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 1996-2010

Year	Persons Served[1]	Services Number in Thousands	Submitted Charges	Allowed Charges	Program Payments	Balanced Billing
			Amounts in Thousands			
Total						
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
2010	32,091,660	1,857,482	302,709,508	122,904,370	95,036,813	41,083
Aged						
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	1,520,310	236,990,481	96,881,250	75,294,810	43,848
2010	26,625,080	1,536,278	247,177,162	100,755,671	78,096,245	39,116
Disabled						
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
2010	5,466,580	321,204	55,532,346	22,148,699	16,940,568	1,968

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 Center for Strategic Planning.

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 2010

Demographic Characteristic	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	32,091,660	1,857,482	57.9	$302,709,508	$9,433
Sex					
Male	13,745,980	780,099	56.8	134,108,480	9,756
Female	18,345,680	1,077,383	58.7	168,601,028	9,190
Age					
Under 65 Years	5,466,580	321,204	58.8	55,532,346	10,159
65-74 Years	12,866,140	664,017	51.6	112,301,660	8,728
75-84 Years	9,116,840	580,823	63.7	93,514,243	10,257
85 Years or Over	4,642,100	291,438	62.8	41,361,259	8,910
Race[3]					
White	26,930,780	1,542,370	57.3	251,202,777	9,328
Other	5,039,060	309,436	61.4	50,578,120	10,037
Type of Entitlement[4]					
Aged	26,348,420	1,489,974	56.5	238,211,639	9,041
Disabled	5,348,020	289,153	54.1	48,192,588	9,011
ESRD	395,220	78,354	198.3	16,305,282	41,256

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 2010

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	$122,904,370	$3,830	$122,352,418	99.6	$95,036,813	$3,027	$41,083	$31
Sex								
Male	53,859,847	3,918	53,632,464	99.6	41,637,360	3,115	17,228	32
Female	69,044,523	3,764	68,719,954	99.5	53,399,453	2,962	23,855	30
Age								
Under 65 Years	22,148,699	4,052	22,120,475	99.9	16,940,568	3,218	1,968	30
65-74 Years	43,964,789	3,417	43,734,113	99.5	33,870,055	2,701	17,148	30
75-84 Years	38,328,913	4,204	38,121,741	99.5	29,865,596	3,317	15,520	32
85 Years or Over	18,461,969	3,977	18,376,088	99.5	14,360,594	3,131	6,448	31
Race[3]								
White	101,939,430	3,785	101,412,829	99.5	78,733,932	2,985	39,221	31
Other	20,589,840	4,086	20,565,714	99.9	16,015,375	3,268	1,768	28
Type of Entitlement[4]								
Aged	97,387,739	3,696	96,867,071	99.5	75,405,672	2,917	38,881	31
Disabled	19,551,585	3,656	19,523,728	99.9	14,845,390	2,885	1,954	30
ESRD	5,965,046	15,093	5,961,619	99.9	4,785,751	12,185	248	36

[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 Center for Strategic Planning.

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 2010

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	32,091,660	1,857,482	57.9	$302,709,508	$9,433
Medical Care	31,115,160	724,717	23.3	101,152,532	3,251
Surgery	19,631,240	111,541	5.7	57,794,212	2,944
Consultation	588,580	1,172	2.0	197,883	336
Diagnostic X-Ray	21,673,020	139,706	6.4	26,424,316	1,219
Diagnostic Laboratory	26,824,920	546,861	20.4	38,397,143	1,431
Radiation Therapy	1,453,880	12,870	8.9	7,047,703	4,848
Anesthesia	7,009,740	14,340	2.0	12,241,149	1,746
Assistance at Surgery	931,440	1,796	1.9	2,809,817	3,017
Other Medical Services	1,056,160	7,003	6.6	1,492,177	1,413
Ambulatory Surgical Center	3,335,420	6,603	2.0	14,846,653	4,451
Renal Supplies in the Home	1,020	24	23.4	30,977	30,369
Psychological Therapy	3,197,600	21,461	6.7	2,635,792	824
Occupational Therapy	260	(6)	1.5	24	93
Pneumococcal Vaccine	14,292,980	31,023	2.2	725,666	51
Physical Therapy	140	(6)	1.1	20	142
Durable Medical Equipment [4]	10,434,200	144,934	13.9	19,086,867	1,829
Other [5]	11,168,960	93,430	8.4	17,826,577	1,596

[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.

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

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 2010

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
$122,904,370	$3,830	$122,352,418	99.6	$95,036,813	$3,027	$41,083	$31
54,556,023	1,753	54,252,192	99.4	40,988,879	1,379	22,542	22
17,605,974	897	17,523,304	99.5	13,720,287	711	6,663	34
72,689	123	71,598	98.5	57,236	98	98	20
8,450,308	390	8,418,671	99.6	6,524,573	311	2,545	20
11,954,221	446	11,931,782	99.8	10,391,883	391	1,887	10
2,199,380	1,513	2,189,459	99.5	1,743,952	1,206	889	174
2,309,339	329	2,306,489	99.9	1,823,407	261	255	21
239,277	257	238,892	99.8	189,527	204	33	24
748,787	709	748,774	99.9	588,487	566	1	6
3,290,271	986	3,290,204	99.9	2,587,808	777	6	151
10,328	10,125	10,328	99.9	8,147	7,988	0	0
1,584,598	496	1,561,612	98.5	808,142	267	1,653	40
9	35	9	99.9	7	28	0	0
543,285	38	542,299	99.8	542,132	38	34	2
9	65	9	99.9	4	35	0	0
10,281,938	985	10,215,208	99.4	7,944,784	777	3,971	15
9,057,935	811	9,051,587	99.9	7,117,558	647	505	10

Table 9.4

Persons Served, Services, Submitted and Allowed Charges, Program Payments for Medicare Physician and Supplier Services, by Place of Service: Calendar Year 2010

Place of Service	Persons Served[1]	Services		Submitted Charges	
		Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
Total	32,091,660	1,857,482	57.9	$302,709,508	$9,433
Office	29,729,860	894,154	30.1	117,503,687	3,952
Home	10,304,400	161,892	15.7	23,411,231	2,272
Inpatient Hospital	7,812,520	194,928	25.0	55,220,117	7,068
Outpatient Hospital [4]	17,537,020	109,009	6.2	31,605,317	1,802
Emergency Room Hospital [4]	10,331,240	46,002	4.5	12,726,185	1,232
Ambulatory Surgical Center	3,623,840	18,215	5.0	24,115,455	6,655
Skilled Nursing Care Facility	2,042,580	24,587	12.0	2,485,679	1,217
Nursing Home	1,993,000	33,419	16.8	2,249,206	1,129
Hospice	7,200	23	3.1	2,859	397
Ambulance [5]	4,757,940	63,131	13.3	10,691,470	2,247
Independent Laboratory	17,776,680	277,222	15.6	17,480,449	983
All Other [6]	8,263,860	34,900	4.2	5,217,854	631

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 2010

	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	$122,904,370	100.0	$3,830	$122,352,418	99.6	$95,036,813	100.0	$3,027
Office	57,362,642	46.7	1,929	56,947,801	99.3	43,080,041	45.3	1,495
Home	12,585,171	10.2	1,221	12,517,773	99.5	9,735,922	10.2	964
Inpatient Hospital	19,179,760	15.6	2,455	19,144,622	99.8	15,181,454	16.0	1,951
Outpatient Hospital [4]	8,372,601	6.8	477	8,352,187	99.8	6,451,507	6.8	376
Emergency Room Hospital [4]	3,483,450	2.8	337	3,480,288	99.9	2,675,479	2.8	263
Ambulatory Surgical Center	5,725,363	4.7	1,580	5,717,522	99.9	4,502,345	4.7	1,244
Skilled Nursing Care Facility	1,625,447	1.3	796	1,624,804	99.9	1,230,226	1.3	609
Nursing Home	1,457,658	1.2	731	1,457,353	99.9	1,082,105	1.1	549
Hospice	1,640	(7)	228	1,640	99.9	1,239	(7)	177
Ambulance [5]	5,601,702	4.6	1,177	5,601,691	99.9	4,434,696	4.7	933
Independent Laboratory	4,918,461	4.0	277	4,918,279	99.9	4,641,560	4.9	261
All Other [6]	2,590,476	2.1	313	2,588,459	99.9	2,020,239	2.1	247

[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.

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

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 2010

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	32,091,660	1,857,482	100.0	57.9	$302,709,508	100.0	$9,433
Total Physicians	31,432,580	1,170,729	63.0	37.2	214,603,827	70.9	6,827
General Practice	1,875,180	12,247	0.7	6.5	1,260,672	0.4	672
General Surgery	3,809,120	13,611	0.7	3.6	6,526,027	2.2	1,713
Allergy and Immunology	436,440	12,158	0.7	27.9	385,297	0.1	883
Otology, Laryngology, Rhinology	3,019,940	14,260	0.8	4.7	2,328,536	0.8	771
Anesthesiology	5,843,200	15,957	0.9	2.7	10,003,050	3.3	1,712
Cardiology	12,210,700	99,292	5.3	8.1	19,874,037	6.6	1,628
Dermatology	6,001,560	41,921	2.3	7.0	4,870,798	1.6	812
Family Practice	14,156,200	125,973	6.8	8.9	10,530,649	3.5	744
Gastroenterology	4,515,220	15,215	0.8	3.4	5,513,490	1.8	1,221
Internal Medicine	17,464,120	197,398	10.6	11.3	21,758,428	7.2	1,246
Manipulative Therapy	118,440	902	(6)	7.6	116,289	(6)	982
Neurology	3,487,660	17,839	1.0	5.1	3,510,792	1.2	1,007
Neurologiclal Surgery	801,060	2,723	0.1	3.4	3,076,054	1.0	3,840
Obstetrics and Gynecology	2,409,600	7,859	0.4	3.3	1,490,461	0.5	619
Ophthalmology	10,910,960	51,508	2.8	4.7	13,902,727	4.6	1,274
Oral Surgery (Dentists Only)	86,620	191	(6)	2.2	60,550	(6)	699
Orthopedic Surgery	5,485,280	36,690	2.0	6.7	12,114,926	4.0	2,209
Pathology	6,196,760	25,990	1.4	4.2	3,720,577	1.2	600
Plastic and Reconstructive Surgery	496,940	1,965	0.1	4.0	1,069,511	0.4	2,152
Physical Medicine and Rehabilitation	1,595,820	16,132	0.9	10.1	2,290,089	0.8	1,435
Psychiatry	2,247,580	16,061	0.9	7.1	2,030,382	0.7	903
Colorectal Surgery (Proctology)	291,140	810	(6)	2.8	399,332	0.1	1,372
Pulmonary Disease	3,161,840	22,432	1.2	7.1	3,488,340	1.2	1,103
Diagnostic Radiology	19,971,360	107,359	5.8	5.4	18,085,090	6.0	906
Thoracic Surgery	403,400	1,279	0.1	3.2	1,325,246	0.4	3,285
Urology	4,414,520	29,875	1.6	6.8	6,107,089	2.0	1,383
Chiropractic	2,086,360	22,634	1.2	10.8	1,012,804	0.3	485
Nuclear Medicine	460,380	910	(6)	2.0	301,522	0.1	655
Pediatric Medicine	272,380	1,518	0.1	5.6	164,821	0.1	605
Geriatric Medicine	521,580	2,937	0.2	5.6	357,208	0.1	685
Nephrology	1,965,060	20,359	1.1	10.4	4,679,520	1.5	2,381
Optometrist	5,566,460	12,980	0.7	2.3	1,245,839	0.4	224
Infectious Disease	994,100	9,041	0.5	9.1	1,276,429	0.4	1,284
Endocrinology	1,452,180	9,201	0.5	6.3	863,800	0.3	595
Podiatry	6,260,720	37,407	2.0	6.0	3,221,175	1.1	515

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 2010

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
$122,904,370	100.0	$3,830	$122,352,418	99.6	$95,036,813	100.0	$3,027	$41,083	$31
88,461,740	72.0	2,814	87,979,112	99.5	67,539,842	71.1	2,213	36,807	33
711,423	0.6	379	698,983	98.3	524,890	0.6	292	853	30
2,233,121	1.8	586	2,228,018	99.8	1,741,432	1.8	465	432	38
234,483	0.2	537	231,815	98.9	177,459	0.2	415	194	30
1,015,339	0.8	336	1,010,636	99.5	762,838	0.8	260	393	20
1,954,544	1.6	334	1,950,822	99.8	1,536,019	1.6	264	332	25
7,665,017	6.2	628	7,645,901	99.8	5,893,166	6.2	491	1,546	28
2,854,404	2.3	476	2,822,567	98.9	2,143,266	2.3	370	2,453	23
6,071,846	4.9	429	6,035,801	99.4	4,395,173	4.6	322	2,625	21
1,883,804	1.5	417	1,873,928	99.5	1,449,912	1.5	326	815	31
11,962,677	9.7	685	11,883,336	99.3	9,052,240	9.5	531	6,442	26
61,180	(6)	517	60,032	98.1	46,692	(6)	404	82	68
1,707,164	1.4	489	1,700,447	99.6	1,302,353	1.4	381	592	29
677,588	0.6	846	673,839	99.4	531,641	0.6	675	317	63
628,822	0.5	261	622,437	99.0	474,460	0.5	202	461	15
6,829,434	5.6	626	6,792,342	99.5	5,156,429	5.4	493	3,003	26
28,476	(6)	329	27,063	95.0	21,965	(6)	263	95	33
3,746,763	3.0	683	3,734,481	99.7	2,879,215	3.0	537	1,025	48
1,212,466	1.0	196	1,207,332	99.6	959,859	1.0	157	447	20
345,993	0.3	696	344,302	99.5	270,187	0.3	554	128	39
1,040,997	0.8	652	1,038,135	99.7	810,425	0.9	514	239	28
1,188,532	1.0	529	1,167,599	98.2	778,571	0.8	358	1,483	39
147,939	0.1	508	147,058	99.4	114,100	0.1	398	77	30
1,861,808	1.5	589	1,857,330	99.8	1,450,691	1.5	465	384	27
5,392,139	4.4	270	5,365,175	99.5	4,170,108	4.4	214	2,204	36
376,229	0.3	933	375,114	99.7	296,834	0.3	745	98	87
2,377,514	1.9	539	2,368,919	99.6	1,823,219	1.9	418	758	38
727,751	0.6	349	651,554	89.5	529,774	0.6	266	4,941	19
95,760	0.1	208	95,370	99.6	74,671	0.1	166	34	25
77,043	0.1	283	76,889	99.8	58,245	0.1	221	7	17
214,994	0.2	412	213,595	99.3	161,467	0.2	317	117	29
2,173,960	1.8	1,106	2,172,011	99.9	1,701,333	1.8	876	165	22
959,626	0.8	172	952,942	99.3	666,905	0.7	130	167	9
670,144	0.5	674	669,276	99.9	527,667	0.6	536	76	20
485,540	0.4	334	478,486	98.5	372,218	0.4	261	562	21
2,037,391	1.7	325	2,030,602	99.7	1,525,219	1.6	249	396	15

Table 9.5--Continued

Persons Served, Services, Submitted and Allowed Charges, Program Payments, and Balance Billing for Medicare Physician and Supplier Services, by Physician Specialty: Calendar Year 2010

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	1,356,600	13,829	0.7	10.2	$2,478,908	0.8	$1,827
Vascular Surgery	1,394,600	4,835	0.3	3.5	2,536,018	0.8	1,818
Cardiac Surgery	370,340	1,266	0.1	3.4	1,365,579	0.5	3,687
Hematology/Oncology	2,024,600	64,229	3.5	31.7	13,126,484	4.3	6,483
Medical Oncology	762,200	19,853	1.1	26.0	4,282,841	1.4	5,619
Radiation Oncology	803,840	12,215	0.7	15.2	6,585,838	2.2	8,193
Emergency Medicine	9,209,460	26,997	1.5	2.9	9,549,344	3.2	1,037
All Other Physician [5]	3,209,520	23,077	1.2	7.2	5,754,942	1.9	1,793
Group Practice	150,420	596	(6)	4.0	87,609	(6)	582
Total Non-Physician	17,064,500	164,759	8.9	9.7	31,969,564	10.6	1,873
Total Suppliers	22,825,240	521,192	28.1	22.8	56,010,824	18.5	2,454

[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.

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

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 2010

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
$1,375,931	1.1	$1,014	$1,368,210	99.4	$1,054,840	1.1	$793	$623	$27
763,400	0.6	547	762,418	99.9	595,584	0.6	433	87	44
390,219	0.3	1,054	388,548	99.6	308,432	0.3	841	150	81
5,690,072	4.6	2,810	5,688,134	99.9	4,496,470	4.7	2,245	173	30
1,810,770	1.5	2,376	1,809,337	99.9	1,426,776	1.5	1,896	129	34
2,075,886	1.7	2,582	2,066,078	99.5	1,642,949	1.7	2,098	882	387
2,805,930	2.3	305	2,802,397	99.9	2,155,142	2.3	238	290	16
1,915,341	1.6	597	1,907,245	99.6	1,492,329	1.6	475	558	18
42,064	(6)	280	41,189	97.9	32,325	(6)	220	62	15
10,106,457	8.2	592	10,092,844	99.9	7,681,321	8.1	457	888	16
24,276,388	19.8	1,064	24,221,879	99.8	19,770,003	20.8	871	3,298	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 2010

	Persons Served [1]		Services		Submitted Charges	
Area of Residence	Number	Percent	Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
All Areas [4]	32,091,660	100.0	1,857,482	58	$302,709,508	$9,433
United States [5]	31,961,220	99.6	1,850,800	58	302,110,560	9,452
Northeast	5,851,800	18.2	368,347	63	58,027,752	9,916
Midwest	7,822,700	24.4	400,376	51	66,383,304	8,486
South	12,806,000	39.9	782,862	61	126,760,031	9,898
West	5,480,720	17.1	299,214	55	50,939,472	9,294
New England	1,753,000	5.5	90,342	52	15,261,323	8,706
Connecticut	417,140	1.3	25,105	60	4,356,087	10,443
Maine	206,300	0.6	8,115	39	1,224,934	5,938
Massachusetts	758,200	2.4	40,600	54	6,904,979	9,107
New Hampshire	175,640	0.5	7,164	41	1,303,443	7,421
Rhode Island	100,320	0.3	5,949	59	848,404	8,457
Vermont	95,400	0.3	3,408	36	623,476	6,535
Middle Atlantic	4,098,800	12.8	278,006	68	42,766,429	10,434
New Jersey	1,044,760	3.3	77,068	74	12,628,286	12,087
New York	1,800,720	5.6	129,814	72	18,837,996	10,461
Pennsylvania	1,253,320	3.9	71,123	57	11,300,147	9,016
East North Central	5,383,460	16.8	287,975	53	48,765,359	9,058
Illinois	1,511,940	4.7	84,529	56	15,237,117	10,078
Indiana	779,880	2.4	38,589	49	6,800,374	8,720
Michigan	1,308,300	4.1	73,788	56	11,110,292	8,492
Ohio	1,184,080	3.7	63,723	54	9,901,580	8,362
Wisconsin	599,260	1.9	27,345	46	5,715,996	9,538
West North Central	2,439,240	7.6	112,402	46	17,617,945	7,223
Iowa	428,540	1.3	18,674	44	2,762,102	6,445
Kansas	356,140	1.1	18,373	52	2,844,970	7,988
Minnesota	481,760	1.5	17,699	37	2,973,885	6,173
Missouri	731,040	2.3	37,499	51	6,115,809	8,366
Nebraska	231,460	0.7	11,311	49	1,703,450	7,360
North Dakota	94,960	0.3	3,695	39	543,982	5,729
South Dakota	115,340	0.4	5,151	45	673,747	5,841
South Atlantic	6,866,380	21.4	427,892	62	69,482,083	10,119
Delaware	134,700	0.4	7,790	58	1,252,281	9,297
District of Columbia	57,260	0.2	3,045	53	522,210	9,120
Florida	2,182,740	6.8	163,215	75	26,673,840	12,220
Georgia	908,740	2.8	53,084	58	9,066,673	9,977
Maryland	643,260	2.0	37,456	58	6,108,144	9,496
North Carolina	1,160,560	3.6	66,319	57	10,450,583	9,005
South Carolina	615,420	1.9	36,709	60	6,080,351	9,880
Virginia	893,100	2.8	46,816	52	7,234,988	8,101
West Virginia	270,600	0.8	13,458	50	2,093,013	7,735

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 2010

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
$122,904,370	100.0	3,830	99.6	$95,036,813	100.0	$3,027	$41,083	$31
122,520,394	99.7	3,833	99.6	94,740,428	99.7	3,030	41,044	31
24,460,307	19.9	4,180	99.5	18,938,279	19.9	3,306	8,061	31
26,435,741	21.5	3,379	99.6	20,332,835	21.4	2,661	8,268	27
50,701,745	41.3	3,959	99.6	39,272,635	41.3	3,127	14,660	30
20,922,601	17.0	3,817	99.4	16,196,679	17.0	3,031	10,054	37
6,068,287	4.9	3,462	99.8	4,647,351	4.9	2,712	1,084	29
1,762,062	1.4	4,224	99.5	1,363,383	1.4	3,329	690	36
531,761	0.4	2,578	99.9	403,024	0.4	2,011	59	26
2,691,594	2.2	3,550	99.9	2,061,972	2.2	2,778	147	20
490,694	0.4	2,794	99.7	372,749	0.4	2,182	104	21
371,097	0.3	3,699	99.9	279,266	0.3	2,855	15	20
221,079	0.2	2,317	99.6	166,957	0.2	1,807	69	22
18,392,020	15.0	4,487	99.4	14,290,928	15.0	3,560	6,978	31
5,247,082	4.3	5,022	99.2	4,095,126	4.3	3,987	3,111	31
8,334,346	6.8	4,628	99.4	6,484,647	6.8	3,675	3,491	35
4,810,591	3.9	3,838	99.9	3,711,155	3.9	3,035	376	18
19,244,169	15.7	3,575	99.7	14,818,771	15.6	2,818	4,627	27
5,712,273	4.6	3,778	99.5	4,407,437	4.6	2,978	2,023	28
2,574,392	2.1	3,301	99.6	1,976,913	2.1	2,600	630	24
5,111,720	4.2	3,907	99.8	3,945,939	4.2	3,086	790	29
4,172,156	3.4	3,524	99.8	3,207,844	3.4	2,779	356	17
1,673,628	1.4	2,793	99.4	1,280,638	1.3	2,187	829	32
7,191,572	5.9	2,948	99.3	5,514,064	5.8	2,314	3,641	28
1,171,379	1.0	2,733	99.1	892,862	0.9	2,137	851	33
1,191,468	1.0	3,346	99.7	917,373	1.0	2,636	292	22
1,167,440	0.9	2,423	99.7	888,449	0.9	1,890	290	22
2,423,369	2.0	3,315	99.6	1,867,892	2.0	2,607	679	21
705,570	0.6	3,048	99.2	540,950	0.6	2,397	419	24
230,791	0.2	2,430	98.9	175,728	0.2	1,901	224	45
301,554	0.2	2,614	96.3	230,810	0.2	2,061	885	38
28,325,952	23.0	4,125	99.5	21,962,008	23.1	3,256	10,615	37
525,841	0.4	3,904	99.8	406,709	0.4	3,079	76	27
221,389	0.2	3,866	98.9	171,953	0.2	3,068	202	37
11,277,264	9.2	5,167	99.4	8,814,204	9.3	4,099	5,771	54
3,430,248	2.8	3,775	99.6	2,645,020	2.8	2,973	1,076	30
2,620,309	2.1	4,073	99.5	2,026,685	2.1	3,204	909	28
4,077,609	3.3	3,513	99.6	3,146,266	3.3	2,756	1,142	25
2,322,800	1.9	3,774	99.7	1,793,745	1.9	2,970	595	25
3,006,778	2.4	3,367	99.7	2,309,542	2.4	2,636	735	24
843,712	0.7	3,118	99.8	647,884	0.7	2,463	109	21

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 2010

	Persons Served [1]		Services		Submitted Charges	
Area of Residence	Number	Percent	Number in Thousands	Per Person Served[1]	Amount in Thousands	Per Person Served[1]
East South Central	2,386,880	7.4	139,839	59	$20,825,455	$8,725
Alabama	620,640	1.9	36,838	59	5,184,692	8,354
Kentucky	595,800	1.9	33,228	56	4,761,298	7,991
Mississippi	419,600	1.3	23,443	56	3,896,335	9,286
Tennessee	750,840	2.3	46,330	62	6,983,131	9,300
West South Central	3,552,740	11.1	215,132	61	36,452,493	10,260
Arkansas	415,740	1.3	22,596	54	3,139,690	7,552
Louisiana	474,820	1.5	26,474	56	4,603,705	9,696
Oklahoma	469,760	1.5	24,679	53	3,731,220	7,943
Texas	2,192,420	6.8	141,384	64	24,977,879	11,393
Mountain	1,811,360	5.6	91,082	50	15,691,829	8,663
Arizona	522,480	1.6	31,452	60	5,148,660	9,854
Colorado	374,600	1.2	17,972	48	3,176,546	8,480
Idaho	146,220	0.5	5,830	40	864,795	5,914
Montana	128,140	0.4	4,808	38	756,843	5,906
Nevada	207,380	0.6	12,490	60	2,492,374	12,018
New Mexico	200,140	0.6	8,385	42	1,539,607	7,693
Utah	163,120	0.5	7,412	45	1,234,149	7,566
Wyoming	69,280	0.2	2,734	39	478,855	6,912
Pacific	3,669,360	11.4	208,133	57	35,247,644	9,606
Alaska	52,980	0.2	1,912	36	526,458	9,937
California	2,568,720	8.0	159,288	62	27,086,400	10,545
Hawaii	109,420	0.3	4,721	43	613,518	5,607
Oregon	309,860	1.0	12,797	41	2,256,233	7,281
Washington	628,380	2.0	29,416	47	4,765,034	7,583
Outlying Areas [6]	130,440	0.4	6,681	51	598,949	4,592

[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 Center for Strategic Planning.

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 2010

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
$8,515,736	6.9	$3,568	99.8	$6,571,022	6.9	$2,814	$1,216	$18
2,301,906	1.9	3,709	99.8	1,776,842	1.9	2,929	242	19
1,987,997	1.6	3,337	99.7	1,534,928	1.6	2,639	330	19
1,460,566	1.2	3,481	99.8	1,127,163	1.2	2,749	245	15
2,765,268	2.2	3,683	99.8	2,132,088	2.2	2,893	399	20
13,860,057	11.3	3,901	99.7	10,739,604	11.3	3,089	2,829	21
1,367,704	1.1	3,290	99.8	1,052,012	1.1	2,594	157	23
1,761,717	1.4	3,710	99.9	1,359,082	1.4	2,933	172	17
1,567,436	1.3	3,337	99.7	1,205,579	1.3	2,625	275	17
9,163,200	7.5	4,179	99.7	7,122,931	7.5	3,315	2,226	21
6,347,128	5.2	3,504	99.0	4,884,471	5.1	2,774	5,280	46
2,147,165	1.7	4,110	98.2	1,663,698	1.8	3,257	3,271	75
1,261,635	1.0	3,368	99.3	973,064	1.0	2,662	698	30
376,496	0.3	2,575	98.5	286,461	0.3	2,023	435	26
333,334	0.3	2,601	99.2	254,196	0.3	2,057	191	25
905,576	0.7	4,367	99.7	698,618	0.7	3,466	236	55
605,263	0.5	3,024	99.5	463,282	0.5	2,398	203	22
524,507	0.4	3,215	99.8	398,090	0.4	2,514	66	24
193,153	0.2	2,788	98.7	147,061	0.2	2,215	180	26
14,575,473	11.9	3,972	99.6	11,312,207	11.9	3,157	4,774	31
166,074	0.1	3,135	99.4	126,829	0.1	2,486	79	29
11,263,051	9.2	4,385	99.6	8,777,446	9.2	3,497	3,624	33
278,269	0.2	2,543	99.4	209,164	0.2	1,950	117	27
895,534	0.7	2,890	99.5	683,514	0.7	2,272	308	20
1,972,544	1.6	3,139	99.6	1,515,255	1.6	2,468	647	29
383,976	0.3	2,944	99.8	296,385	0.3	2,412	39	31

Table 9.7

Persons Served, Services, Allowed Charges, and Program Payments for Medicare Physician and Supplier Services, by Leading BETOS Classifications: Calendar Year 2010

BETOS Classification	BETOS Codes	Persons Served[1]	Services			Allowed Charges			Program Payments		
			Number in Thousands	Percent	Per Person Served[1]	Amount in Thousands	Percent	Per Person Served[1]	Amount in Thousands	Percent	Per Person Served[2]
Total All BETOS Groups	Total	32,091,660	1,857,482	100.0	58	$122,904,370	100.0	$3,830	$95,036,813	100.0	$3,027
Office Visits - Established	M1B	28,103,660	221,537	11.9	8	16,546,606	13.5	589	11,581,216	12.2	435
Other Drugs	O1E	7,921,200	88,426	4.8	11	8,899,383	7.2	1,123	6,998,629	7.4	916
Hospital Visits - Subsequent	M2B	6,821,220	95,667	5.2	14	7,104,079	5.8	1,041	5,637,233	5.9	829
Ambulance	O1A	4,773,820	63,264	3.4	13	5,976,986	4.9	1,252	4,732,262	5.0	992
Minor Procedures - Other (MPFS)	P6C	10,413,100	120,307	6.5	12	4,187,966	3.4	402	3,259,248	3.4	323
Lab Tests - Other (Non-MPFS)	T1H	19,988,080	233,403	12.6	12	3,700,758	3.0	185	3,689,334	3.9	185
Hospital Visits - Initial	M2A	6,571,020	22,074	1.2	3	3,546,181	2.9	540	2,785,121	2.9	426
Other Durable Medical Equipment	D1E	7,055,800	82,331	4.4	12	3,419,412	2.8	485	2,605,623	2.7	379
Specialist - Ophthalmology	M5C	13,278,300	40,837	2.2	3	3,108,380	2.5	234	2,206,068	2.3	176
Office Visits - New	M1A	14,970,020	25,555	1.4	2	3,059,219	2.5	204	2,198,399	2.3	154
Lab Tests - Other (MPFS)	T1G	8,551,840	39,136	2.1	5	2,527,693	2.1	296	1,984,772	2.1	235
Emergency Room Visit	M3	9,546,740	19,280	1.0	2	2,503,729	2.0	262	1,919,356	2.0	205
Eye Procedures - Cataract Removal/Lens Insertion	P4B	1,225,140	3,586	0.2	3	2,474,684	2.0	2,020	1,954,009	2.1	1,597
Prosthetic/Orthotic Devices	D1F	3,707,400	25,068	1.3	7	2,334,051	1.9	630	1,830,587	1.9	499
Anesthesia	P0	6,818,800	13,708	0.7	2	2,295,545	1.9	337	1,810,230	1.9	266
Ambulatory Procedures - Skin	P5A	6,130,560	32,852	1.8	5	2,232,476	1.8	364	1,711,941	1.8	286
Oxygen And Supplies	D1C	1,608,540	18,946	1.0	12	2,223,282	1.8	1,382	1,706,835	1.8	1,065
Nursing Home Visit	M4B	2,735,920	26,251	1.4	10	2,019,557	1.6	738	1,516,327	1.6	562
Chemotherapy	O1D	413,440	12,998	0.7	31	2,004,519	1.6	4,848	1,585,810	1.7	3,857
All Other BETOS Groups	---	---	672,256	36.2	---	42,739,864	34.8	---	33,323,815	35.1	---

[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. The leading BETOS codes are based on the amount of allowed charges for 2010. 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 Center for Strategic Planning.

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 2010

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	---	1,857,482	$302,709,508	$122,904,370	99.6	$95,036,813
Leading Diagnoses [2]	---	1,076,426	154,144,745	65,257,054	99.5	50,379,642
Infectious and Parasitic Diseases (MDC 1)	001-139	22,429	2,393,906	1,230,230	99.7	944,543
Dermatophytosis	110	10,049	634,390	430,146	99.7	314,434
Neoplasm (MDC 2)	140-239	142,479	40,397,421	15,369,142	99.6	12,106,264
Malignant Neoplasm of Colon	153	8,269	2,274,656	851,313	99.9	674,222
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	15,808	4,048,612	1,490,175	99.8	1,182,896
Other Malignant Neoplasm of Skin	173	8,601	3,265,706	1,571,105	99.5	1,229,523
Malignant Neoplasm of Female Breast	174	17,019	4,223,070	1,722,919	99.4	1,369,102
Malignant Neoplasm of Prostate	185	14,729	5,043,494	1,745,297	99.7	1,375,125
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (MDC 3)	240-279	231,233	16,433,632	7,483,576	99.5	5,879,243
Thyroiditis	244	15,219	994,860	384,173	99.3	319,711
Diabetes Mellitus	250	131,006	8,192,646	4,347,405	99.6	3,336,789
Disorders of Lipoid Metabolism	272	51,656	2,942,701	1,111,915	99.2	904,767
Disorders of Fluid, Electrolyte, and Acid-Base Balance	276	7,975	887,545	380,666	99.8	302,618
Diseases of the Blood and Blood-Forming Organs (MDC 4)	280-289	56,090	6,710,263	2,611,102	99.9	2,120,147
Other and Unspecified Anemias	285	28,378	3,190,553	1,152,273	99.9	948,484
Mental Disorders (MDC 5)	290-319	45,344	5,600,923	3,116,722	99.2	2,014,856
Schizophrenic Disorders	295	6,743	745,644	416,307	99.8	270,155
Affective Psychoses	296	12,861	1,640,276	942,099	98.7	568,731
Diseases of the Nervous System and Sense Organs (MDC 6)	320-389	122,871	31,077,572	13,678,366	99.6	10,392,221
Other Retinal Disorders	362	20,722	5,026,713	2,808,358	99.8	2,168,337
Glaucoma	365	15,243	2,140,504	1,184,092	99.3	852,436
Cataract	366	16,627	10,864,362	3,735,942	99.5	2,857,068

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 2010

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	232,309	$41,067,400	$16,534,088	99.6	$12,697,823
Essential Hypertension	401	68,918	5,619,068	2,946,142	99.2	2,148,901
Acute Myocardial Infarction	410	2,902	869,370	320,264	99.9	252,688
Other Acute and Subacute Forms of Ischemic Heart Disease	411	1,922	652,071	217,479	99.9	170,728
Angina Pectoris	413	3,110	796,954	306,266	99.9	237,761
Other Forms of Chronic Ischemic Heart Disease	414	28,504	6,933,784	2,597,606	99.7	1,992,213
Other Diseases of Endocardium	424	5,602	2,301,485	716,272	99.5	554,484
Cardiac Dysrhythmias	427	41,402	5,180,858	2,095,713	99.6	1,626,592
Heart Failure	428	19,413	3,347,676	1,496,697	99.8	1,176,434
Ill-Defined Descriptions and Complications of Heart Disease	429	2,573	342,922	129,591	99.5	98,757
Acute, But Ill-Defined, Cerebrovascular Disease	436	4,709	746,649	406,124	99.8	317,190
Diseases of the Respiratory System (MDC 8)	460-519	123,511	16,600,336	7,373,786	99.7	5,639,511
Acute Bronchitis and Bronchiolitis	466	5,008	423,905	233,496	99.1	161,089
Allergic Rhinitis	477	19,022	465,929	274,822	99.1	203,328
Pneumonia, Organism Unspecified	486	9,197	1,387,687	654,586	99.8	511,962
Asthma	493	9,614	1,111,881	506,241	99.6	383,044
Other Diseases of Lung	518	14,482	2,926,552	1,297,201	99.9	1,024,483
Diseases of the Digestive System (MDC 9)	520-579	41,736	12,880,200	4,269,933	99.7	3,318,930
Diseases of the Genitourinary System (MDC 10)	580-629	95,340	16,949,621	6,475,345	99.7	5,113,888
Chronic Renal Failure	585	28,388	5,694,391	2,309,776	99.9	1,841,302
Calculus of Kidney and Ureter	592	3,126	980,595	261,713	99.7	203,669
Other Disorders of Urethra and Urinary Tract	599	23,366	2,379,109	1,010,229	99.7	802,342
Hyperplasia of Prostate	600	6,667	1,111,084	446,938	99.5	340,844
Diseases of the Skin and Subcutaneous Tissue (MDC 12)	680-709	63,096	6,500,033	3,483,152	99.3	2,616,036
Other Dermatoses	702	26,309	1,714,062	967,249	98.8	706,814
Chronic Ulcer of Skin	707	9,539	1,678,568	815,770	99.9	639,829

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 2010

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	251,473	$42,268,347	$15,347,010	99.1	$11,802,155
Rheumatoid Arthritis and Ofher Inflammatory Polyarthrophathies	714	9,102	1,994,655	1,069,338	99.7	828,846
Osteoarthrosis and Allied Disorders	715	35,735	7,515,587	2,680,341	99.5	2,064,627
Other and Unspecified Arthropathies	716	3,052	450,419	185,016	99.1	140,471
Other and Unspecified Disorders of Joint	719	43,417	3,844,548	1,795,749	99.7	1,374,104
Other and Unspecified Disorders of Back	724	44,413	8,014,439	2,624,629	99.5	2,032,032
Peripheral Enthesopathies and Allied Syndromes	726	13,365	1,752,703	632,496	99.6	479,458
Other Disorders of Soft Tissues	729	14,676	1,743,761	753,987	99.6	573,145
Non-Allopathic Lesions, Not Elsewhere Classified	739	20,864	951,405	675,194	89.8	492,488
Congenital Anomalies (MDC 14)	740-759	2,005	570,452	197,813	99.4	151,822
Symptoms, Signs, and Ill-Defined Conditions (MDC 16)	780-799	220,427	34,978,349	14,421,445	99.7	11,215,052
General Symptoms	780	46,919	7,363,012	3,186,436	99.8	2,500,042
Symptoms Involving Respiratory System and Other Chest Symptoms	786	56,398	9,358,147	3,835,331	99.8	2,966,662
Symptoms Involving Digestive System	787	16,978	2,787,429	1,076,126	99.8	840,944
Symptoms Involving Urinary System	788	12,899	1,613,314	695,661	99.5	539,953
Sudden Death, Cause Unknown	798	14	6,132	3,149	99.9	2,375
Other Ill-Defined and Unknown Causes of Morbidity and Mortality	799	5,640	1,251,063	562,370	99.9	436,696
Injury and Poisoning (MDC 17)	800-999	57,386	15,445,943	5,695,446	99.8	4,445,505
Fracture of Neck of Femur	820	3,975	1,570,524	513,709	99.9	405,673
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	V01-V82	148,079	12,558,858	5,499,593	99.3	4,486,448
Need for Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	V04	27,870	622,077	459,389	99.8	455,170
Special Investigations and Examinations	V72	6,432	525,196	223,780	99.3	178,103

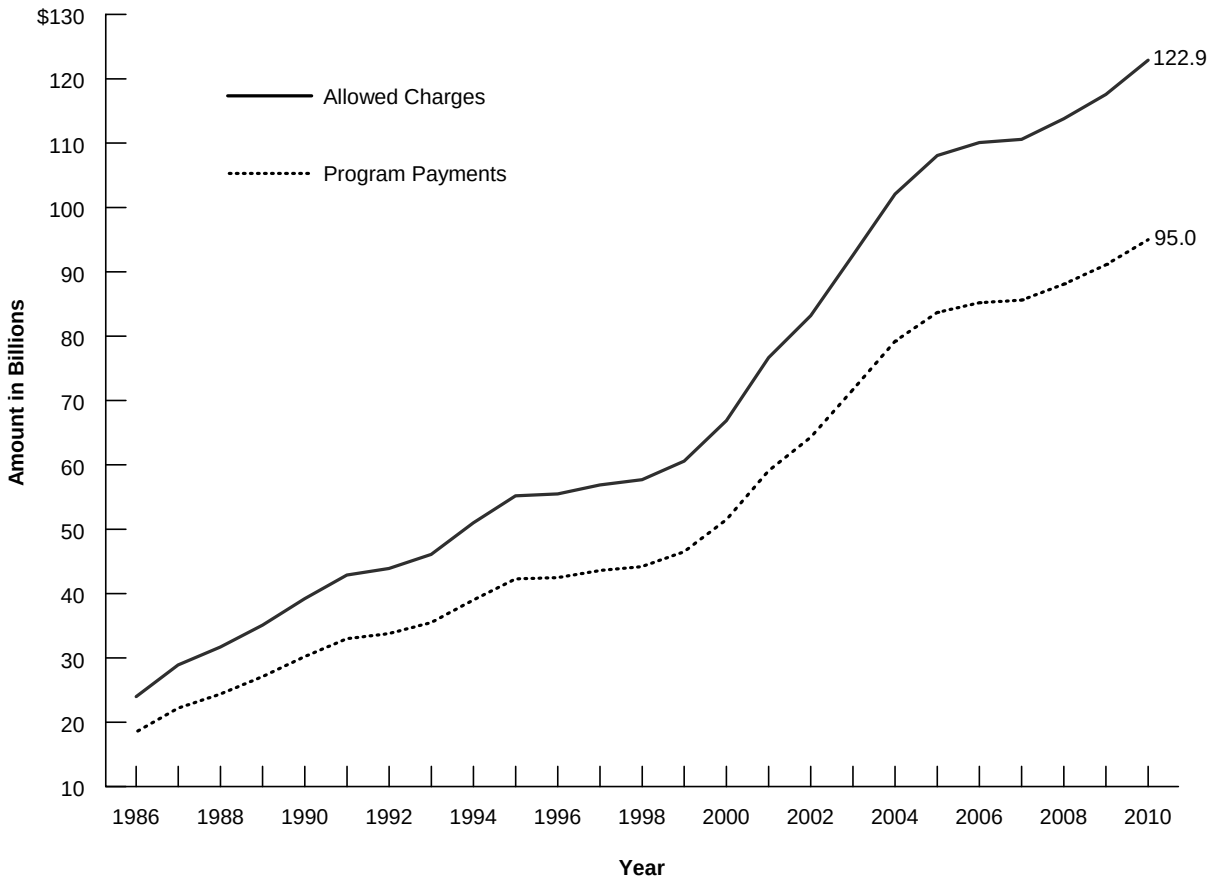
[1]ICD-9-CM is International Classification of Diseases, 9th Revision, Clinical Modification. Only the first listed or principal diagnosis has been used.

[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.

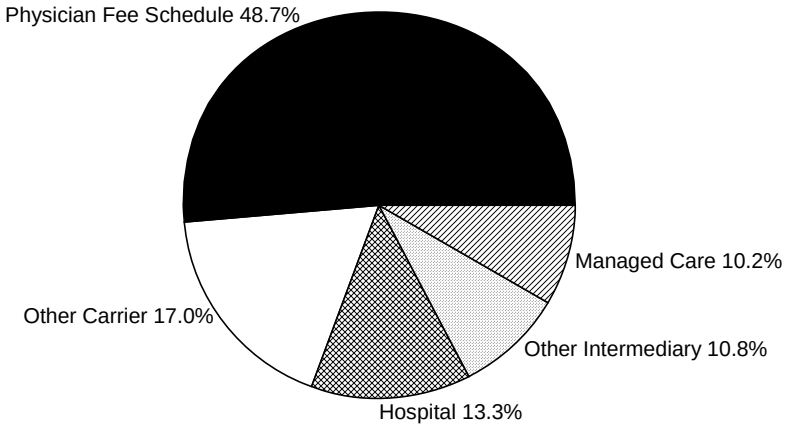
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Center for Strategic Planning.

Figure 9.1
Trends in Medicare Physician and Supplier Allowed Charges and Program Payments: Calendar Years 1986-2010



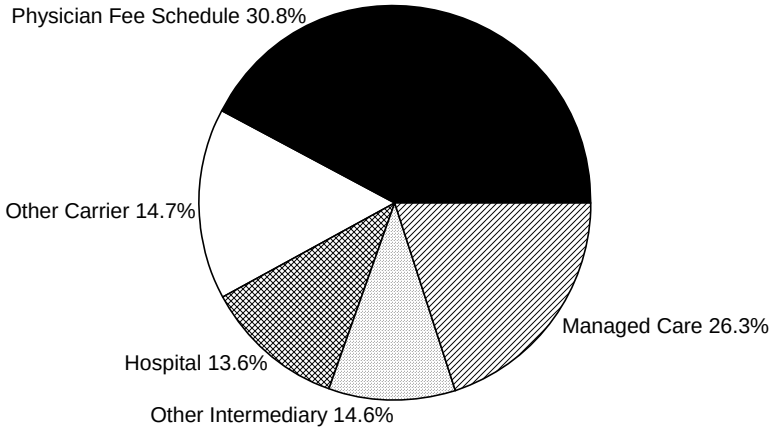
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Center for Strategic Planning. See Table 9.1.

Figure 9.2
Distribution of Medicare Supplementary Medical Insurance Benefit Payments, by Type of Provider: Calendar Years 1995 and 2010



1995

(Total Benefit Payments = $65.0 Billion)



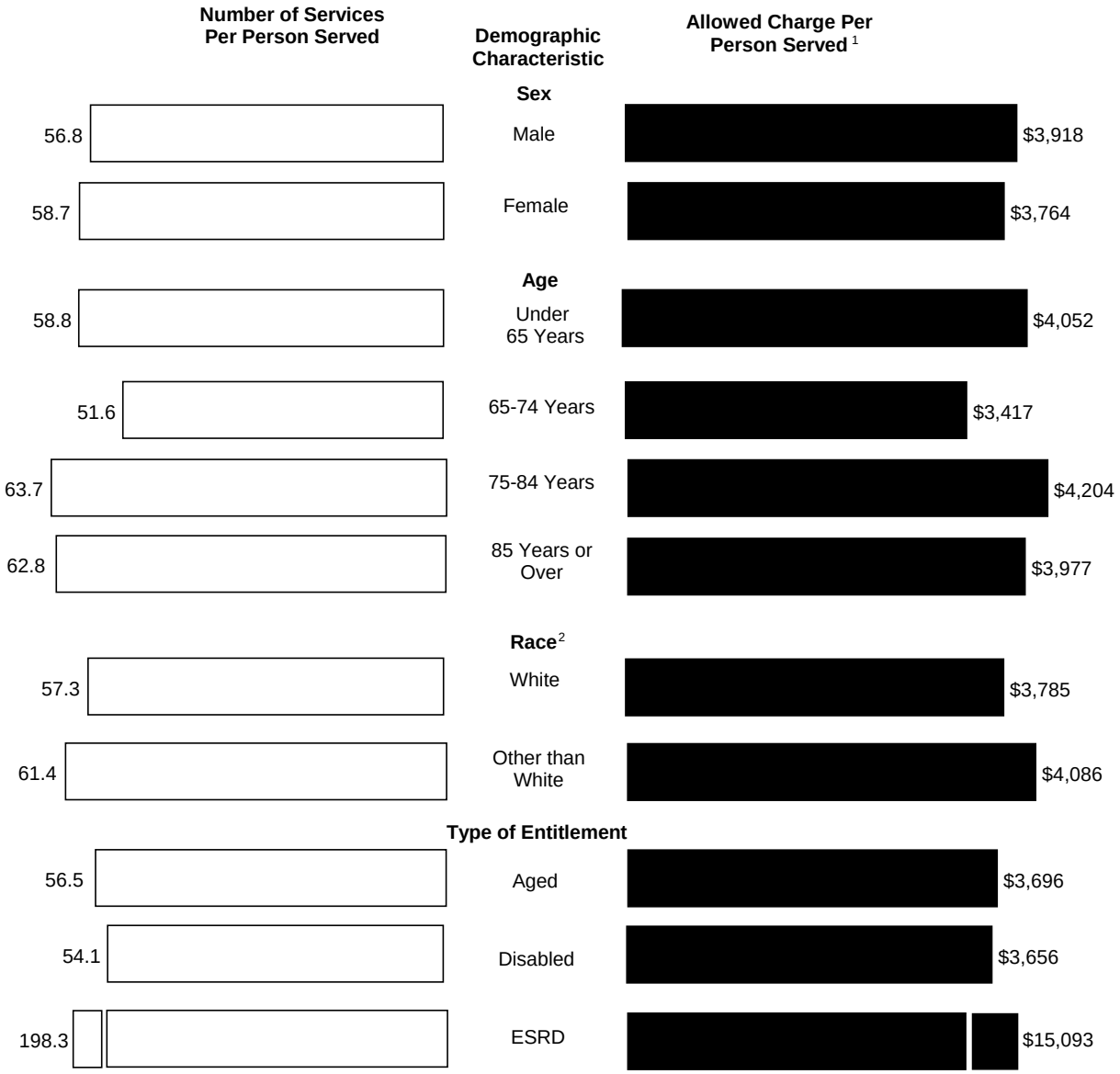
2010

(Total Benefit Payments = $209.5 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 Center for Strategic Planning.

Figure 9.3
Number of Medicare Physician and Supplier Services, and Allowed Charges per Person Served, by Selected Demographic Characteristics: Calendar Year 2010

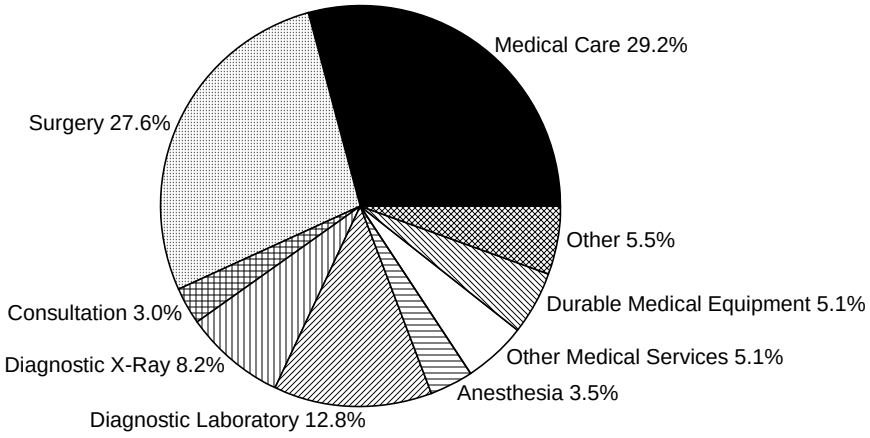


[1] Includes beneficiaries who received covered services, but for whom no program payments were reported during the year.
[2] Excludes unknown race.

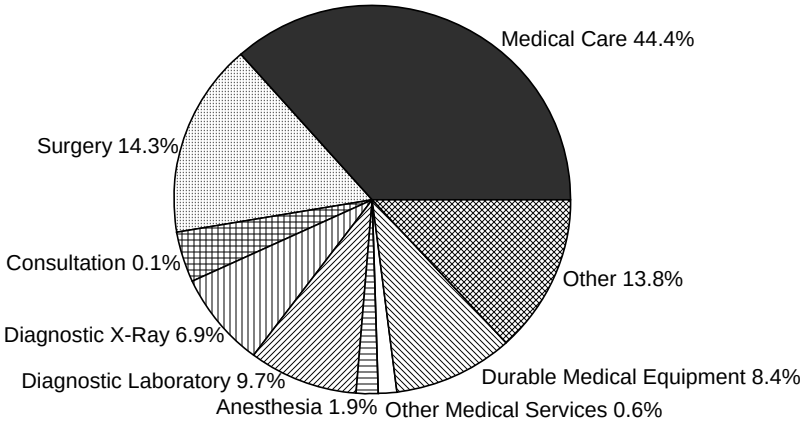
NOTE: ESRD is end stage renal disease.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Center for Strategic Planning. See Table 9.2.

Figure 9.4
Percent Distribution of Medicare-Allowed Charges for Physician and Supplier Services, by Type of Service: Calendar Years 1990 and 2010



1990
(Total Allowed Charges = $37.4 Billion)

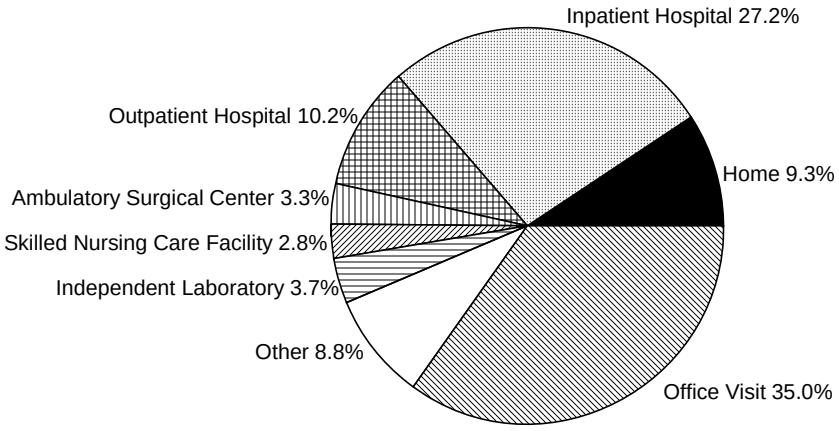


2010
(Total Allowed Charges = $122.9 Billion)

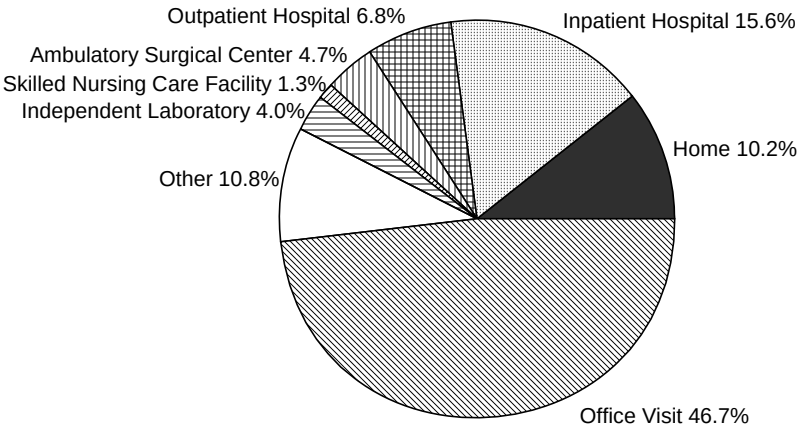
NOTE: Other includes ambulatory surgery center services, therapeutic radiology, psychological therapy assistance at surgery, etc.

SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Center for Strategic Planning. See Table 9.3.

Figure 9.5
Percent Distribution of Medicare-Allowed Charges for Physician and Supplier Services, by Place of Service: Calendar Years 1995 and 2010



1995
(Total Allowed Charges = $55.2 Billion)

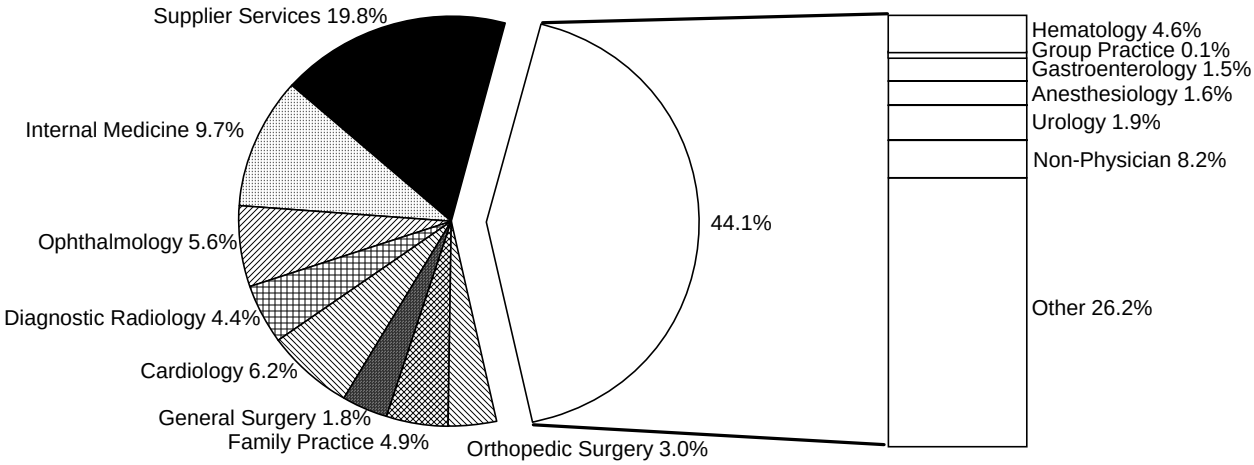


2010
(Total Allowed Charges = $122.9 Billion)

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 Center for Strategic Planning. See Table 9.4.

Figure 9.6
Percent Distribution of Medicare-Allowed Charges for Selected Physician and Related Services, by Type of Physician Specialty: Calendar Year 2010

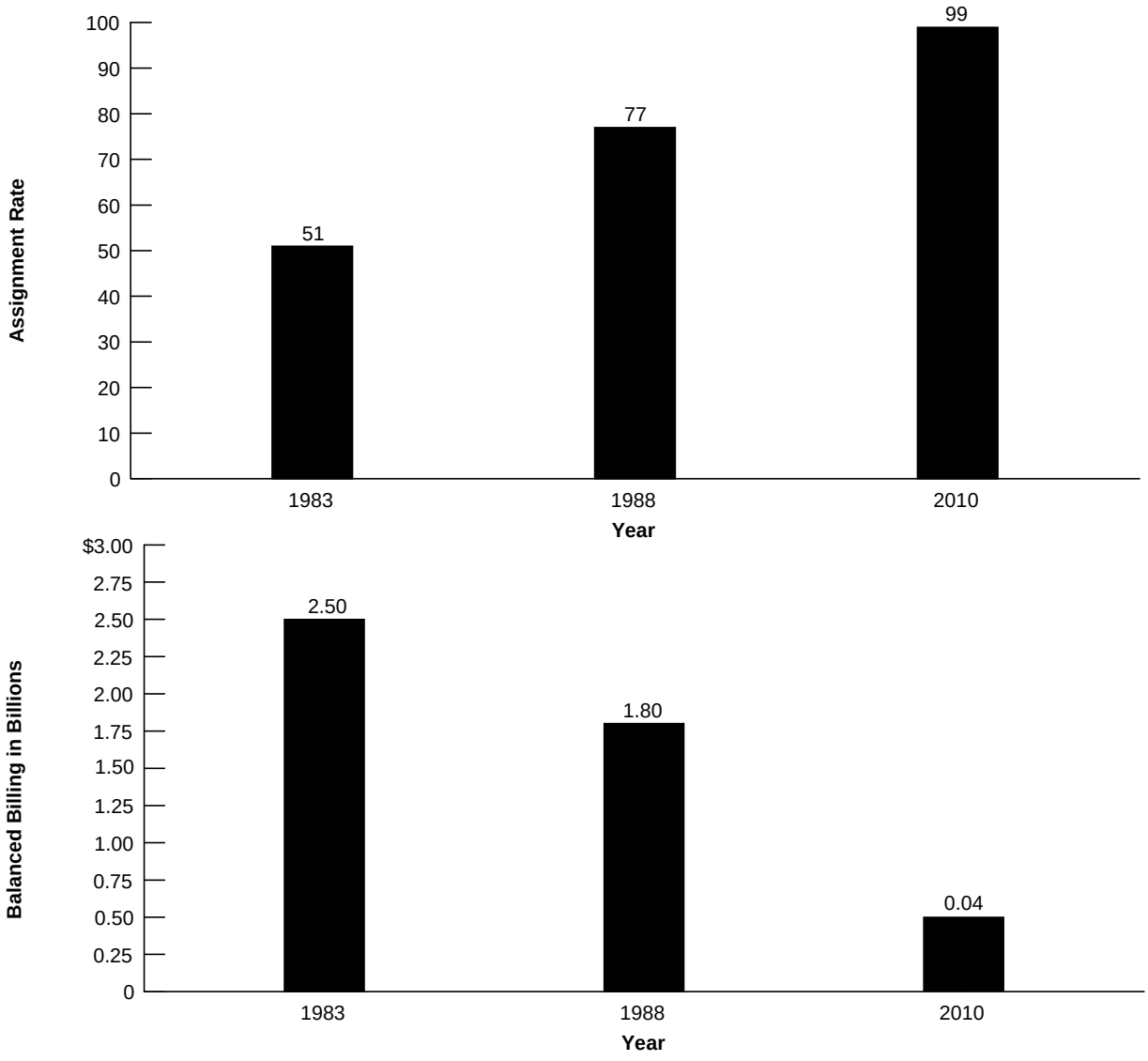


(Total Allowed Charges=$122.9 Billion)

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

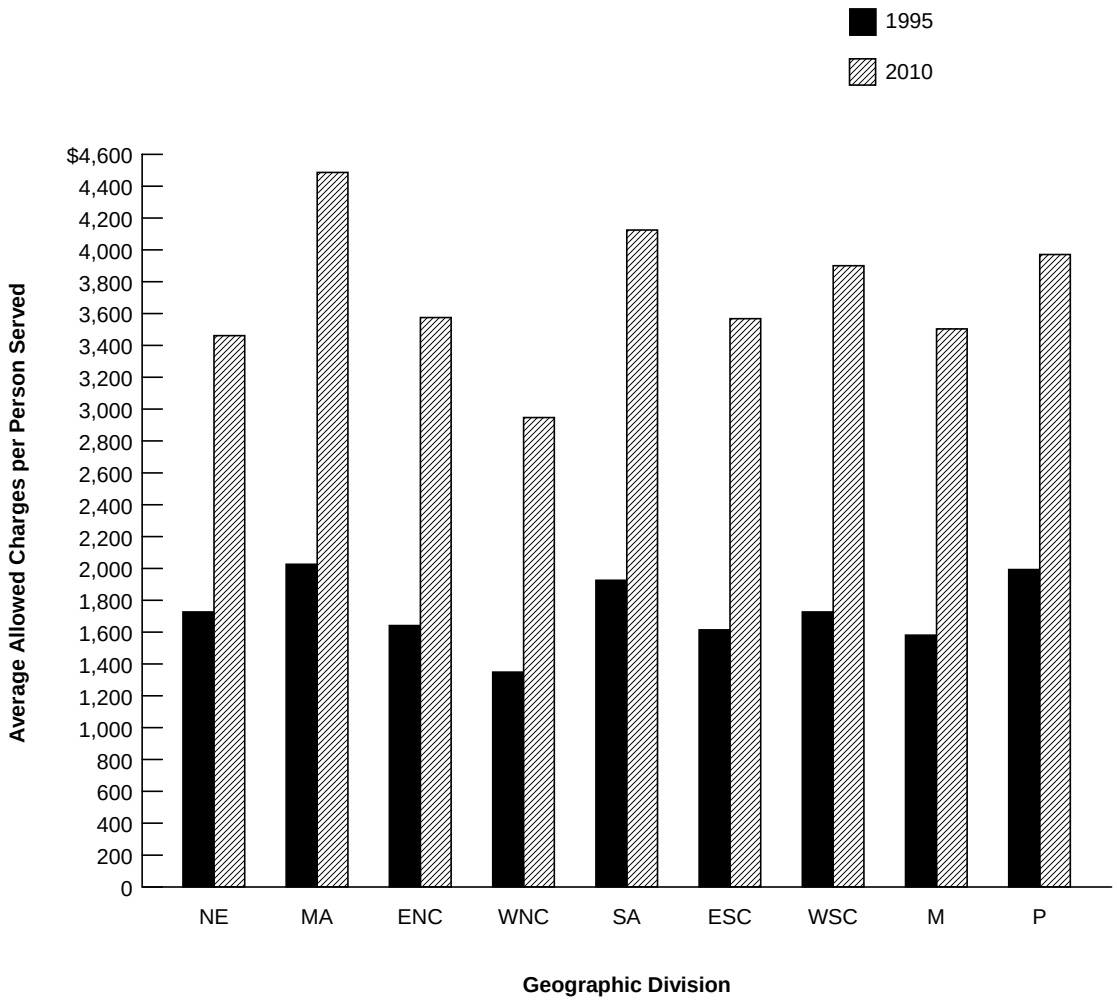
SOURCE: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Center for Strategic Planning. See Table 9.5.

Figure 9.7
Trends in Medicare Assignment Rates and Amount of Balanced Billing: Selected Calendar Years 1983, 1988, and 2010



SOURCES: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Standard Analytical Files; data development by the Center for Strategic Planning. See Table 9.6.

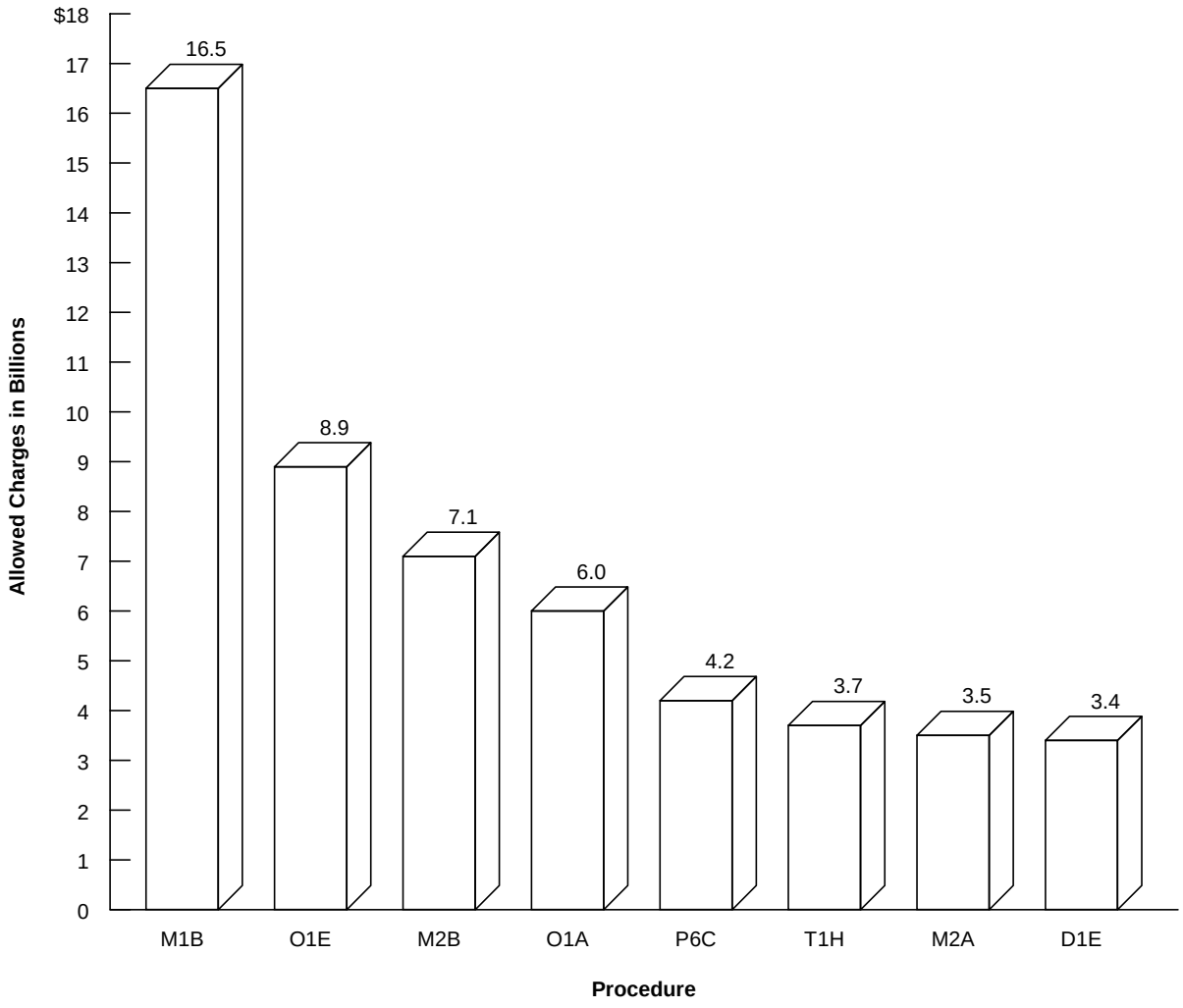
Figure 9.8
Average Allowed Charges per Person Served for Medicare Physician and Supplier Services, by Geographic Division: Calendar Years 1995 and 2010



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 Center for Strategic Planning. See Table 9.6.

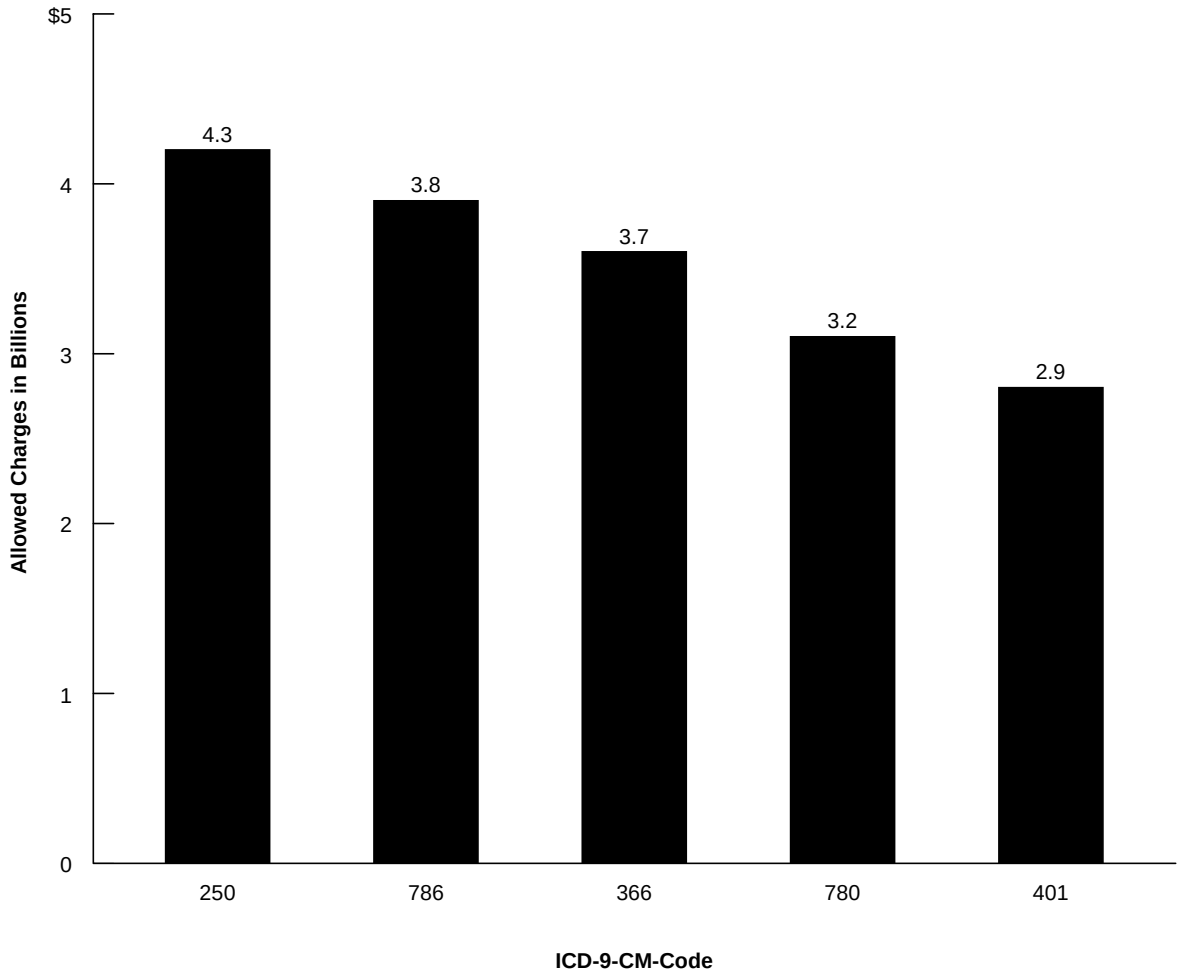
Figure 9.9
Leading Medicare Physician and Supplier BETOS Procedures, Based on Allowed Charges: Calendar Year 2010



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; P6C--minor procedures, other (medicare fee schedule); T1H--lab tests, other (non-medicare fee schedule); M2A--hospital visits, initial; 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 Center for Strategic Planning. See Table 9.7.

Figure 9.10
Leading Medicare Physician and Supplier Principal Diagnoses, Based on Allowed Charges: Calendar Year 2010



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 Center for Strategic Planning. See Table 9.8.