	3,528
Hematology/Oncology	1,908,280	65,282	3.6	34.2	12,729,163	4.4	6,670
Medical Oncology	763,320	22,302	1.2	29.2	4,490,721	1.6	5,883
Radiation Oncology	816,040	12,110	0.7	14.8	6,103,349	2.1	7,479
Emergency Medicine	8,881,540	25,672	1.4	2.9	8,460,405	2.9	953
All Other Physician [5]	NA	22,640	1.2	NA	5,340,670	1.9	NA
Group Practice	242,760	835	(6)	3.4	150,523	0.1	620
Total Non-Physician	15,809,880	153,493	8.4	9.7	28,818,186	10.0	1,823
Total Suppliers	22,544,080	501,028	27.4	22.2	52,022,504	18.1	2,308

[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]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.

[6]Less than 0.05 percent.

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 Standard Analytical Files; 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 2009

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
$1,295,639	1.1	$983	$1,286,989	99.3	$996,090	1.1	$776	$721	$27
690,656	0.6	524	689,489	99.8	539,993	0.6	417	99	49
364,923	0.3	1,022	363,296	99.6	288,204	0.3	818	146	53
5,570,614	4.7	2,919	5,568,093	99.9	4,409,338	4.8	2,342	225	32
1,909,055	1.6	2,501	1,907,126	99.9	1,503,692	1.7	2,001	173	45
1,942,320	1.7	2,380	1,932,002	99.5	1,539,728	1.7	1,955	927	349
2,572,524	2.2	290	2,569,428	99.9	1,984,352	2.2	228	271	16
1,793,681	1.5	NA	1,785,061	99.5	1,400,777	1.5	NA	622	NA
58,760	(6)	242	58,430	99.4	45,454	(6)	194	24	15
9,234,492	7.9	584	9,219,400	99.8	6,989,418	7.7	450	937	15
23,570,788	20.0	1,046	23,507,084	99.7	19,211,004	21.1	856	4,021	16

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 2009

Area of Residence	Persons Served [1]		Services		Submitted Charges	
	Number	Per-cent	Number in Thousands	Per Person Served [1]	Amount in Thousands	Per Person Served [1]
All Areas [4]	31,646,640	100.0	1,826,304	58	$287,934,772	$9,098
United States [5]	31,503,100	99.5	1,817,442	58	287,202,599	9,117
Northeast	5,787,560	18.3	362,469	63	55,075,293	9,516
Midwest	7,681,420	24.3	394,023	51	63,246,586	8,234
South	12,665,180	40.0	769,701	61	121,069,804	9,559
West	5,368,940	17.0	291,249	54	47,810,916	8,905
New England	1,727,940	5.5	88,803	51	14,474,370	8,377
Connecticut	419,860	1.3	24,804	59	4,150,723	9,886
Maine	205,900	0.7	8,072	39	1,204,561	5,850
Massachusetts	739,760	2.3	39,936	54	6,529,729	8,827
New Hampshire	172,680	0.5	7,102	41	1,255,863	7,273
Rhode Island	95,640	0.3	5,617	59	781,224	8,168
Vermont	94,100	0.3	3,272	35	552,270	5,869
Middle Atlantic	4,059,620	12.8	273,666	67	40,600,923	10,001
New Jersey	1,031,300	3.3	75,681	73	11,847,238	11,488
New York	1,803,620	5.7	129,267	72	18,158,122	10,068
Pennsylvania	1,224,700	3.9	68,717	56	10,595,564	8,652
East North Central	5,268,760	16.6	281,930	54	46,352,180	8,798
Illinois	1,481,920	4.7	82,417	56	14,360,440	9,690
Indiana	778,660	2.5	38,254	49	6,515,583	8,368
Michigan	1,131,600	3.6	64,557	57	9,432,570	8,336
Ohio	1,275,780	4.0	69,476	55	10,592,282	8,303
Wisconsin	600,800	1.9	27,225	45	5,451,305	9,073
West North Central	2,412,660	7.6	112,093	47	16,894,406	7,002
Iowa	423,140	1.3	18,368	43	2,593,997	6,130
Kansas	351,460	1.1	18,055	51	2,695,977	7,671
Minnesota	474,440	1.5	18,475	39	2,944,841	6,207
Missouri	727,200	2.3	37,119	51	5,859,618	8,058
Nebraska	229,160	0.7	11,191	49	1,653,800	7,217
North Dakota	94,280	0.3	3,637	39	512,997	5,441
South Dakota	112,980	0.4	5,248	46	633,176	5,604
South Atlantic	6,814,180	21.5	421,592	62	66,365,382	9,739
Delaware	129,420	0.4	7,545	58	1,187,686	9,177
District of Columbia	55,420	0.2	2,851	51	473,761	8,549
Florida	2,172,520	6.9	161,898	75	25,449,754	11,714
Georgia	947,720	3.0	54,055	57	8,934,726	9,428
Maryland	632,180	2.0	36,483	58	5,927,876	9,377
North Carolina	1,132,620	3.6	64,389	57	9,827,044	8,676
South Carolina	600,100	1.9	34,945	58	5,621,928	9,368
Virginia	878,180	2.8	46,168	53	6,878,529	7,833
West Virginia	266,020	0.8	13,259	50	2,064,076	7,759

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 2009

Allowed Charges				Program Payments			Balance Billing	
Amount in Thousands	Per-cent	Per Person Served [1]	Percent of Charges Assigned [2]	Amount in Thousands	Per-cent	Per Person Served [3]	Amount in Thousands	Per Person With Liability
$117,586,191	100.0	3,716	99.5	$91,115,719	100.0	$2,944	$46,083	$31
117,085,295	99.6	3,717	99.5	90,725,758	99.6	2,944	46,054	31
23,562,109	20.0	4,071	99.5	18,279,060	20.1	3,224	8,758	31
25,061,963	21.3	3,263	99.5	19,316,213	21.2	2,578	10,024	29
48,500,351	41.2	3,829	99.6	37,640,303	41.3	3,033	16,323	30
19,960,872	17.0	3,718	99.3	15,490,182	17.0	2,955	10,949	38
5,833,431	5.0	3,376	99.7	4,477,742	4.9	2,650	1,148	28
1,695,340	1.4	4,038	99.4	1,311,240	1.4	3,176	759	36
516,316	0.4	2,508	99.8	393,010	0.4	1,974	66	22
2,584,274	2.2	3,493	99.9	1,983,670	2.2	2,736	127	17
486,327	0.4	2,816	99.7	371,264	0.4	2,206	108	21
345,476	0.3	3,612	99.9	263,377	0.3	2,817	14	17
205,699	0.2	2,186	99.5	155,181	0.2	1,705	74	20
17,728,678	15.1	4,367	99.4	13,801,318	15.1	3,468	7,610	31
5,079,007	4.3	4,925	99.1	3,974,037	4.4	3,917	3,400	30
8,148,221	6.9	4,518	99.3	6,344,913	7.0	3,585	3,788	34
4,501,450	3.8	3,676	99.8	3,482,367	3.8	2,914	422	18
18,177,356	15.5	3,450	99.6	14,023,513	15.4	2,727	5,457	27
5,385,193	4.6	3,634	99.4	4,159,458	4.6	2,869	2,443	30
2,466,052	2.1	3,167	99.6	1,896,438	2.1	2,502	781	25
4,324,717	3.7	3,822	99.8	3,347,410	3.7	3,034	767	29
4,384,175	3.7	3,436	99.8	3,381,277	3.7	2,715	498	17
1,617,219	1.4	2,692	99.2	1,238,931	1.4	2,114	969	30
6,884,607	5.9	2,854	99.2	5,292,700	5.8	2,251	4,566	31
1,093,601	0.9	2,584	98.6	835,867	0.9	2,028	1,248	40
1,120,642	1.0	3,189	99.6	864,694	0.9	2,519	383	27
1,161,003	1.0	2,447	99.5	888,014	1.0	1,924	405	26
2,315,664	2.0	3,184	99.5	1,786,987	2.0	2,516	757	20
684,680	0.6	2,988	99.2	526,483	0.6	2,359	443	25
217,186	0.2	2,304	98.3	166,194	0.2	1,818	325	57
291,830	0.2	2,583	96.0	224,460	0.2	2,049	1,004	43
27,193,944	23.1	3,991	99.5	21,123,055	23.2	3,157	11,703	36
497,198	0.4	3,842	99.8	385,612	0.4	3,031	81	24
200,889	0.2	3,625	98.8	156,396	0.2	2,875	200	37
10,957,315	9.3	5,044	99.3	8,577,467	9.4	4,006	6,311	54
3,379,608	2.9	3,566	99.5	2,613,163	2.9	2,815	1,279	28
2,534,438	2.2	4,009	99.5	1,964,080	2.2	3,161	995	27
3,819,503	3.2	3,372	99.6	2,950,355	3.2	2,655	1,284	25
2,145,523	1.8	3,575	99.6	1,656,990	1.8	2,814	584	22
2,847,870	2.4	3,243	99.6	2,194,311	2.4	2,551	831	24
811,600	0.7	3,051	99.7	624,681	0.7	2,417	139	24

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 2009

Area of Residence	Persons Served [1]		Services		Submitted Charges	
	Number	Per-cent	Number in Thousands	Per Person Served [1]	Amount in Thousands	Per Person Served [1]
East South Central	2,355,120	7.4	137,169	58	$20,058,080	$8,517
Alabama	602,440	1.9	35,248	59	4,859,630	8,067
Kentucky	588,620	1.9	33,029	56	4,650,790	7,901
Mississippi	409,600	1.3	22,497	55	3,673,888	8,969
Tennessee	754,460	2.4	46,396	62	6,873,772	9,111
West South Central	3,495,880	11.0	210,939	60	34,646,343	9,911
Arkansas	407,120	1.3	22,146	54	3,125,787	7,678
Louisiana	472,520	1.5	25,974	55	4,397,698	9,307
Oklahoma	466,740	1.5	24,440	52	3,649,929	7,820
Texas	2,149,500	6.8	138,380	64	23,472,930	10,920
Mountain	1,762,240	5.6	87,956	50	14,469,701	8,211
Arizona	500,760	1.6	29,963	60	4,715,415	9,417
Colorado	363,560	1.1	17,501	48	2,923,444	8,041
Idaho	144,400	0.5	5,765	40	827,034	5,727
Montana	125,720	0.4	4,720	38	694,781	5,526
Nevada	199,800	0.6	11,859	59	2,267,925	11,351
New Mexico	195,540	0.6	8,190	42	1,425,847	7,292
Utah	163,960	0.5	7,251	44	1,154,971	7,044
Wyoming	68,500	0.2	2,707	40	460,285	6,719
Pacific	3,606,700	11.4	203,293	56	33,341,215	9,244
Alaska	50,920	0.2	1,861	37	509,532	10,007
California	2,525,520	8.0	155,268	62	25,538,138	10,112
Hawaii	110,700	0.3	4,679	42	595,337	5,378
Oregon	301,400	1.0	12,218	41	2,081,147	6,905
Washington	618,160	2.0	29,268	47	4,617,061	7,469
Outlying Areas [6]	143,540	0.5	8,862	62	732,173	5,101

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

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

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

[4]Consists of United States and outlying areas.

[5]Includes 50 States and District of Columbia.

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

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

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical files; 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 2009

Allowed Charges				Program Payments			Balance Billing	
Amount in Thousands	Percent	Per Person Served [1]	Percent of Charges Assigned [2]	Amount in Thousands	Percent	Per Person Served [3]	Amount in Thousands	Per Person With Liability
$8,103,918	6.9	$3,441	99.8	$6,268,756	6.9	$2,723	$1,470	$19
2,128,786	1.8	3,534	99.8	1,647,378	1.8	2,797	298	21
1,919,146	1.6	3,260	99.7	1,485,658	1.6	2,583	408	19
1,361,251	1.2	3,323	99.7	1,051,934	1.2	2,632	275	15
2,694,735	2.3	3,572	99.7	2,083,786	2.3	2,822	488	20
13,202,489	11.2	3,777	99.7	10,248,493	11.2	3,000	3,150	21
1,320,770	1.1	3,244	99.8	1,021,071	1.1	2,573	211	24
1,679,074	1.4	3,553	99.8	1,297,179	1.4	2,824	225	19
1,527,990	1.3	3,274	99.7	1,178,848	1.3	2,590	347	20
8,674,654	7.4	4,036	99.6	6,751,394	7.4	3,208	2,368	22
5,953,606	5.1	3,378	98.8	4,596,012	5.0	2,679	5,998	47
1,996,021	1.7	3,986	97.8	1,553,908	1.7	3,170	3,756	78
1,182,964	1.0	3,254	99.2	915,123	1.0	2,575	728	31
364,114	0.3	2,522	98.2	278,061	0.3	1,988	537	27
311,851	0.3	2,481	99.1	238,435	0.3	1,968	218	26
860,083	0.7	4,305	99.8	663,310	0.7	3,407	169	34
565,300	0.5	2,891	99.3	433,834	0.5	2,288	319	33
490,223	0.4	2,990	99.8	373,152	0.4	2,345	75	20
183,048	0.2	2,672	98.6	140,188	0.2	2,140	196	25
14,007,267	11.9	3,884	99.6	10,894,171	12.0	3,088	4,951	30
166,045	0.1	3,261	99.2	127,686	0.1	2,598	103	37
10,819,581	9.2	4,284	99.6	8,447,277	9.3	3,415	3,647	32
269,381	0.2	2,433	99.4	203,817	0.2	1,889	130	31
833,328	0.7	2,765	99.4	638,661	0.7	2,180	390	23
1,918,931	1.6	3,104	99.5	1,476,731	1.6	2,446	680	27
500,896	0.4	3,490	99.9	389,961	0.4	2,864	29	17

Table 9.7

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 2009

BETOS Classification	BETOS Codes	Persons Served [1]	Services: Number in Thousands	Services: Percent	Services: Per Person Served [1]	Allowed Charges: Amount in Thousands	Allowed Charges: Percent	Allowed Charges: Per Person Served [1]	Program Payments: Amount in Thousands	Program Payments: Percent	Program Payments: Per Person Served [2]
Total All BETOS Groups	Total	31,646,640	1,826,304	100.0	58	$117,586,191	100.0	$3,716	$91,115,719	100.0	$2,944
Office Visits - Established	M1B	27,716,080	215,303	11.8	8	14,673,068	12.5	529	10,296,769	11.3	394
Other Drugs	O1E	7,767,060	87,530	4.8	11	8,172,202	6.9	1,052	6,424,037	7.1	859
Hospital Visit - Subsequent	M2B	6,689,120	94,371	5.2	14	6,652,698	5.7	995	5,279,754	5.8	793
Ambulance	O1A	4,600,880	61,590	3.4	13	5,777,731	4.9	1,256	4,582,174	5.0	996
Consultations	M6	12,580,060	28,371	1.6	2	4,419,614	3.8	351	3,391,186	3.7	274
Minor Procedures - Other (MFS)	P6C	10,123,820	117,447	6.4	12	3,982,142	3.4	393	3,108,431	3.4	317
Lab Tests, Other (Non-MFS)	T1H	19,828,320	221,262	12.1	11	3,466,937	2.9	175	3,455,496	3.8	175
Other Durable Medical Equipment	D1E	6,912,280	78,589	4.3	11	3,278,523	2.8	474	2,506,656	2.8	371
Specialist - Ophthalmology	M5C	13,123,600	38,636	2.1	3	2,775,087	2.4	211	1,977,434	2.2	162
Lab Tests, Other (MFS)	T1G	8,424,860	36,991	2.0	4	2,353,299	2.0	279	1,851,646	2.0	224
Eye Procedure - Cataract Removal/Lens Insertion	P4B	1,238,600	3,499	0.2	3	2,340,277	2.0	1,889	1,850,229	2.0	1,496
Chemotherapy	O1D	412,620	14,587	0.8	35	2,324,788	2.0	5,634	1,838,336	2.0	4,487
Emergency Room Visit	M3	9,287,660	18,512	1.0	2	2,320,213	2.0	250	1,786,521	2.0	197
Orthotic Devices	D1F	3,622,980	25,157	1.4	7	2,192,533	1.9	605	1,718,644	1.9	478
Oxygen and Supplies	D1C	1,565,020	18,316	1.0	12	2,155,687	1.8	1,377	1,672,603	1.8	1,071
Anesthesia	P0	6,623,740	13,197	0.7	2	2,152,707	1.8	325	1,698,876	1.9	257
Ambulatory Procedure - Skin	P5A	5,992,940	31,978	1.8	5	2,056,197	1.7	343	1,580,954	1.7	271
Standard Imaging - Nuclear Medicine	I1E	5,077,580	19,125	1.0	4	1,986,260	1.7	391	1,564,062	1.7	311
Advanced Imaging - CAT: Other	I2B	6,166,600	17,284	0.9	3	1,819,193	1.5	295	1,418,315	1.6	233
Oncology - Radiation Therapy	P7A	314,160	9,647	0.5	31	1,792,500	1.5	5,706	1,422,918	1.6	4,538
All Other BETOS Groups	---	NA	674,912	37.0	NA	40,894,535	34.8	NA	31,690,678	34.8	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] The average program payment per person served does not reflect beneficiaries who received covered services, but for whom no program payments were reported.

NOTES: BETOS is the Berenson-Eggers Type of Service system for classifying HCPCS (Healthcare Common Procedure Coding System) codes. Data by BETOS category in this table may differ from other sources because of the update of the HCPCS-BETOS crosswalk used to code the services rendered. MFS is Medicare fee schedule. CAT is Computerized Axial Tomography. NA is not applicable. The leading BETOS codes are based on the amount of allowed charges for 2009. 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 Standard Analytical Files; 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 2009

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	---	1,826,304	$287,934,772	$117,586,191	99.5	$91,115,719
Leading Diagnoses [2]	---	1,066,059	148,147,985	62,826,351	99.5	48,639,356
Infectious and Parasitic Diseases (MDC 1)	001-139	22,245	2,277,554	1,178,450	99.6	907,582
Dermatophytosis	110	9,942	610,131	415,107	99.6	304,511
Neoplasm (MDC 2)	140-239	143,270	39,020,165	14,898,910	99.5	11,750,314
Malignant Neoplasm of Colon	153	9,202	2,475,689	1,006,627	99.9	799,972
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	16,197	3,992,182	1,474,232	99.7	1,168,826
Other Malignant Neoplasm of Skin	173	8,419	3,024,239	1,453,721	99.3	1,139,319
Malignant Neoplasm of Female Breast	174	17,267	4,224,888	1,712,154	99.3	1,360,458
Malignant Neoplasm of Prostate	185	15,092	4,759,298	1,609,549	99.6	1,269,030
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	224,726	15,254,791	7,043,533	99.4	5,566,363
Thyroiditis	244	14,756	928,747	359,970	99.3	304,136
Diabetes Mellitus	250	128,641	7,850,608	4,170,971	99.4	3,226,727
Disorders of Lipoid Metabolism	272	51,473	2,848,738	1,069,570	99.2	880,170
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	7,914	839,900	366,418	99.8	291,964
Diseases of the Blood and Blood-Forming Organs (MDC 4)	280-289	55,478	6,456,202	2,553,467	99.9	2,080,804
Other and Unspecified Anemias	285	28,330	3,130,248	1,168,673	99.9	962,905
Mental Disorders (MDC 5)	290-319	43,789	5,159,282	2,935,413	99.2	1,826,451
Schizophrenic Disorders	295	6,705	690,721	389,771	99.8	240,447
Affective Psychoses	296	12,515	1,531,609	895,608	98.6	512,490
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	115,226	28,617,453	12,336,865	99.5	9,390,614
Other Retinal Disorders	362	18,480	4,266,944	2,337,410	99.8	1,805,930
Glaucoma	365	14,957	2,010,179	1,080,733	99.2	781,572
Cataract	366	16,677	10,628,227	3,574,514	99.5	2,740,292

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 2009

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	234,967	$40,155,200	$16,236,167	99.6	$12,526,911
Essential Hypertension	401	68,918	5,365,625	2,786,217	99.1	2,053,507
Acute Myocardial Infarction	410	2,951	808,912	302,502	99.9	238,871
Other Acute and Subacute Forms of Ischemic Heart Disease	411	2,074	653,414	221,413	99.9	173,938
Angina Pectoris	413	3,611	888,423	343,088	99.9	267,372
Other Forms of Chronic Ischemic Heart Disease	414	31,246	7,308,740	2,759,077	99.7	2,126,993
Other Diseases of Endocardium	424	5,746	2,253,263	736,494	99.5	572,554
Cardiac Dysrhythmias	427	40,172	4,850,496	1,977,284	99.6	1,539,970
Heart Failure	428	19,925	3,226,619	1,465,840	99.7	1,154,593
Ill-Defined Descriptions and Complications of Heart Disease	429	2,842	357,390	141,040	99.4	108,269
Acute, But Ill-Defined, Cerebrovascular Disease	436	4,994	774,103	432,955	99.8	339,226
Diseases of the Respiratory System (MDC 8)	460-519	123,058	15,990,176	7,163,496	99.7	5,499,553
Acute Bronchitis and Bronchiolitis	466	5,106	412,028	225,037	99.0	155,512
Allergic Rhinitis	477	18,804	438,686	258,267	99.0	191,801
Pneumonia, Organism Unspecified	486	9,341	1,352,993	638,929	99.8	500,810
Asthma	493	9,265	1,039,079	476,796	99.6	361,628
Other Diseases of Lung	518	14,035	2,771,053	1,216,348	99.8	961,059
Diseases of the Digestive System (MDC 9)	520-579	40,854	12,255,573	4,097,789	99.6	3,191,799
Diseases of the Genitourinary System (MDC 10)	580-629	94,236	15,934,383	6,231,414	99.7	4,934,182
Chronic Renal Failure	585	27,350	5,207,660	2,161,250	99.9	1,725,021
Calculus of Kidney and Ureter	592	2,939	890,192	244,491	99.6	190,925
Other Disorders of Urethra and Urinary Tract	599	23,088	2,237,401	962,017	99.7	767,597
Hyperplasia of Prostate	600	6,572	1,112,726	458,715	99.5	352,377
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	60,981	6,052,358	3,237,775	99.2	2,443,854
Other Dermatoses	702	25,542	1,596,757	894,216	98.6	658,201
Chronic Ulcer of Skin	707	9,153	1,566,981	776,241	99.8	609,683

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 2009

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	244,213	$39,729,504	$14,430,450	99.0	$11,123,202
Rheumatoid Arthritis and Ofher Inflammatory Polyarthrophathies	714	9,087	1,922,274	1,022,018	99.7	793,138
Osteoarthrosis and Allied Disorders	715	35,156	7,081,547	2,531,415	99.4	1,955,749
Other and Unspecified Arthropathies	716	3,063	417,374	177,635	99.1	135,704
Other and Unspecified Disorders of Joint	719	41,614	3,636,037	1,680,020	99.7	1,290,477
Other and Unspecified Disorders of Back	724	43,031	7,655,285	2,491,225	99.5	1,930,680
Peripheral Enthesopathies and Allied Syndromes	726	13,363	1,639,551	594,943	99.5	452,713
Other Disorders of Soft Tissues	729	14,222	1,629,130	707,193	99.5	539,726
Non-Allopathic Lesions, Not Elsewhere Classified	739	20,555	924,067	653,074	89.3	481,233
Congenital Anomalies (MDC 14)	740-759	2,013	563,725	195,438	99.4	150,412
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	219,584	33,794,369	14,171,745	99.7	11,058,764
General Symptoms	780	46,938	7,047,930	3,132,138	99.7	2,464,088
Symptoms Involving Respiratory System and Other Chest Symptoms	786	57,789	9,278,395	3,878,281	99.8	3,012,208
Symptoms Involving Digestive System	787	17,007	2,617,984	1,037,663	99.7	812,229
Symptoms Involving Urinary System	788	12,722	1,574,506	671,536	99.4	524,043
Sudden Death, Cause Unknown	798	13	5,324	3,034	99.9	2,303
Other Ill-Defined and Unknown Causes of Morbidity and Mortality	799	5,239	1,092,967	508,698	99.9	397,681
Injury and Poisoning (MDC 17)	800-999	56,154	14,471,233	5,358,310	99.7	4,186,501
Fracture of Neck of Femur	820	4,110	1,550,115	512,891	99.8	405,642
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	V01-V82	143,867	11,938,979	5,397,533	99.2	4,384,501
Need for Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	V04	25,046	551,698	397,765	99.8	393,863
Special Investigations and Examinations	V72	6,859	588,915	263,579	99.2	209,223

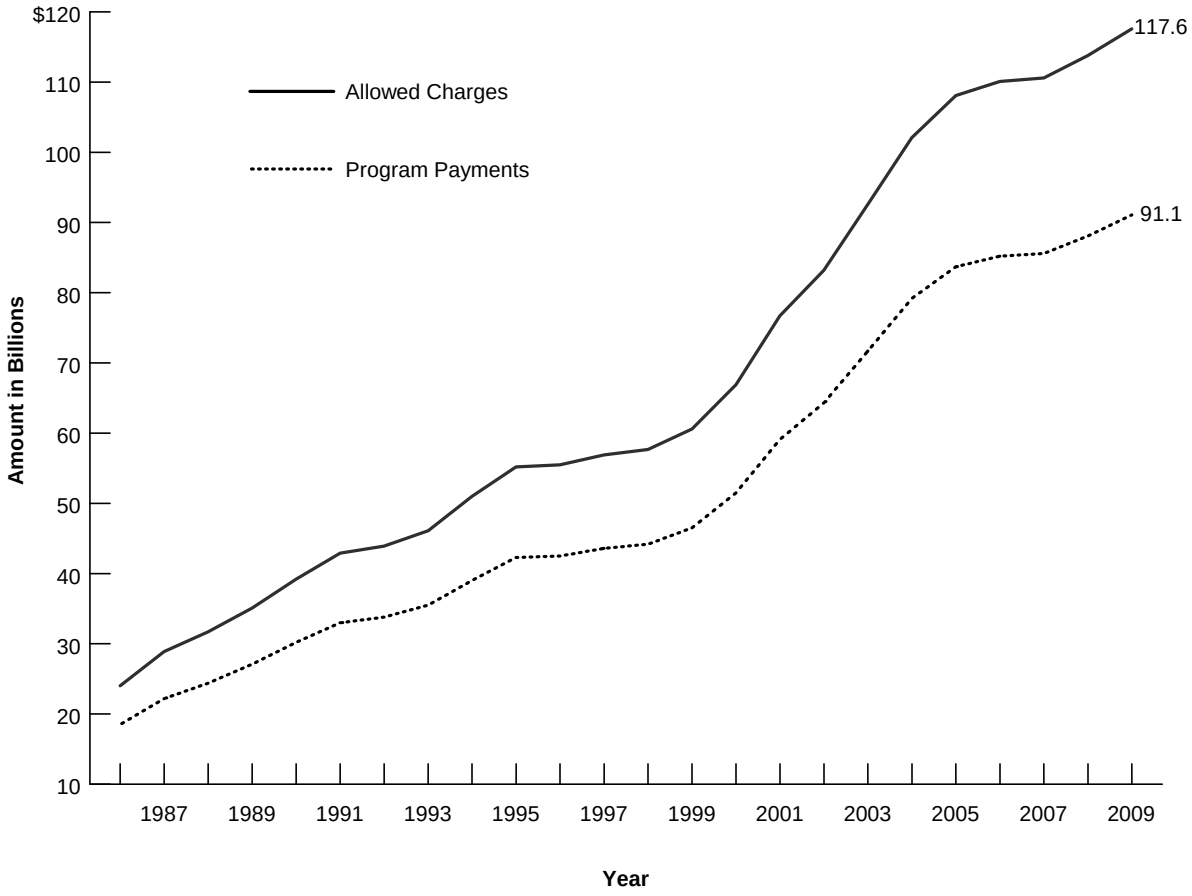
[1]ICD-9-CM is International Classification of Diseases, 9th Revision, Clinical Modification. Only the first listed or principal diagnosis has been used.

[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.

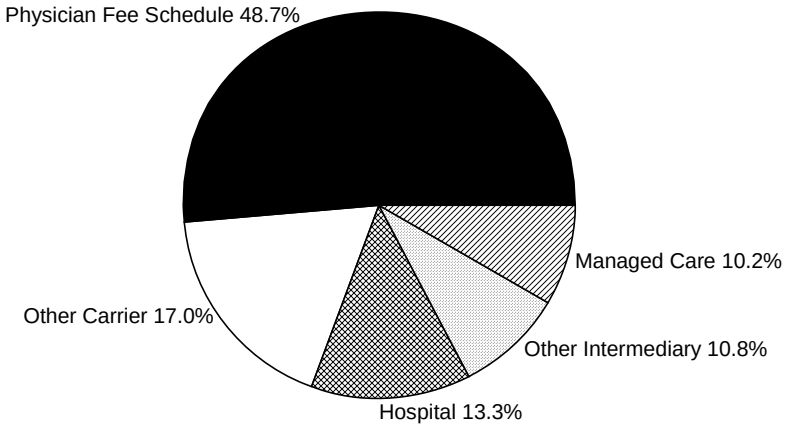
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Office of Research, Development, and Information.

Figure 9.1
Trends in Medicare Physician and Supplier Allowed Charges and Program Payments: Calendar Years 1986-2009



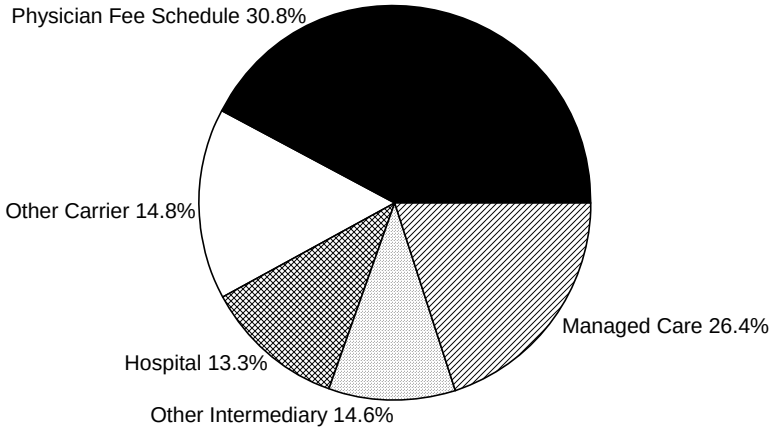
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Office of Research, Development, and Information.

Figure 9.2
Distribution of Medicare Supplementary Medical Insurance Benefit Payments, by Type of Provider: Calendar Years 1995 and 2009



1995

(Total Benefit Payments = $65.0 Billion)



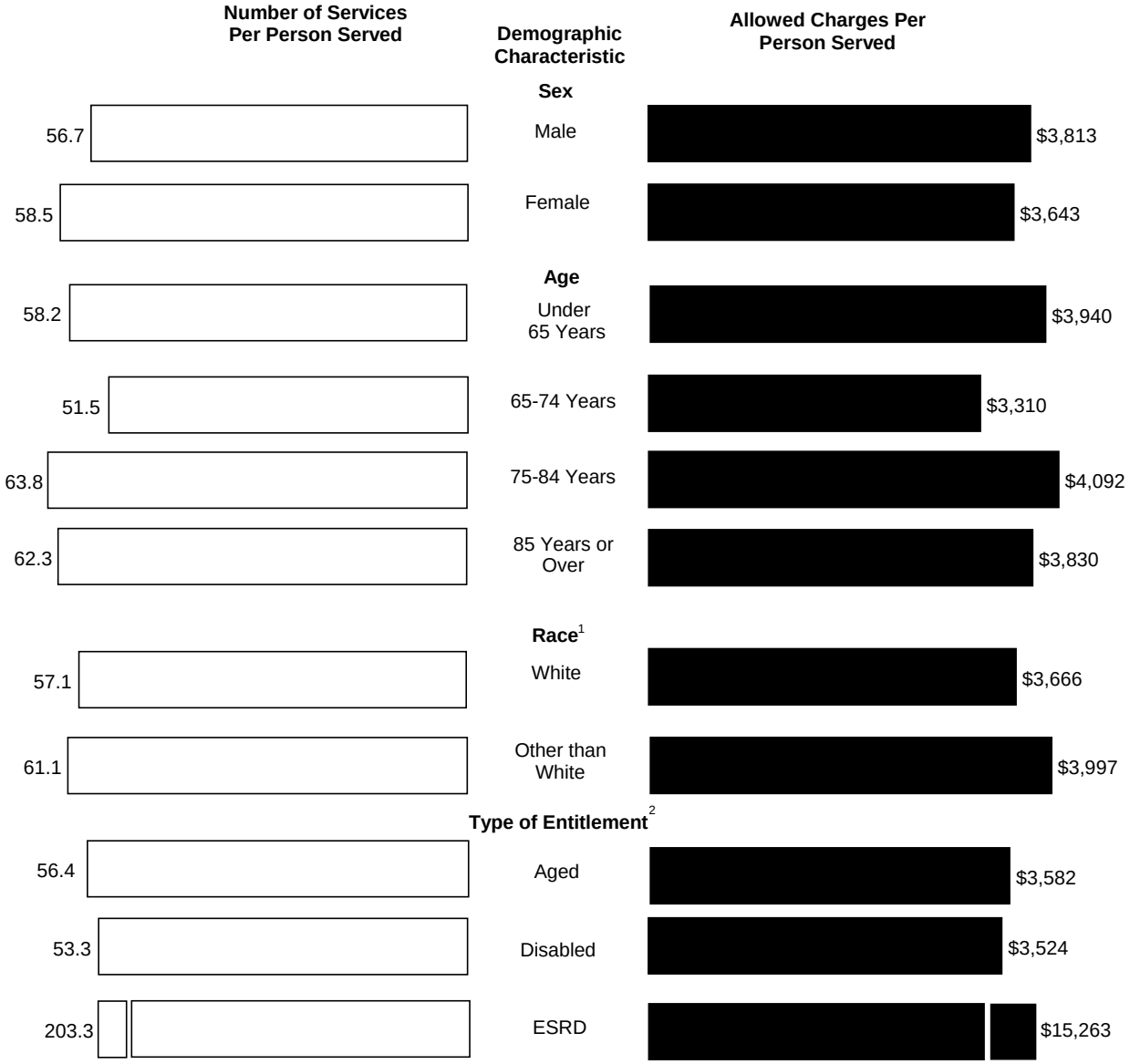
2009

(Total Benefit Payments = $202.4 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 2009

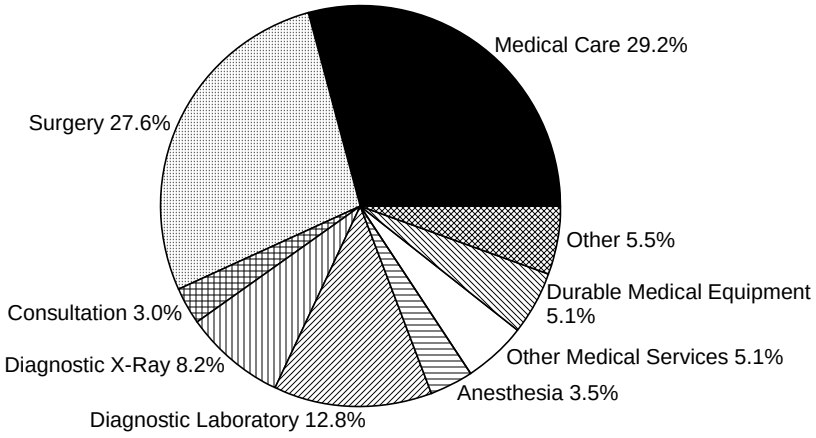


[1] Includes beneficiaries who received covered services, but for whom no program payments were reported during the year.
[2] The average program payment per person served does not reflect beneficiaries who received covered services, but for whom no program payments were reported.

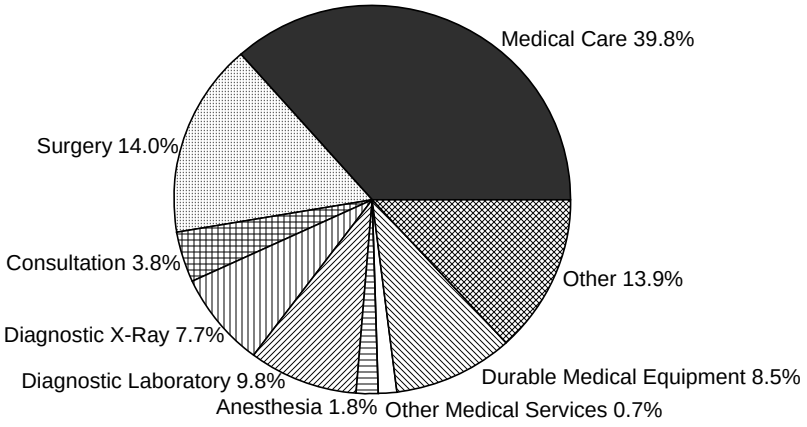
NOTE: ESRD is end stage renal disease.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; 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 2009



1990
(Total Allowed Charges = $37.4 Billion)

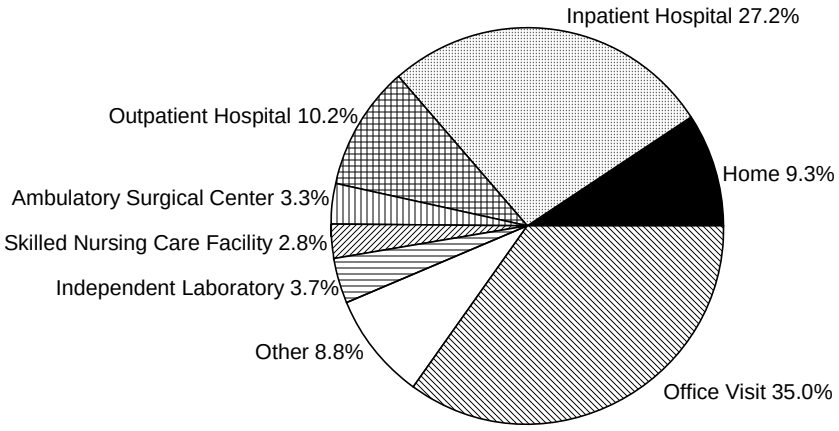


2009
(Total Allowed Charges = $117.6 Billion)

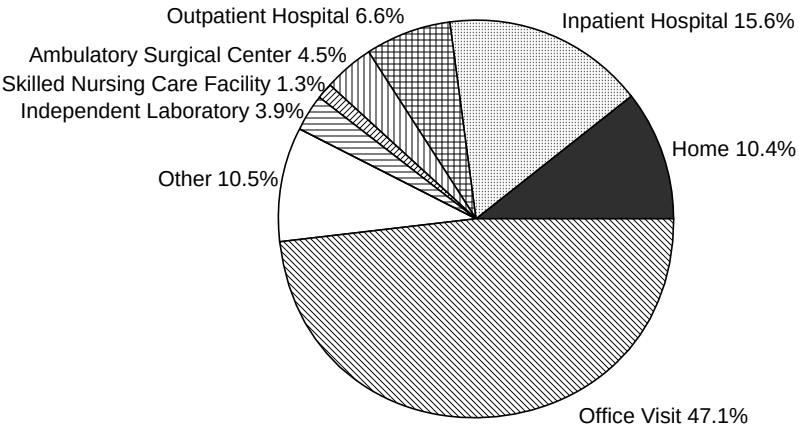
NOTE: Other includes ambulatory surgery center services, therapeutic radiology, psychological therapy assistance at surgery, etc.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; 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 2009



1995
(Total Allowed Charges = $55.2 Billion)

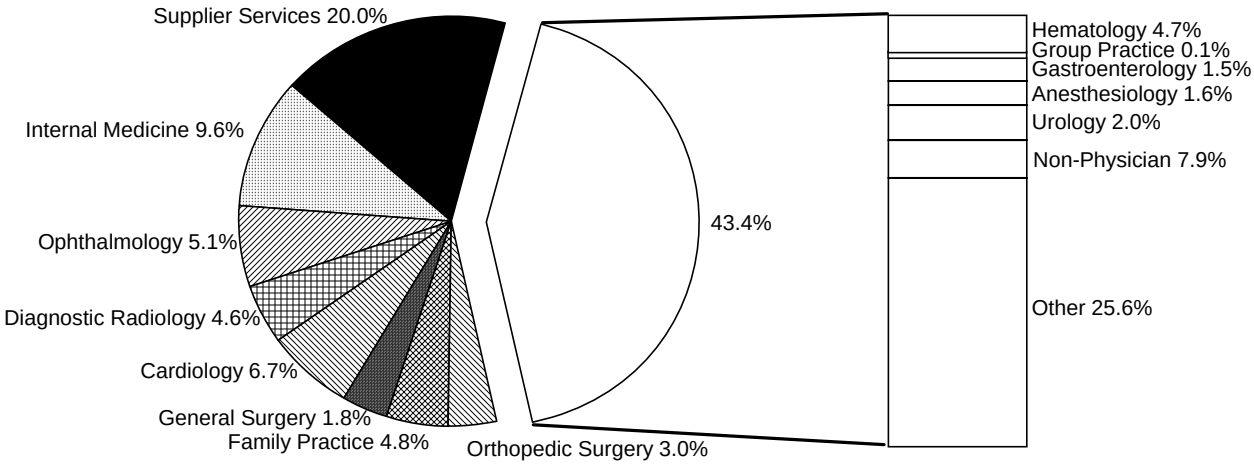


2009
(Total Allowed Charges = $117.6 Billion)

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 Standard Analytical Files; 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 2009

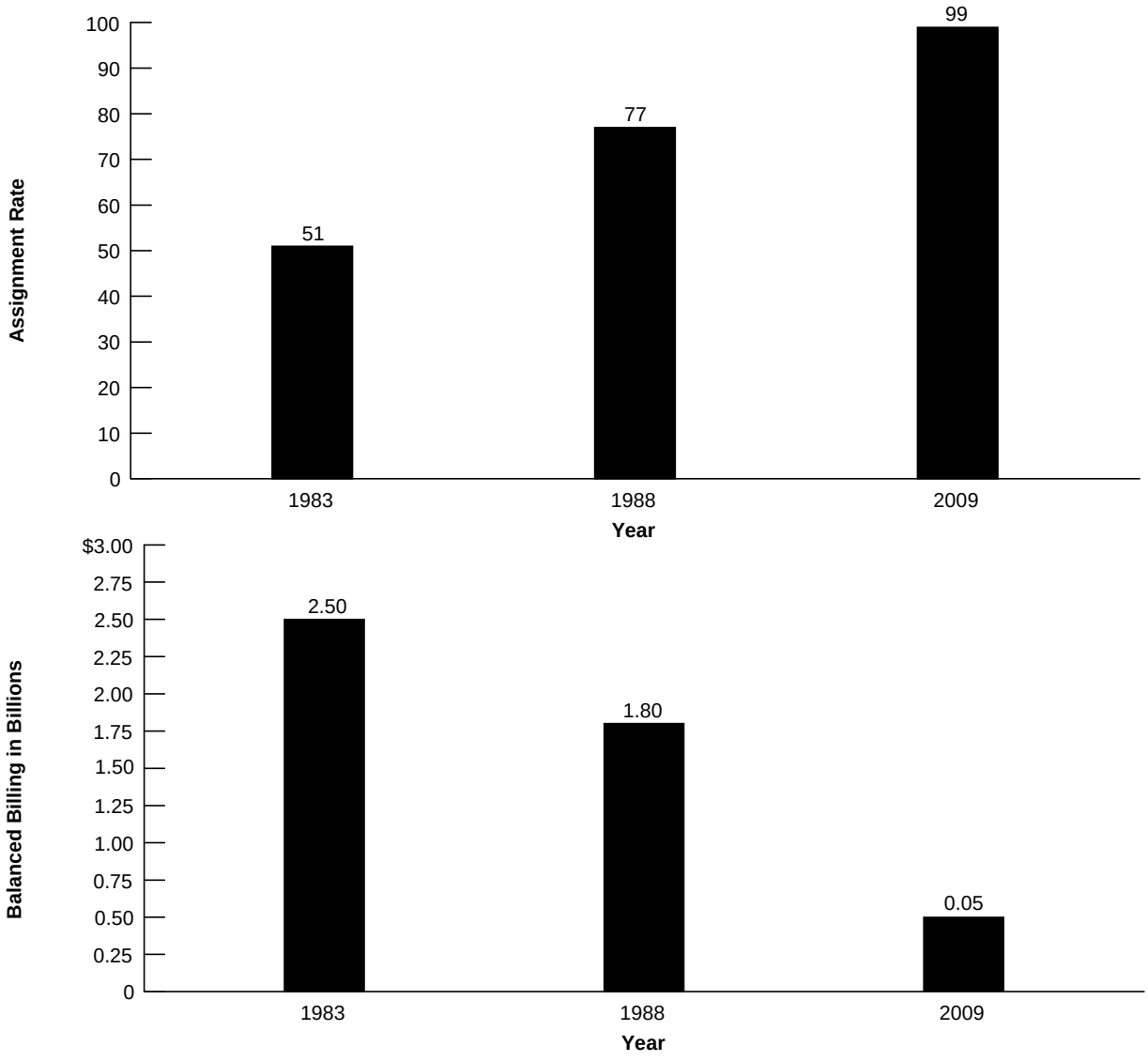


(Total Allowed Charges=$117.6 Billion)

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.

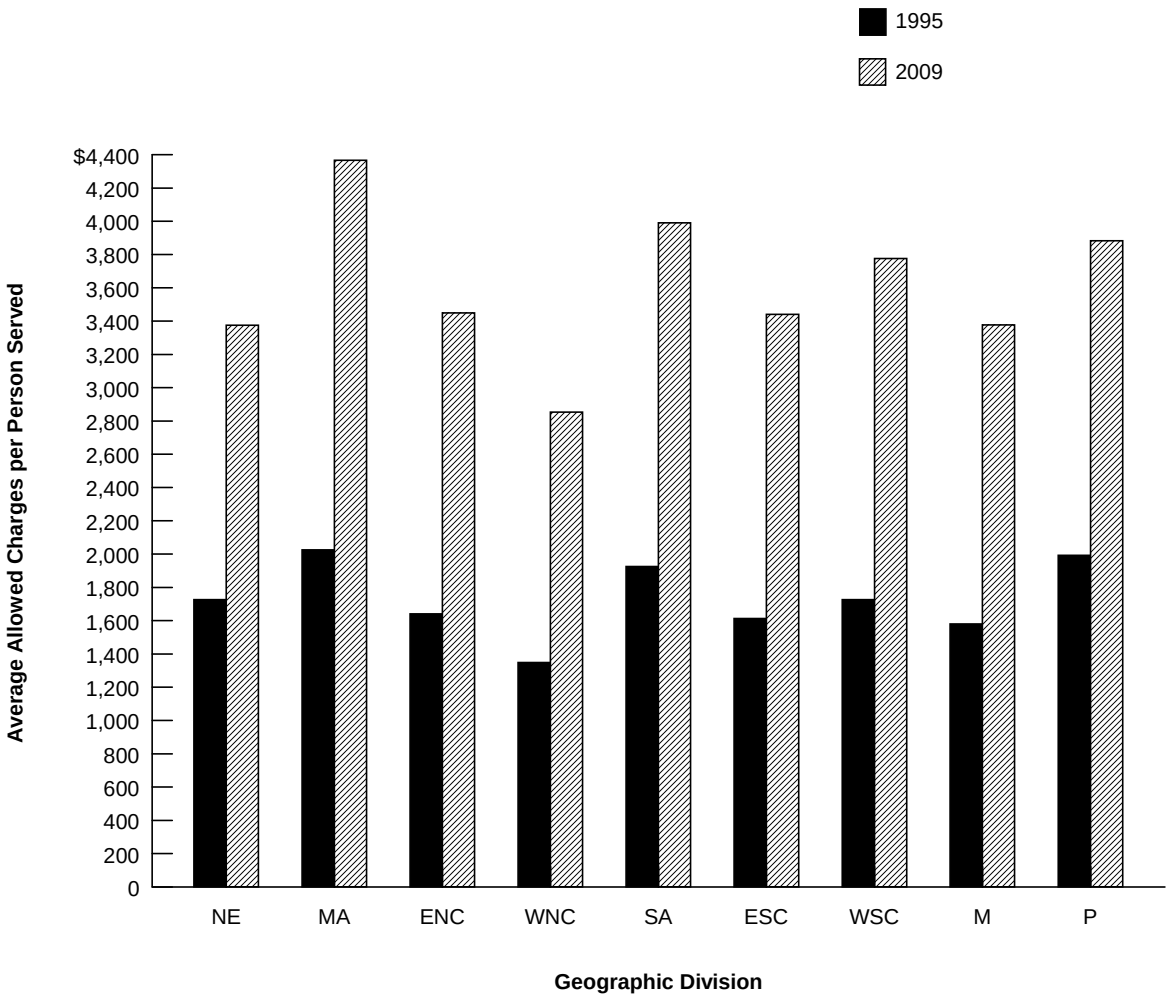
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Office of Research, Development, and Information.

Figure 9.7
Trends in Medicare Assignment Rates and Amount of Balanced Billing: Selected Calendar Years 1983, 1988, and 2009



SOURCES: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Office of Research, Development, and Information.

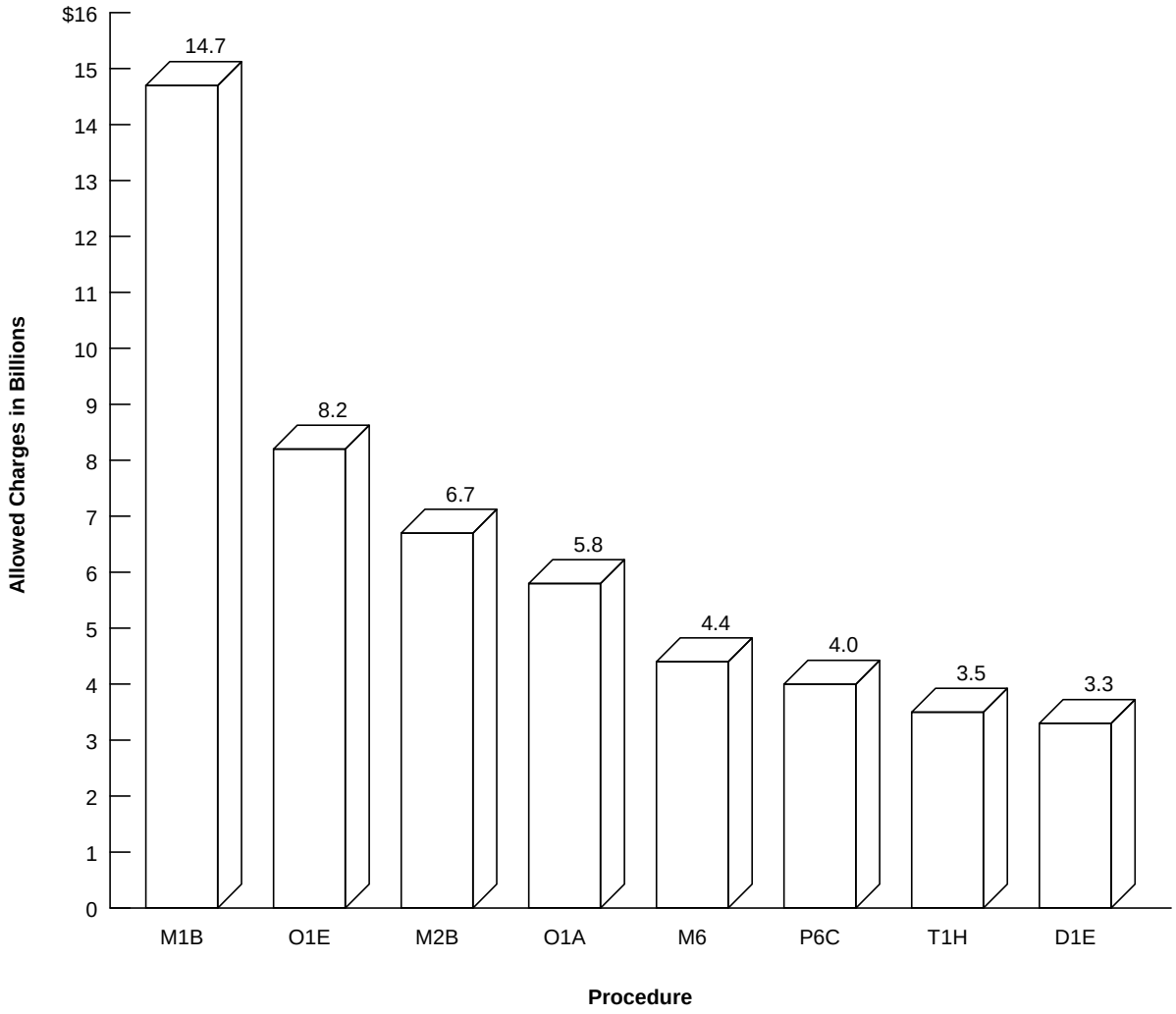
Figure 9.8
Average Allowed Charges per Person Served for Medicare Physician and Supplier Services, by Geographic Division: Calendar Years 1995 and 2009



NOTES: Average allowed charges 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 Standard Analytical Files; data development by the Office of Research, Development, and Information.

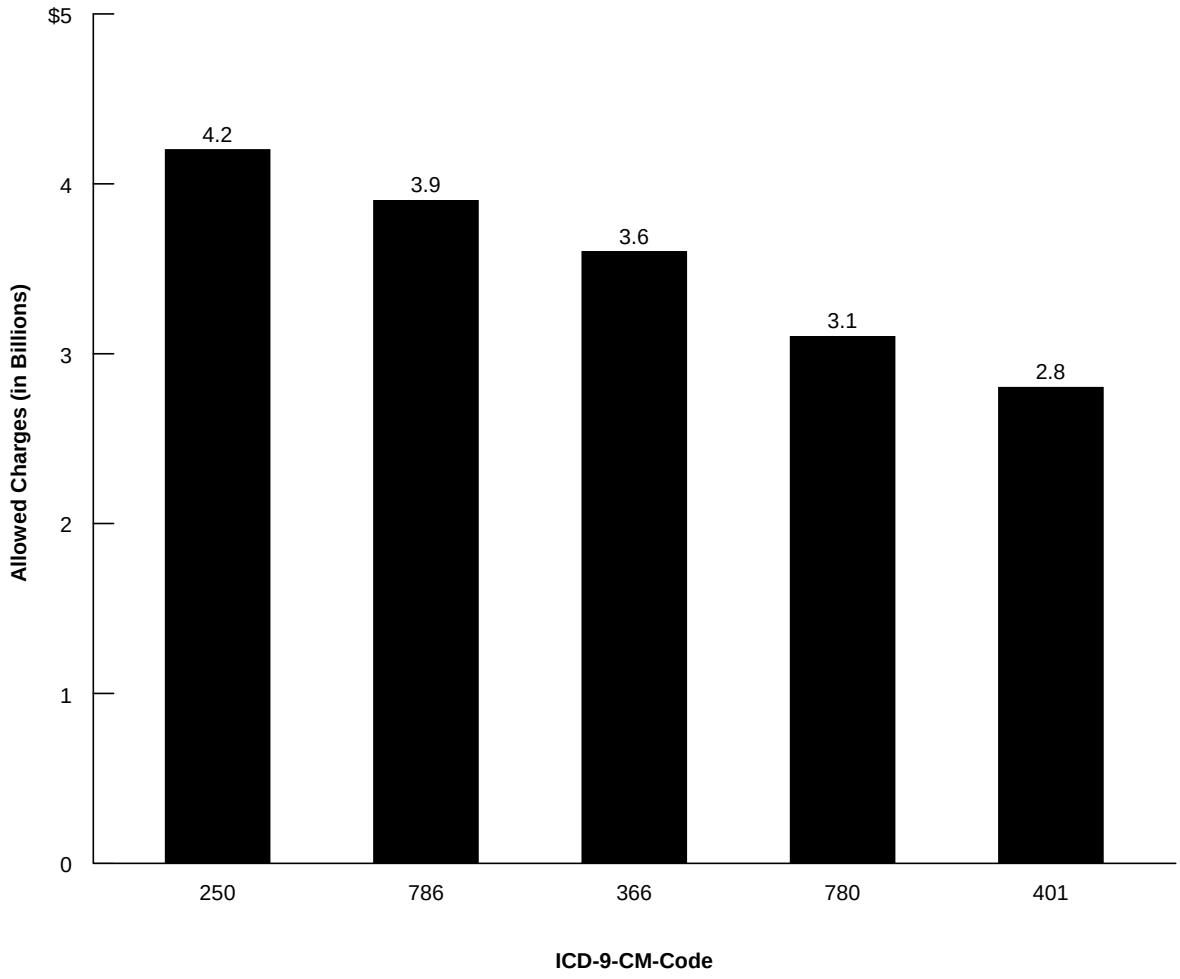
Figure 9.9
Leading Medicare Physician and Supplier BETOS Procedures, Based on Allowed Charges: Calendar Year 2009



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); T1H--lab tests, other (non-medicare fee schedule); D1E--other durable medical equipment.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; 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 2009



NOTE: Diagnoses have the following codes from the *International Classification of Diseases, 9th Revision, Clinical Modification:* diabetes mellitus, 250; symptoms involving respiratory system and other chest symptoms, 786; cataract, 366; general symptoms, 780; essential hypertension, 401.

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