UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

APR 11 2014

The Honorable Carl Levin
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report responds to House Report 113-102, Page 178, accompanying H.R. 1960 of the National Defense Authorization Act for Fiscal Year (FY) 2014. The report describes TRICARE's policies and procedures related to the use of ancillary services through referrals by TRICARE providers. It also presents the level of TRICARE expenditures for ancillaries and an analysis of the use of ancillary services during the FY 2007-2013 period.

The report details TRICARE policies and procedures (utilization controls, pre-authorizations, financial incentives, provider profiling, and unit price controls) used to control the cost of ancillary services. We also report the associated use of ancillary services during the FY 2007-2013 period, which revealed the use and costs of advanced imaging services and other radiology services have declined during the FY 2007-2013 period. When comparing the TRICARE and Medicare utilization trends from 2007-2011, TRICARE's per capita trend in the use of radiology services is lower than Medicare's. In addition, the TRICARE radiology trend has continued to decline after 2011. Even though the Managed Care Support Contractors (MCSCs) are not pre-authorizing radiology services, TRICARE radiology costs have actually decreased since FY 2007. There has been increased use of physical therapy services over the FY 2007-2013 period. One of the MCSCs, United, started requiring prior authorization for physical therapy services in the middle of FY 2013, but it is too early to tell what effect that effort will have on physical therapy use and costs. We will monitor physical therapy referrals for possible change to TRICARE policy. A similar letter has been sent to the Chairman of the House Armed Services Committee.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

APR 11 2014

The Honorable Howard P. "Buck" McKeon
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed report responds to House Report 113-102, Page 178, accompanying H.R. 1960 of the National Defense Authorization Act for Fiscal Year (FY) 2014. The report describes TRICARE's policies and procedures related to the use of ancillary services through referrals by TRICARE providers. It also presents the level of TRICARE expenditures for ancillaries and an analysis of the use of ancillary services during the FY 2007-2013 period.

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

APR 11 2014

The Honorable Barbara A. Mikulski
Chairwoman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Madam Chairwoman:

The enclosed report responds to House Report 113-102, Page 178, accompanying H.R. 1960 of the National Defense Authorization Act for Fiscal Year (FY) 2014. The report describes TRICARE's policies and procedures related to the use of ancillary services through referrals by TRICARE providers. It also presents the level of TRICARE expenditures for ancillaries and an analysis of the use of ancillary services during the FY 2007-2013 period.

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Richard C. Shelby
Vice Chairman

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

APR 11 2014

The Honorable Harold Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed report responds to House Report 113-102, Page 178, accompanying H.R. 1960 of the National Defense Authorization Act for Fiscal Year (FY) 2014. The report describes TRICARE's policies and procedures related to the use of ancillary services through referrals by TRICARE providers. It also presents the level of TRICARE expenditures for ancillaries and an analysis of the use of ancillary services during the FY 2007-2013 period.

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

Report to Congress

The Department of Defense

Ancillary Services

Report to Congress and Defense Committees

Requested by: The House Armed Services Committee (HASC) Report 113-102, Pg. 178, National Defense Authorization Act (NDAA) for Fiscal Year 2014

The estimated cost of report or study for the Department of Defense is approximately $4,810 for the 2014 Fiscal Year. This includes $0 in expenses and $4,810 in DoD labor.

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INTRODUCTION

The enclosed report responds to House Report 113-102, Page 178, accompanying H.R. 1960, of the National Defense Authorization Act for Fiscal Year (FY) 2014. The committee documented a concern with the long term viability of the TRICARE benefit for service members and their families. In that regard the committee is committed to ensuring that adequate protections are in place to make certain that the Department of Defense (DoD) is not paying excessive costs for ancillary services through referrals by TRICARE providers. Therefore, the committee requested the Secretary, no later than April 1, 2014, to submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the policies and procedures in place to avoid paying excessive costs for provider referred ancillary services under TRICARE and the effectiveness of such policies and procedures in avoiding excessive costs.

BACKGROUND

During the past 15 years the rapid growth in ancillary services had led to concerns about the appropriate use of these services in the Medicare program and employer-sponsored health plans. Ancillaries are typically defined to include radiology services, diagnostic tests, therapy services (physical, speech, and occupational), and clinical laboratory services. A major concern has been that physicians refer patients to entities such as radiology centers in which the provider has a financial relationship. In response to this concern and the growing cost of ancillary services in the Medicare program, the Congress established statutory provisions, known as the Ethics in Patient Referrals Act, also known as the Stark law, to prohibit physicians from referring Medicare patients to entities with which they have a financial relationship. An exception in the law allows Medicare physicians to provide most ancillary services in their own offices under specified conditions.

The Medicare Payment Advisory Commission (MedPAC), the organization that advises the Congress on Medicare, has analyzed a number of options to help control the use of ancillaries in Medicare, including changes to the Stark law about the types of ancillary services that could be performed in physician offices, reducing Medicare payment rates for diagnostic tests performed by self-referring physicians, and requiring physicians to obtain prior authorization before performing certain ancillary services.[1] A particular focus of attention by MedPAC and the Government Accountability Office (GAO) has been on the use of advanced imaging services, such as Magnetic Resonance Imaging (MRI) and Computed Tomography Scans (CT-scans), which have increased very rapidly over the past 15 years.

Commercial health insurance plans grapple with some of the same issues as Medicare and have developed procedures to control the cost of ancillaries, particularly radiology and physical therapy services. Employer-sponsored health insurance providers often use mandatory pre-authorization requirements to decrease unnecessary utilization of some ancillary services, particularly advanced imaging services. Because advanced imaging procedures are often quite expensive and may be used inappropriately, pre-authorization for these types of services ensures appropriateness in use and reimbursement. However, pre-authorization can be difficult to implement and administer, and employer-sponsored plans have implemented

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[1] MedPAC, Report to Congress: Aligning Incentives in Medicare, June 2010.

alternative approaches including focused utilization initiatives such as provider-level monitoring and scorecards, as well as enabling payer-provider collaboratives to implement decision-support tools for clinical practice and appropriate use. These clinical decision-support tools include computerized alerts and reminders to care providers and patients; clinical guidelines; condition-specific order sets; focused patient data reports and summaries; documentation templates; diagnostic support; and contextually relevant reference information.

After many years of rapid growth, it appears that there has been a recent slowdown in the rate of increase in the use and cost of advanced medical imaging services, including CT scans and MRIs among both Medicare and commercially insured non-elderly populations. An analysis of this slowdown and its potential causes suggest this decline is due to several major factors: 1) expansion of prior authorization requirements by commercial insurers for most advanced imaging services; 2) increased patient cost sharing required by commercial health plans; 3) reduced reimbursement by Medicare for images in physician offices and freestanding imaging centers; and 4) increased recognition by both providers and patients of advanced imaging procedures with unproven medical value.[2] Although most TRICARE eligible beneficiaries have not been directly affected by prior authorization requirements and increased cost sharing for ancillary services, the forces described above have probably had an impact on provider practice patterns for all patients, regardless of payer. Another force affecting use of radiology services is the effort by different physician groups to identify services which are inappropriate/ineffective, such as the "Choosing Wisely" initiative of the American Board of Internal Medicine (ABIM) Foundation. For this initiative, several specialty societies have identified a number of specific radiology services that are overused. The effect to educate consumers and providers about these specific procedures may have also helped to reduce the use of radiology procedures in recent years.

TRICARE POLICIES AND PROCEDURES

TRICARE has a variety of policies and procedures used to control the cost of ancillary services. The measures that affect the levels of utilization of services and their unit costs are discussed separately.

Utilization Controls. The primary mechanism to control utilization of services by TRICARE beneficiaries is through the referral requirements in TRICARE Prime.[3] The Managed Care Support Contractors (MCSCs) control the use of ancillary services through ***Primary Care Manager (PCM) referral requirements*** for the 3.3 million Prime enrollees and the 1.4 million Active Duty Service Member (ADSM) beneficiaries. For all ADSMs and Active Duty Family Member (ADFM) and Non-Active Duty Dependent (NADD) TRICARE Prime enrollees, each MCSC requires a referral before a beneficiary can seek care for any diagnostic service or treatment not provided by a PCM.[4] These PCM referral requirements for ADSMs and Prime enrollees are designed to control unnecessary use of services by ensuring that beneficiaries have approval from their PCM before receiving care from a specialist or receiving ancillary services.

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[2] Lee, DW and Levy F (2012). The sharp slowdown in growth of medical imaging: an early analysis suggests combination of policies was the cause. *Health Affairs*, 31,8: 1876-1884.

[3] Of the 6.8 million non-Medicare beneficiaries who lived in the U.S. in FY13 who were eligible for TRICARE, about 3.3 million were enrolled in TRICARE Prime and 1.4 million were Active Duty Service Members (ADSMs). The remaining 2 million non-enrolled non-Medicare beneficiaries used TRICARE Standard (non-network) or Extra (network) providers or relied on other health insurance.

[4] TRICARE Prime Remote Active Duty Family Members and TRICARE Young Adult Prime beneficiaries must also have a referral.

However, once a referral from the PCM is approved, there are no further restrictions on the use of services ordered by the specialty provider, except that the services must be medically necessary and appropriate. For example, a beneficiary could be referred by either his civilian PCM or Military Treatment Facility (MTF) PCM to an orthopedic surgeon for a follow-up visit. In this case, the orthopedic surgeon could order ancillary services without any further approvals.[5] This is allowed to reduce administrative burdens which may prevent our beneficiaries' timely access to needed care.

TRICARE does mandate that some types of civilian care and services require a ***pre-authorization*** from the MCSCs in addition to a referral. For example, ADSMs are required to obtain prior authorization approval from the MTF to which they are enrolled, the Military Service Point of Contact if not enrolled to an MTF, and/or the MCSC for any civilian-provider care. Certain TRICARE services must be pre-authorized, such as some mental health and substance abuse services, organ transplants, adjunctive dental care, and some home infusion services. However, TRICARE does not require prior authorization for any standard imaging, advanced imaging, or physical therapy services. The TRICARE MCSCs are allowed to add pre-authorization requirements. Some require pre-authorization for bariatric surgery, home care services, and others. Only one MCSC, United West, requires prior authorization for any ancillary services. United requires it for some speech therapy services, physical therapy, and occupational therapy, but not for radiology services. In contrast, the six Uniformed Services Family Health Plan (USFHP) plans require both referrals for ancillary services and prior authorization for advanced imaging and physical therapy services. Most of the USFHP plans do not require prior authorization for standard imaging.

Even though the TRICARE MCSCs do not require prior authorizations for the vast majority of ancillary services for their TRICARE beneficiaries, all of them have implemented prior authorization requirements in their commercial plans for outpatient advanced imaging services and some other ancillary services, such as sleep studies and physical therapy/occupational therapy. For example, United Healthcare's commercial benefit plans include advanced notification/prior authorization requirements for CT, MRI, Positron Emission Tomography (PET) scans, and nuclear medicine procedures, where the physician/healthcare professional ordering the service is required to get an authorization number prior to scheduling the procedure. HealthNet has similar requirements for many of its commercial plans and contracts with a third-party company to manage this administrative process. This may affect provider practice patterns for all beneficiaries, including TRICARE beneficiaries.

TRICARE also maintains a list of "Questionable Covered Services" subject to review by the MCSCs for reimbursement. This list includes some advanced imaging ancillary procedures, but it is unclear how often this list is used by the MCSCs to review the utilization of these services.

The USFHP plans also ***do provider profiling*** by comparing provider use of radiology and physical therapy with industry benchmarks. If providers are identified outside benchmarks, the

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[5] One feature of the Prime benefit offsets the referral mechanism: a Point of Service (POS) option which is available to ADFM and NADD Prime enrollees and allows them to self-refer to any TRICARE-authorized (network or non-network) provider for a TRICARE-covered medical/surgical or behavioral health service without a referral from their PCM or MCSC approval. However, the very high level of cost-shares in the POS option deters non-referred use of care among Prime beneficiaries who normally have no cost-shares for ancillary services obtained with a referral. The POS option is not available to ADSMs.

information is shared with the provider and the provider is educated. The MCSCs do not have formal provider profiling.

Three ***financial incentives*** in the MCSC contracts also have an impact on the utilization of ancillary services. First, the MCSCs have an incentive to ensure that civilian PCMs refer care to network providers due to a contract incentive in the TRICARE Third Generation (T3) contracts related to network provider discounts. For all beneficiaries (Prime and Standard), the MCSCs receive 10 percent of all provider discount savings above a government-set threshold. Thus, the more care provided by network providers who offer discounts, the greater the incentive payments. This mechanism helps steer TRICARE beneficiaries to providers who have been selected by the MCSC to be network providers and who should be more efficient. A second financial incentive in the T3 contracts also encourages the use of network providers. If the network share of Prime claims falls below a government-specified standard, the MCSC is penalized. These two incentives encourage civilian PCMs to refer care to network providers. A third contract incentive also helps control the utilization of ancillary services for the 1.5 million Prime enrollees with civilian PCMs because the MCSCs are at financial risk for increased costs incurred by civilian-PCM Prime enrollees. Each year, each MCSC's actual trend in the costs for civilian-PCM Prime enrollees is compared to the per capita trend reported in the National Health Expenditures accounts. If the MCSC's cost trend is higher than the national standard, the contractor is responsible for 30 percent of the remaining trend differential. Recognizing that MCSCs do not have as much control over the utilization of services by MTF Prime enrollees and Standard beneficiaries, there is no financial risk in the T3 contracts for the cost trends for the other 5.3 million beneficiaries. Thus, the three T3 contract provisions provide incentives for controlling the level of ancillary services use, particularly for civilian Prime enrollees. The incentives are much weaker for Standard beneficiaries and for MTF-PCM enrollees and ADSMs. In contrast, the USFHP plans are at 100 percent risk for healthcare costs because they receive a fixed capitation payment with no risk sharing or other financial incentives. This provides a very strong financial incentive for the USFHPs to control the utilization and costs of ancillary services.

Unit price controls. TRICARE does have tight controls on the unit prices paid for ancillary services. TRICARE beneficiaries who are referred to providers who order ancillary tests for these beneficiaries typically receive these services either in a physician's office, radiology center, or hospital outpatient department (HOPD). TRICARE has unit price controls in all these settings:

- First, the maximum payment for ancillary services in physician offices and freestanding radiology centers is established through the TRICARE CHAMPUS Maximum Allowable Charge (CMAC) system, and HOPD prices are established by the TRICARE Outpatient Prospective Payment System (OPPS) payment system. The TRICARE maximum payment levels are equal to the Medicare payment levels and are typically about 15-30 percent below the level of commercial payments.

- Second, many civilian providers of ancillary services are network providers who provide discounts. These network providers give discounts to TRICARE and, as a result, TRICARE pays even less than Medicare for these ancillary services. As discussed above, the MCSCs have an incentive to steer patients to network providers

because of the financial incentives in the MCS contracts for increased discounts and the use of network providers.

The linkage of these TRICARE payment mechanisms to Medicare pricing has been advantageous for TRICARE. In recent years, Congress mandated that no imaging study in a physician's office should be paid more by Medicare than Medicare would have paid for that study in an HOPD. In addition, in recent years Centers for Medicare & Medicaid Services (CMS) has reduced the prices paid under Medicare for certain advanced imaging procedures. For example, payment for a very common TRICARE MRI code (Current Procedural Terminology code 73721) was reduced by 30 percent from 2011-2012. Because TRICARE's physician pricing is based on the Medicare fee schedule prices, these Medicare changes have also been implemented by TRICARE.

FINDINGS

As discussed above, there are concerns about an inappropriately high level of use of ancillary services in Medicare and other health programs. In the Medicare program, much of this concern relates to the use of advanced imaging services, such as MRIs, CT-scans, and PET scans. To determine whether a problem exists in the TRICARE program, we analyzed FY13 data and found that for the 6.8 million ADSMs, ADFMs, and NADDs who live in the United States and who are not eligible for Medicare, TRICARE paid about $1.6 billion for referred ancillary services in FY13. This is equal to about $230 per eligible beneficiary. About 60 percent of these amounts are purchased care. We included the costs in both direct care and purchased care for ADSMs, ADDs, and NADDs, but excluded TRICARE for Life (TFL) beneficiaries. We included ancillary costs in physician offices, freestanding radiology centers, and HOPDs, but excluded the cost of ancillary services in inpatient and Emergency Room (ER) settings because ancillaries in these settings are typically not related to provider referrals. We defined ancillaries to include radiology services (advanced imaging, ultrasounds, and standard imaging), physical therapy, and sleep studies. We further subdivided advanced imaging into three subgroups: 1) MRIs; 2) CT-scans; and 3) nuclear medicine.

TRICARE costs for ancillary services have increased by less than 2 percent per year from FY 07-13. We found that TRICARE costs for advanced imaging decreased by over 25 percent from FY 07-13, while TRICARE's expenditures for physical therapy and sleep studies almost doubled over this period (see Table 1 and Figure 1).

We found that most of the change in TRICARE costs was due to changes in the utilization of services rather than changes in the cost per service (see Table 2). We found that the cost per service for each of the five categories of ancillaries increased by 13-18 percent from FY 07-13, an average of about 2-3 percent per year. Utilization trends varied widely over the FY 07-13 period, with the use of radiology services declining in all three types of radiology (advanced imaging, ultrasound, and standard imaging). The use of physical therapy and sleep studies increased very rapidly during this period.

Radiology: We focused on radiology and found that TRICARE beneficiaries received about 7 million radiology services in physician offices, HOPDs, or freestanding imaging centers in FY13, or about one radiology service per beneficiary (see Table 3). We found that:

- Each of the four major groups of TRICARE beneficiaries received about 0.2-0.3 radiology services per Evaluation and Management (E&M) visit (see Table 3).

- Due to their older age and higher disease burden, NADD Prime enrollees had the most radiology services per E&M visit (0.31).

- The number of radiology services per E&M visit increases with age, particularly for women (due largely to the increase in mammogram screenings for women age 45 and over)(see Figure 2).

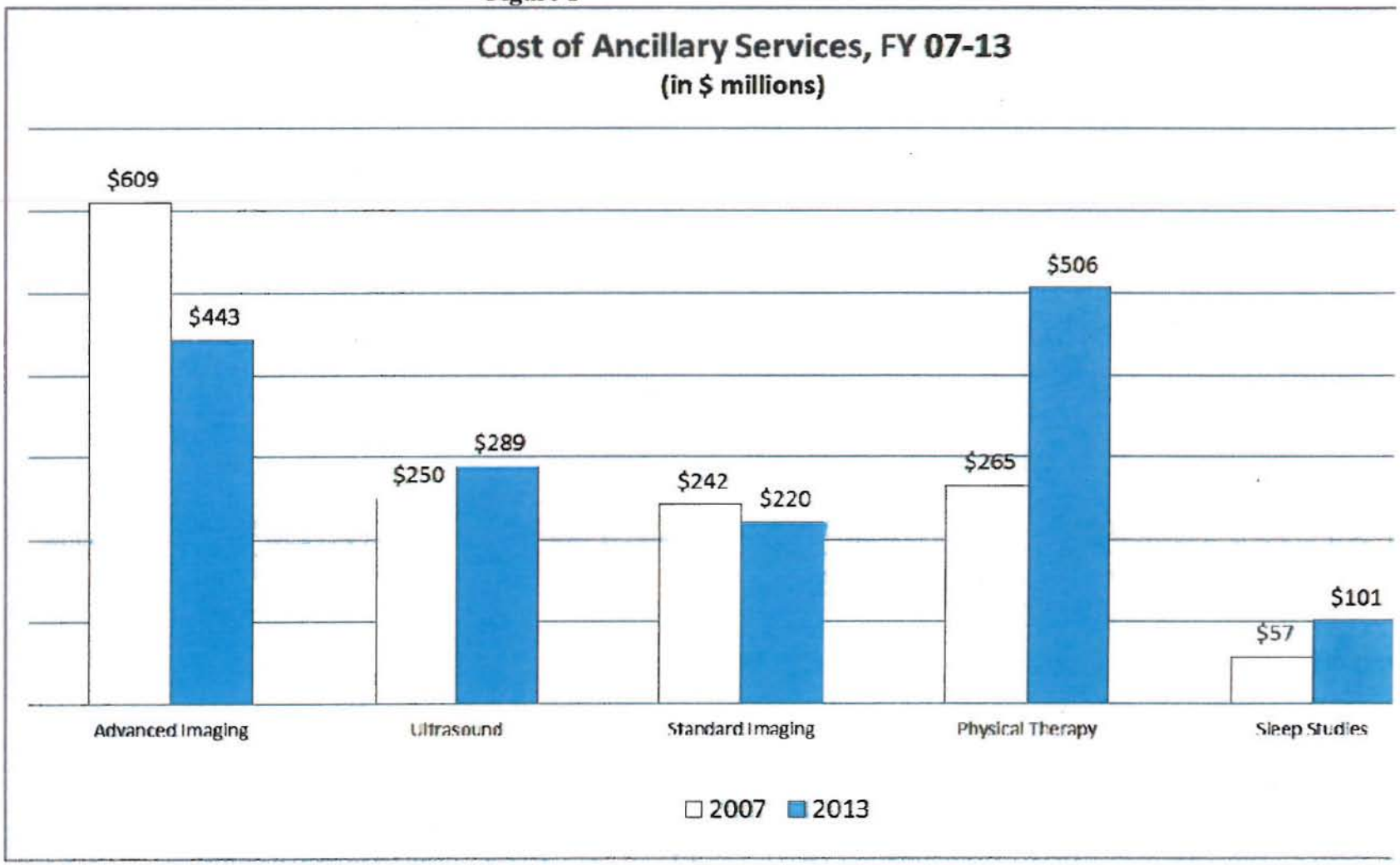
Advanced Imaging: We specifically analyzed the use of advanced imaging services (e.g., MRIs, CT-scans, and PET-scans) and found that use also increases with age. Much of the increase in the use of advanced imaging is related to the fact that older TRICARE beneficiaries have more E&M visits. For example, although the number of advanced imaging services per person is about four times as high for 55-64 year-old male NADDs as for 18-39 year-old men, the number of advanced imaging services per E&M visit is only about twice as high (see Figure 3). We also examined the use of advanced imaging services by beneficiaries in similar age and gender groups and found that the number of advanced imaging services per E&M visit was about 10-20 percent lower for TRICARE beneficiaries with civilian PCMs than for similar beneficiaries with MTF-PCMs (see Figure 3).

Table 1
Trend in TRICARE Costs for Ancillary Services, FY 07-13

Type of Ancillary Service	Costs in FY07 ($M)			Costs in FY13 ($M)			Percentage Change		
	DC	PC	TOTAL	DC	PC	TOTAL	DC	PC	TOTAL
Advanced Imaging	$258	$351	$609	$168	$275	$443	-35%	-22%	-27%
Ultrasound	$139	$111	$250	$136	$153	$289	-2%	38%	16%
Standard Imaging	$145	$96	$242	$99	$120	$219	-32%	25%	-10%
Physical Therapy	$118	$147	$265	$160	$346	$506	36%	135%	91%
Sleep Studies	$11	$46	$57	$36	$65	$101	227%	41%	77%
Totals	$671	$751	$1,422	$599	$959	$1,558	-11%	28%	10%

Note: DC is direct care, PC is purchased care. Includes costs for non-TFL ADSMs, ADDs, and NADDs. Excludes costs in inpatient and ER settings.

Figure 1



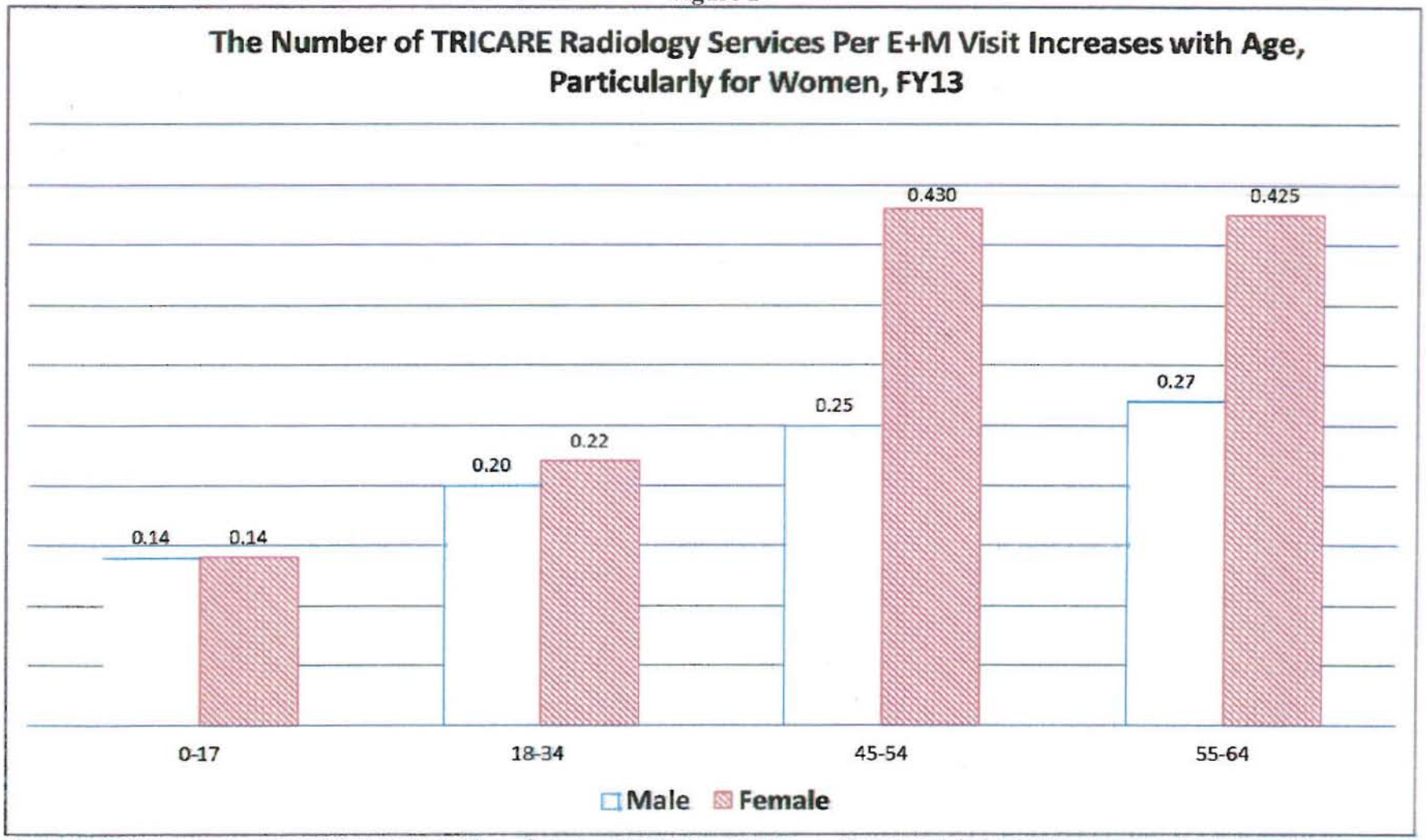
Note: Includes costs for non-TFL TRICARE beneficiaries (ADSMs, ADFMs, and NADDs) in both direct care and purchased care. Excludes inpatient and ER costs.

Table 2
Trends in Utilization and Costs Per Service for Ancillaries, FY 07-13

Type of Ancillary Service	Change in Utilization (thousands of services) FY07	FY13	% Change	Change in Cost per Service FY07	FY13	% Change	Percentage Change in Costs FY07-13
Advanced Imaging	1,818	1,165	-36%	$335	$379	13%	-27%
Ultrasound	1,994	1,973	-1%	$125	$147	18%	16%
Standard Imaging	5,069	4,048	-20%	$48	$54	13%	-9%
Physical Therapy	12,528	21,284	70%	$21	$24	14%	91%
Sleep Studies	78	120	54%	$729	$841	15%	77%

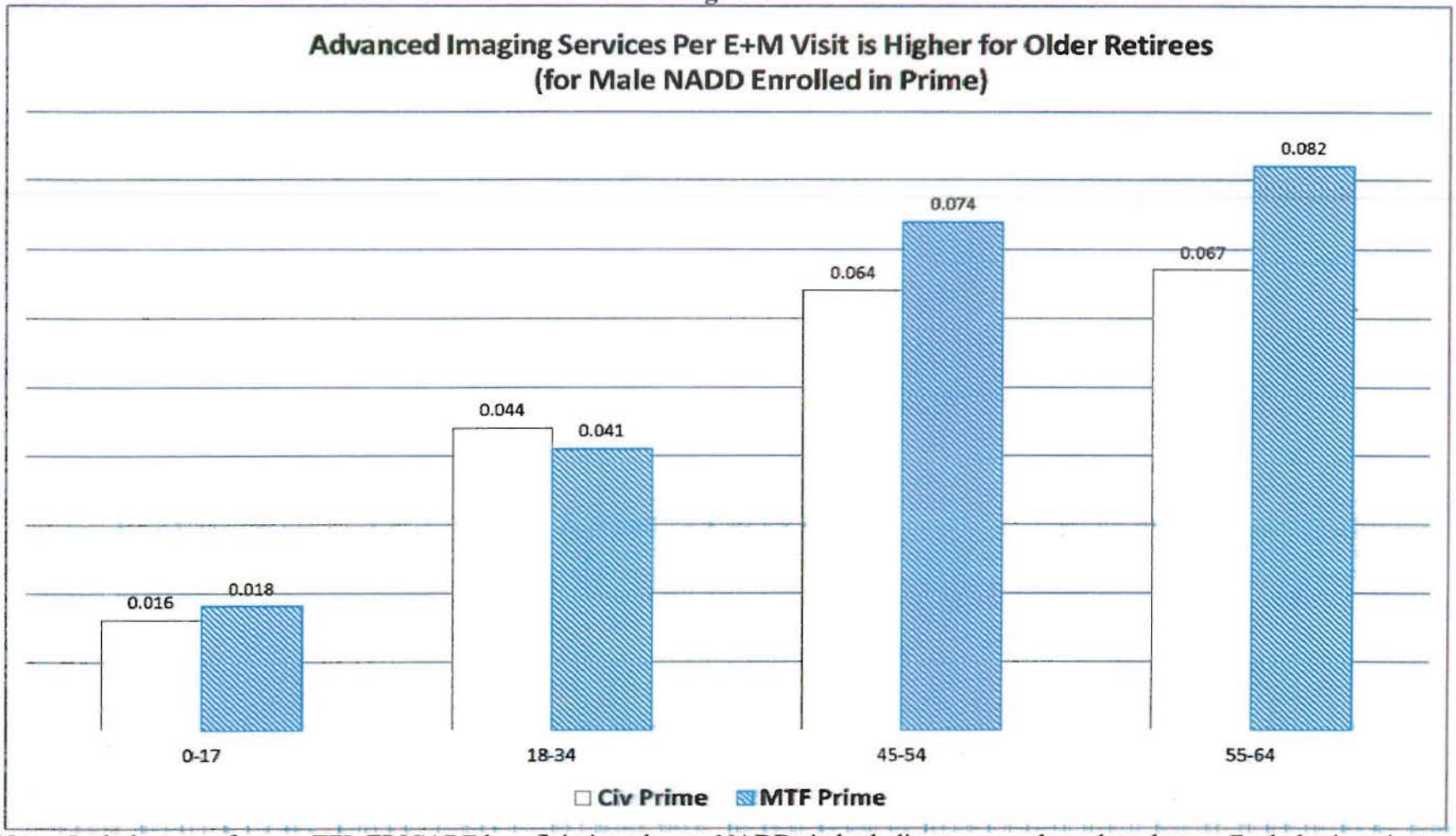
Note: Includes costs for non-TFL ADSMs, ADFMs, and NADDs in both direct and purchase care. Excludes costs in inpatient and ER settings. Physical Therapy (PT) services are typically counted in 15-minute increments. Thus, the number of PT services cannot be compared directly with the number of radiology services.

Figure 2



Note: Includes costs for non-TFL TRICARE beneficiaries (ADSMs, ADFMs, and NADDs) in both direct care and purchased care. Excludes inpatient and ER services.

Figure 3



Note: Includes costs for non-TFL TRICARE beneficiaries who are NADDs in both direct care and purchased care. Excludes inpatient and ER services.

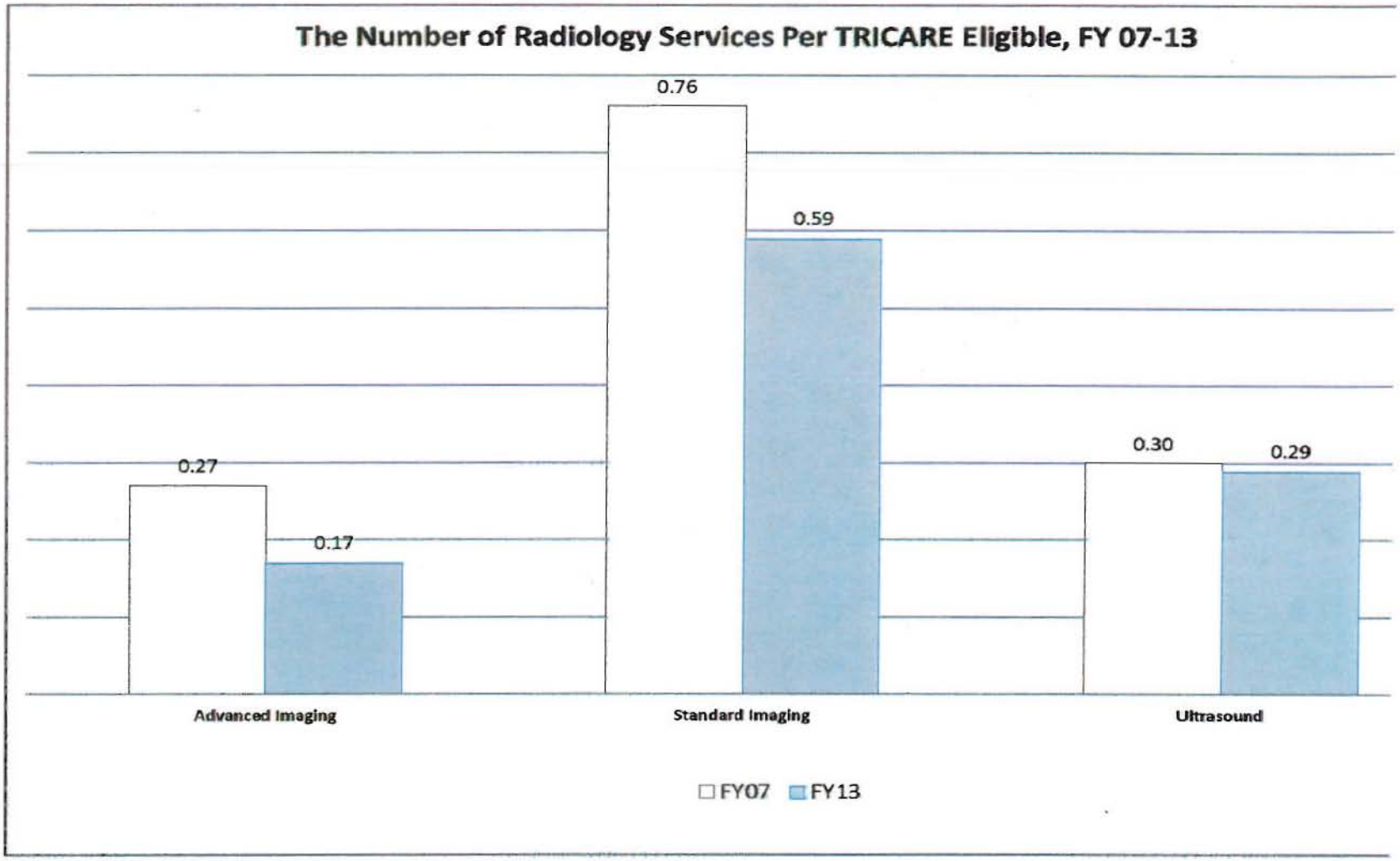
Table 3
TRICARE Radiology Services and E&M Visits in FY13
(numbers in thousands)

Bencat/Enrollment Status	Number of Non-Medicare Eligible Beneficiaries	Radiology Services	E&M Visits	Radiology Services per E&M Visit
ADSM	1,429	1,890	7,446	0.25
ADFM Prime	1,747	1,517	7,333	0.21
NADD Prime	1,596	2,250	7,175	0.31
Non-Prime	2,071	1,517	5,944	0.25
	6,843	7,174	27,898	0.26

Advanced Imaging Trends from FY 07-13: We calculated the number of ancillary services per eligible over the FY 07-13 period and found that advanced imaging services actually declined on a per eligible basis by about 40 percent. This exceeds the decline in standard imaging (about 22 percent) and for ultrasounds (less than 5 percent)(see Figure 4). The costs of advanced imaging per eligible also declined for ADSMs, ADFMs, and NADDs by 24-33 percent. As a percentage of E&M visits, the number of advanced imaging services has declined for all beneficiary categories (see Figure 5).

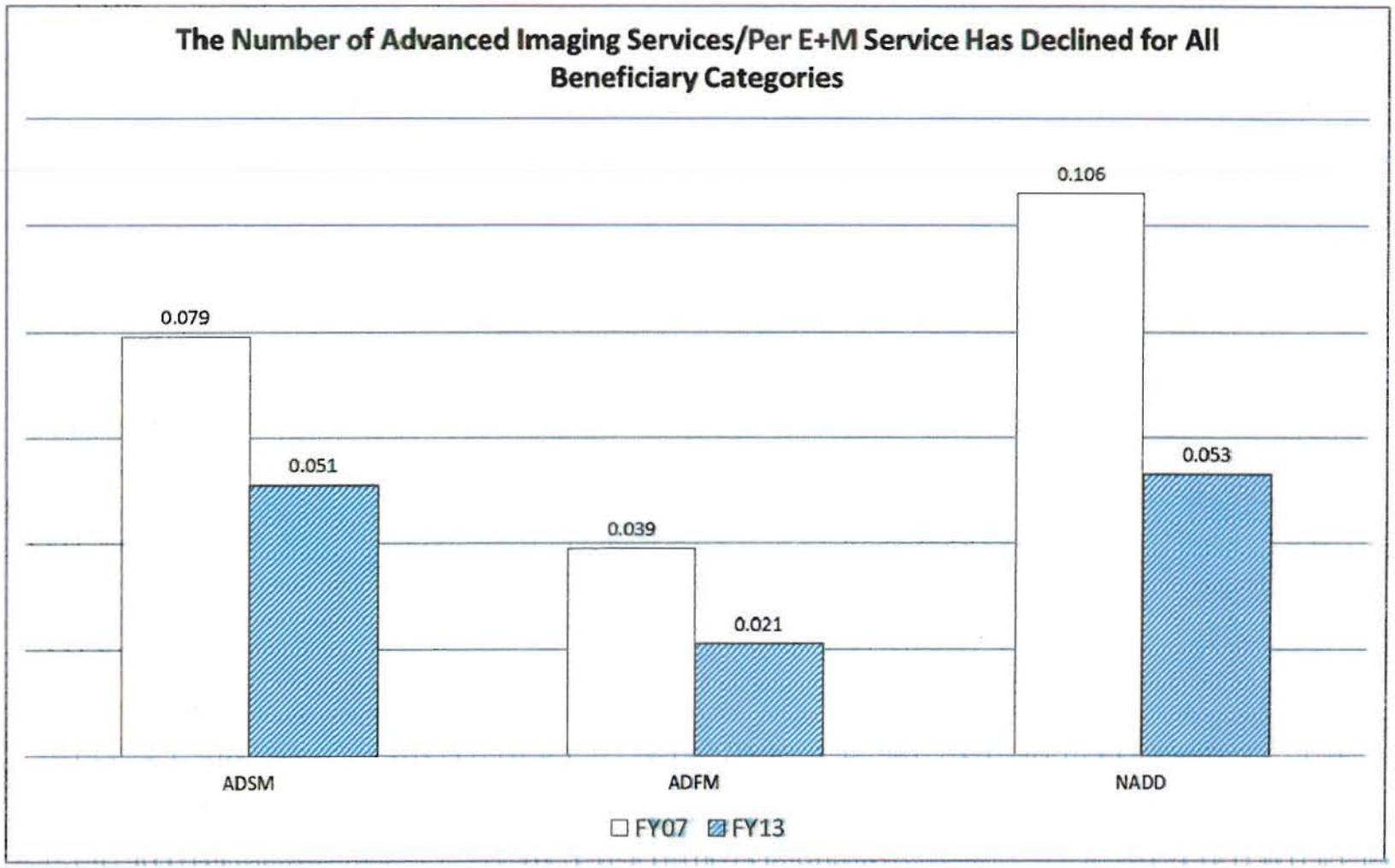
Physical Therapy: Both costs and services have increased rapidly for physical therapy over the FY 07-13 period (see Tables 1 and 3). The majority of this growth has happened in purchased care. The share of physical therapy costs in purchased care increased from 55 percent in FY 07 to 68 percent in FY 13. Physical therapy services have increased across all enrollment types and beneficiary categories. NADDs use the most physical therapy services (8.4 million services in FY 13), but ADSMs use the most physical therapy services per E&M visit (see Table 4). Although ADFMs use the least amount of physical therapy of any beneficiary category, their use is growing the fastest.

Figure 4



Note: Includes costs for non-TFL TRICARE beneficiaries (ADSMs, ADFMs, and NADDs) in both direct care and purchased care. Excludes inpatient and ER services.

Figure 5



Note: Includes costs for non-TFL TRICARE beneficiaries (ADSMs, ADFMs, and NADDs) in both direct care and purchased care. Excludes inpatient and ER services.

Table 4

Physical Therapy Services per E&M Visit by Beneficiary Category, FY 07-13

Beneficiary Category	FY07	FY13	Percent Change
ADSM	0.72	1.05	46%
ADFM	0.31	0.54	77%
NADD	0.58	0.76	31%

There are a number of reasons that may contribute to the increase in physical therapy services. In some cases, physical therapy can be used in place of more expensive interventions. There may also be a direct relationship between the declining use of advanced imaging, and the increasing use of physical therapy services.[6] Increased focus on prevention may also be leading to the increased use of physical therapy services. Physical therapy services are currently allowed under the in-office ancillary services (IOAS) exception to the Stark Law, and as such, the controls under that law may not be inhibiting the growth in physical therapy services. However, there has been some effort to remove the IOAS exception for physical therapy.

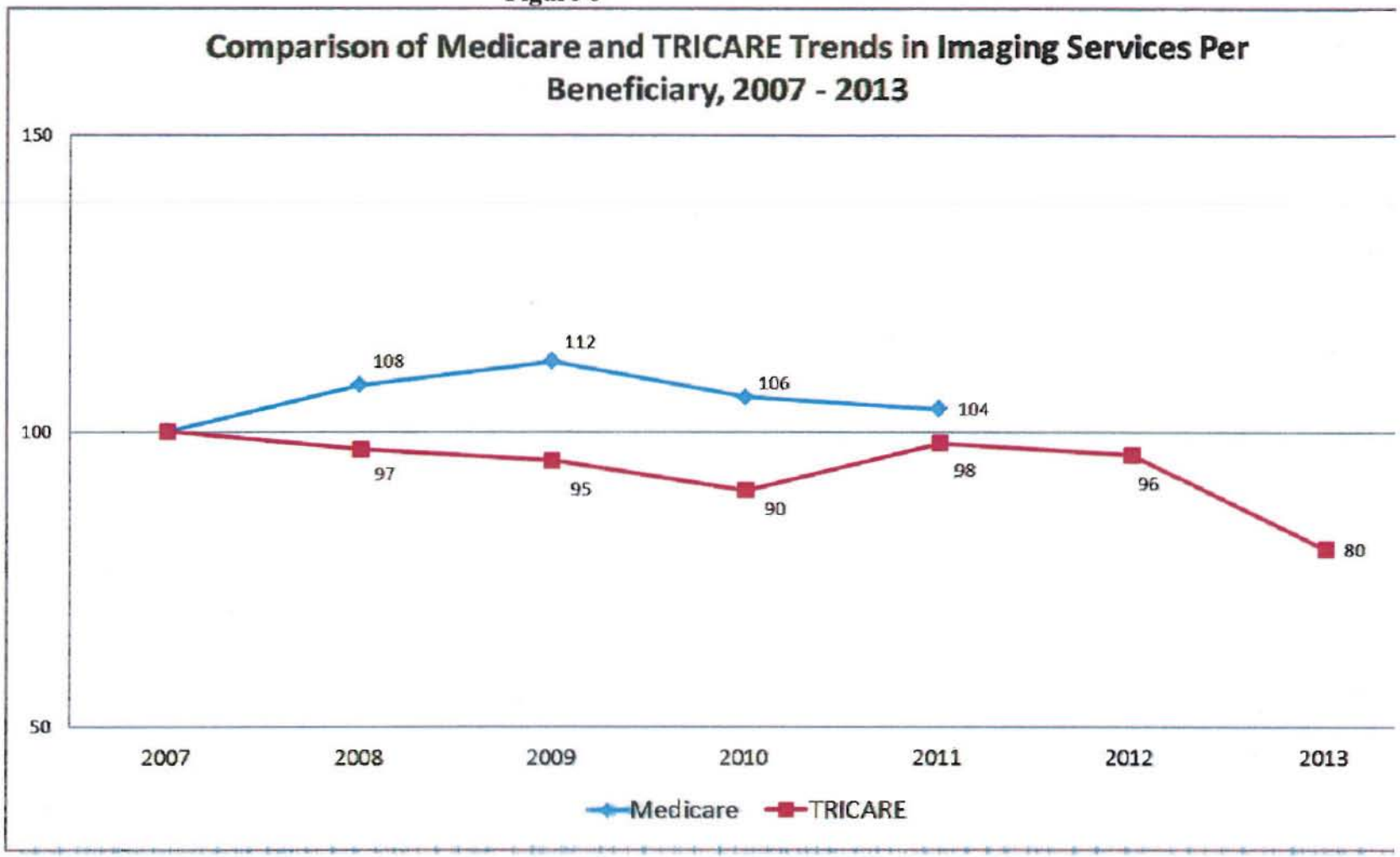
COMPARISON WITH OTHER PROGRAMS

It is difficult to compare the absolute level of utilization for ancillary services between TRICARE and Medicare because Medicare beneficiaries are older and use more services. However, we were able to compare the trend in the use of radiology services between Medicare and TRICARE over the FY 07-11 period.[7] The number of imaging services per beneficiary in Medicare increased slightly from 2007-2009 and then decreased from 2009-2011 (see Figure 6). TRICARE use decreased slightly from FY 2007-2011 and has decreased since then, particularly from FY 2012-2013. Thus, it appears that TRICARE trends are lower than Medicare trends in the use of radiology services per beneficiary.

[6] For example, physicians may prescribe physical therapy prior to determining whether an MRI is required.

[7] Medicare use is measured by multiplying the number of services for Medicare beneficiaries by the RVUs per service. We did a similar calculation for TRICARE.

Figure 6



Note: Medicare data on imaging from June 2013 MedPAC database (Chart 7-8). Medicare data is not available after 2011.

During the 2007-2009 period, commercial use of MRI and CT-scans increased slightly.[8] As discussed above, during this period TRICARE use of advanced imaging was declining. More importantly, TRICARE use of advanced imaging has declined since 2009. Thus, although it is difficult to compare the trends, it appears that TRICARE use was declining while commercial use was increasing slightly.

SUMMARY

The use and costs of advanced imaging services and other radiology services have declined during the FY 07-13 period. When comparing the TRICARE and Medicare utilization trends from 2007-11, TRICARE's per capita trend in the use of radiology services is lower than Medicare's. In addition, the TRICARE radiology trend has continued to decline after 2011. Even though the MCSCs are not pre-authorizing radiology services, TRICARE radiology costs have actually decreased since FY07. There has been increased use of physical therapy services over the FY 07-13 period for ADSMs, ADFMs, and NADDs. One of the MCSCs, United, started requiring prior authorization for physical therapy services in the middle of FY13, but it is too early to tell what effect that effort will have on physical therapy use and costs. We will revisit this change and use it as a process improvement if applicable. That being said, we believe current TRICARE policies and procedures (utilization controls, pre-authorizations, financial incentives , provider profiling and unit price controls) are being used to effectively to control the cost of ancillary services.

[8] Lee, DW and Levy F (2012). The sharp slowdown in growth of medical imaging: an early analysis suggests combination of policies was the cause. *Health Affairs*, 31,8: 1876-1884.