



Report on Texas Medicaid Laboratory and Imaging Diagnostic Ancillary Services

**As Required by
Rider 16, S.B. 1
85th Regular Session**

**Texas Health and Human
Services Commission**

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Executive Summary

As required by the 2018-19 General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission [HHSC], Rider 16), the HHSC is submitting the report, "Report on Texas Medicaid Laboratory and Imaging Diagnostic Ancillary Services." This report is an update of the 2016 study required by the 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 53) that examined in-office diagnostic ancillary services (DAS) for the time frame from fiscal year 2012 to 2015. The present study extends this time frame to include information on services provided from fiscal years 2016 and 2017. For this report, we continue to use the methods implemented for the previous biennium's Rider 53 report.¹ Our findings show that:

- Overall laboratory and imaging diagnostic services utilization and costs from fiscal years 2012 to 2017 increased at a lower rate than rates found by the Legislative Budget Board (LBB) from fiscal years 2008 to 2011.
- Average Fee-for-Service (FFS) client costs for fiscal year 2017 were \$178 while average managed care organization (MCO) costs were \$246. Laboratory spending was 58 percent of total DAS expenditures.
- Although total Medicaid enrollment increased by 10 percent from fiscal years 2012 to 2017, overall DAS utilization increased by only 2 percent for the same time frame. Much of the growth in DAS utilization for this period was due to increases in Laboratory utilization. Overall Laboratory DAS utilization increased by 12 percent while Imaging DAS utilization declined by 16 percent.
- Overall DAS spending increases have been significantly less than Medicaid total expenditure increases since fiscal year 2012. Laboratory DAS expenditures followed laboratory utilization growing at a slightly lower rate than the Medicaid rate (29 percent) while Imaging DAS expenditures declined by 2.3 percent consistent with the decline of imaging utilization. These trends

¹ Report on Texas Medicaid Laboratory and Imaging Diagnostic Ancillary Services. 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 53).

reiterate that spending on DAS services is growing at a slower rate than Medicaid spending in general.

- Despite the growth in total DAS expenditures and utilization, the average costs per client and the average number of units per client has not significantly increased since 2012. Average costs per client and average units per clients have remained consistent since fiscal year 2012. These rates have fluctuated within narrow ranges since fiscal year 2012 and do not demonstrate clear increases or decreases through time.
- Consistent with the ongoing shift from FFS to managed care that began in March 2012, increasingly larger fractions of laboratory and imaging utilization and expenditures continue to shift to the managed care model.
- Due to data limitations described below, we cannot determine if individual providers deliver potentially unnecessary services at levels significantly higher than the statewide average.

For previous years, as well as for the current analysis, Texas Medicaid In-Office Diagnostic Ancillary Services studies were mandated by the Riders to utilize methods that required information about the referring and the rendering providers from the FFS claims administrator and the MCOs in order to comply with the requirement of completing the reports following Federal and national methods. These data points are necessary to identify the clinician who referred the client for laboratory or imaging services to determine whether the services were an “in-office” self-referral service or not. However, while the referring provider information is captured on claims and encounters, this information is not required in all scenarios. As a result, claims and encounters data received by HHSC are inconsistently billed and reported with a referring provider.² Further, providers are

² A requirement to mandate the submission to HHSC of referring provider information by MCOs, if an encounter is processed with a referring provider, was scheduled to take effect October 1, 2018. HHSC is currently working on a MCO requirement to submit the NPI for rendering provider on institutional claims. However, the requirement will not provide complete information on the institutional claim form because the CMS-1450 does not have a discrete rendering provider field. Currently, a single field designated as attending provider is available to be used for the rendering provider. This is a significant limitation if multiple rendering providers were required for the encounter. An effective date for the requirement has not yet been set. It is unknown when the additional information will become available. The referring provider national provider identifier (NPI) requirement is situational - if a provider submits the referring NPI on the claim, MCOs are expected to submit the Referring NPI on the encounter. The Referring edit in place does not require referring provider to be submitted.

not always required to submit information on the rendering provider. If the rendering provider information is missing from the claim or encounter, the billing provider is substituted into the rendering provider field.

Given the above limitations, in 2016 HHSC followed the method utilized by the 2013 LBB *Texas State Government Effectiveness and Efficiency Report (GEER)*³ to analyze laboratory and imaging trends. We tested whether laboratory and imaging costs continued to grow at rates outpacing overall Medicaid utilization previously found for the 2013 GEER report. Our assumption was that sustained or increased growth indicated a potential issue of diagnostic ancillary service abuse. Conversely, if ancillary service utilization tracked both current Medicaid utilization and cost trends, previous concerns about over-utilization of these services may be unwarranted. Regardless, if abuse of these services does occur at the individual provider level, this analysis will not be able to detect differences by practice.

³ Texas Legislative Budget Board. (2013) Texas State Government Effectiveness and Efficiency Report: Selected Issues and Recommendations. Report submitted to the 83rd Texas Legislature January 2013. PP 143-150, 'Reduce Unnecessary in-office Diagnostic Ancillary Services in the Texas Medicaid Program to Control Costs.'

1. Introduction

Rider 16, Medicaid In-Office Diagnostic Ancillary Services, directs HHSC to study utilization of in-office diagnostic ancillary services provided by a clinician compared to the utilization of services provided by independent laboratories. Rider 16 states:

Out of funds appropriated above in all Strategies in Goal B, Medicaid & CHIP Support, the Health and Human Services Commission shall collect data necessary to allow the agency to quantify the amount of in-office diagnostic ancillary services provided to clients in the Texas Medicaid fee-for-service and managed care programs and routinely analyze this data. The agency shall review methodologies used by the federal government and national researchers to estimate the amount of in-office diagnostic ancillary services provided to Medicare clients and adopt a similar methodology for quantifying the amount of these services provided to Texas Medicaid clients. The agency shall submit a report on in-office diagnostic ancillary service use in the Texas Medicaid program, including strategies implemented by the agency to reduce unnecessary diagnostic ancillary services, to the Legislative Budget Board and the Governor by December 1, 2018.

This report is an update of the 2016 study required by the 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 53). That study examined in-office diagnostic ancillary services for the time frame from fiscal year 2012 to fiscal year 2015. The present study extends this time frame to include information on services provided from fiscal years 2016 and 2017.

2. Background and Limitations

The "Texas State Government Effectiveness and Efficiency Report (GEER)"⁴ published by the Texas Legislative Budget Board in 2013 suggested that reducing unnecessary in-office diagnostic ancillary services in Texas Medicaid could result in potential cost savings. The concern expressed by the LBB, based on national research, indicated a growing use of in-office diagnostic ancillary services (such as laboratory tests and certain types of diagnostic imaging) by Texas Medicaid providers could increase healthcare spending without concomitant improved patient outcomes, shortened illness duration or improved patient convenience.⁵ The report included a recommendation based on their findings to collect information which would allow HHSC to quantify in-office ancillary services by providers and routinely analyze these data.

Changes in the Social Security Act and the implementation of federal regulations in the late 1980s placed restrictions on physicians from referring Medicaid and Medicare clients for certain services in which they, or a family member, had a financial interest.^{6,7,8} In these arrangements, it was possible that a physician who rented or owned both diagnostic imaging and laboratory resources could provide unnecessary and excessive services which could result in lucrative reimbursements.

Beginning in 1989, the Centers for Medicare and Medicaid Services promulgated a series of regulations that prohibited or limited self-referral, but federal law provides

⁴ Texas Legislative Budget Board. (2013) Texas State Government Effectiveness and Efficiency Report: Selected Issues and Recommendations. Report submitted to the 83rd Texas Legislature January 2013. PP 143-150, 'Reduce Unnecessary in-office Diagnostic Ancillary Services in the Texas Medicaid Program to Control Costs.'

⁵ United States Government Accountability Office. (2013). Medicare: Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer. GAO Report 13-445.

⁶ Schneider, J., Ohsfeldt, R., Scheibling, C., and Jeffers, S. (2012), Organizational Boundaries of Medical Practice: The Case of Physician Ownership of Ancillary Services. Health Economics Review 2:7. Springer.

⁷ Bishop, T., Federman, A., and Ross, J. (2010). Laboratory Test Ordering at Physician Offices with and without On-site Laboratories. J. Gen. Intern. Med. 25 (10):1057-63.

⁸ Mitchell, J. (2012). Linkages between Utilization of Prostate Surgical Pathology Services and Physician Self-Referral. Medicaid & Medicare Research Review 2 (3): E1-E17.

an exception to the physician self-referral ban for some health services that meet the definition of an in-office ancillary service.^{9,10}

In 2013, the LBB GEER report reviewed fiscal years 2008 to 2011 Medicaid claims and encounters information to determine the extent, if any, of potential abuses of the self-referral waiver. However, specific information on Texas Medicaid spending for in-office diagnostic ancillary services by practice was, and remains, unavailable due to limitations in key data necessary for this type of analysis within the HHSC claims and encounters data.

Rider 16 was designed to remedy the lack of information necessary to identify the possibility of inappropriate use of ancillary services. The Rider directs HHSC to collect data necessary to quantify the amount of in-office diagnostic ancillary services provided to clients in the Texas Medicaid and routinely analyze these data.

The 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Health and Human Services Commission, Rider 61), required a similar report as set forth by the current Rider 16. Notification was sent to the LBB and The Office of the Governor stating that HHSC was unable to obtain the required data in order to complete the report due on December 1, 2014. In December 2016, a report was completed in response to the 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 53).¹¹As with Rider 61, HHSC was unable to obtain required data from the FFS claims administrator and the MCOs for laboratory and imaging services. In order to complete the report, HHSC needed information about the referring providers and the rendering providers. These data points are necessary to identify the physician who referred the client for laboratory or imaging services to determine whether the services were an "in-office" self-referral service

⁹ MedPac. (2010). Report to Congress: Aligning Incentives in Medicare. Chapter 8: Addressing the Growth of Ancillary Services in Physician's Offices. 213-237.

¹⁰ MedPac. (2011). Report to Congress: Medicare and the Health Care Delivery System. Chapter 2: Improving Payment Accuracy and Appropriate Use of Ancillary Services. 27-59.

¹¹ Report on Texas Medicaid Laboratory and Imaging Diagnostic Ancillary Services. 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 53).

or not.¹² Given the above limitations, HHSC took the approach to follow the method utilized by the 2013 LBB GEER report to analyze laboratory and imaging trends. We tested whether laboratory and imaging costs continued to grow at rates outpacing overall Medicaid utilization as was found from the 2013 GEER report. Our assumption was that sustained or increased growth indicated potential issues of diagnostic ancillary service abuse. Conversely, if ancillary service utilization tracked both current Medicaid utilization and cost trends, previous concerns about over-utilization of these services may be unwarranted. Regardless, if abuse of these services does occur at the individual provider level, the analyses would not be able to detect differences by practice.

HHSC remains unable to adequately determine self-referral trends for the following reasons:

- **In order to determine the extent of self-referral, information on the referring provider is required.** While the referring provider information is captured on claims and encounters, this information is not required in all scenarios. As a result, claims and encounters data received by HHSC are not always billed and reported with a referring provider. Services requiring a referring provider have the referring provider listed on the submitted claim/encounter. Services not requiring designation of a referring provider may not provide this information. FFS and each MCO may designate different services or scenarios where a provider referral is required. Due to this variability in the services requiring a referring provider across the program, it is not possible to assess the completeness of the referring provider information.

¹² A requirement to mandate the submission to HHSC of referring provider information by MCOs, if an encounter is processed with a referring provider, was scheduled to take effect October 1, 2018. HHSC is currently working on a MCO requirement to submit the NPI for rendering provider on institutional claims. However, the requirement will not provide complete information on the institutional claim form because the CMS-1450 does not have a discrete rendering provider field. Currently, a single field designated as attending provider is available to be used for the rendering provider. This is a significant limitation if multiple rendering providers were required for the encounter. An effective date for the requirement has not yet been set. It is unknown when the additional information will become available. The referring provider national provider identifier (NPI) requirement is situational - if a provider submits the referring NPI on the claim, MCOs are expected to submit the Referring NPI on the encounter. The Referring edit in place does not require referring provider to be submitted.

- **Providers are not always required to submit information on the rendering provider.** If the rendering provider information is missing from the claim or encounter, the billing provider is substituted into the rendering provider field. Although it may be permissible to impute the billing provider into the rendering provider field for certain services, we assume that the claims and encounters information is accurate. For example, automated laboratory tests do not require a rendering provider. Providers typically file claims/encounters with the billing provider information only. Services requiring clinician involvement are obligated to be billed with a rendering provider. However, because not all services require a designation of a rendering provider, it is not possible to perform an assessment of the completeness of rendering provider content.

Without these data, HHSC is unable to complete a revised report in the manner specified by Rider 16. In order to undertake this report, HHSC would require complete, consistent, and accurately reported referring and rendering provider information.

Despite these reporting limitations, processes are in place to ensure that services are not over utilized. These processes include:

- **Prior Authorization:** Complex services (e.g., CTs/MRIs) in both the FFS and MCO models require an authorization which, as an industry standard, is a stringent way to control utilization of certain medical services. Medical staff review requests based on submitted documentation supporting medical need.
- **Edits and Audits:** Specific limitation edits and audits are used to counter excessive use of in-office ancillary diagnostics. For example, within FFS the laboratory procedure code 80069 (renal function panel) is limited to one test per six months. If a provider bills a second test within six months, the claim is denied. MCOs have similar limitations in place based on medical appropriateness; specific limitations are up to the individual MCO's discretion. Claims and encounters editing and auditing is an additional tool to monitor utilization and prevent over-utilization by only allowing reasonable testing and preventing providers from unnecessary over-utilization.

3. Laboratory and Imaging Services: Fiscal Years 2012-2017

To review utilization and costs associated with laboratory and imaging services, fiscal year 2012 was used as a baseline for analyses. We followed the utilization data to determine whether unusual increases in either of these types of services occurred over a four year period.¹³

In 2013, the LBB GEER report reviewed fiscal years 2008-2011 Medicaid claims and encounters information and found that spending on diagnostic services increased by over 50 percent while, for the same period, overall Medicaid spending increased by 32 percent. In-office diagnostic laboratory spending represented almost 56 percent of total diagnostic ancillary service expenditures during fiscal year 2011. For fiscal year 2011, FFS average costs per client were \$339 while MCO average costs were \$298. Average FFS client costs for fiscal year 2017 were \$178 while MCO costs were \$246 (Table 1). Laboratory spending was 58 percent of total DAS expenditures.

Medicaid enrollment increased 10.2 percent from fiscal year 2012 to 2017 while total DAS utilization increased by only 2.2 percent during the same period. Laboratory DAS utilization increased by 11.8 percent and imaging DAS declined by 16 percent (Figure 1).

¹³ Please note that the Texas Medicaid model changed on March 1, 2012, when the program became a predominantly managed care model. This is reflected in the population shift and associated utilization.

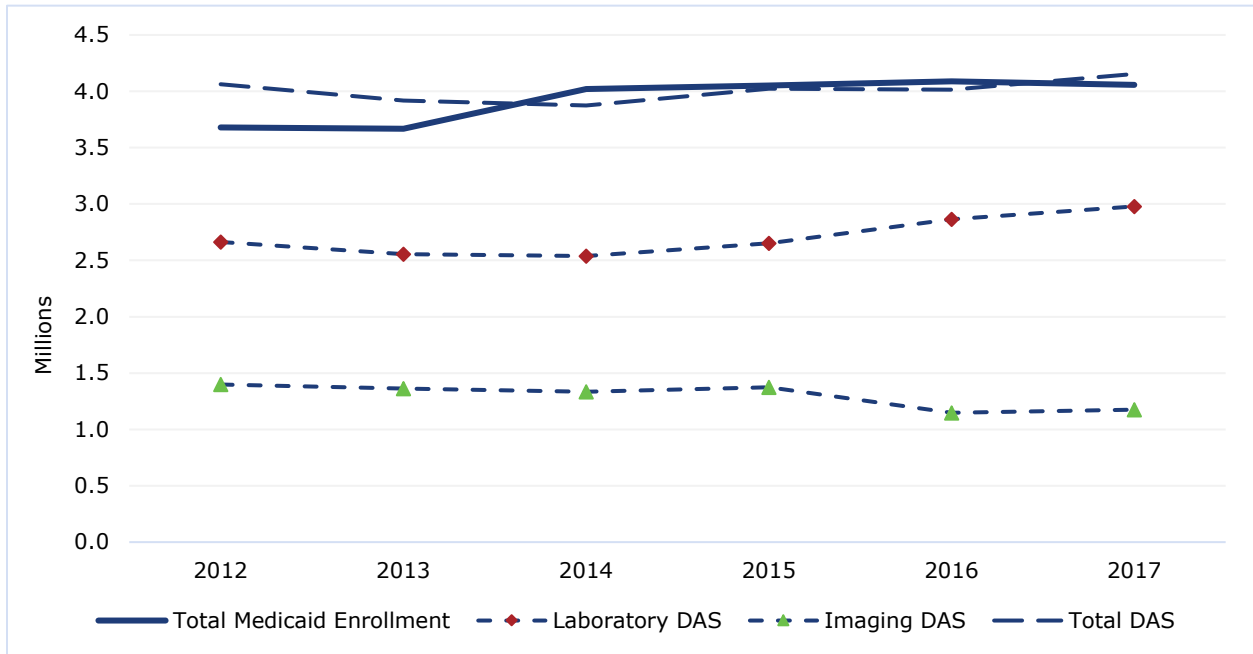
Table 1: FY 2012-2017 Fee-for-Service (FFS) and Managed Care Organization (MCO) Utilization Review of Laboratory and Imaging Services*

Fiscal Year	Category	FFS					MCO				
		Unduplicated Client Count	Average Cost Per Client	Total Paid Units	Average Cost Per Unit	Total Paid Amount	Unduplicated Client Count	Average Cost Per Client	Total Paid Units	Average Cost Per Unit	Total Paid Amount
2012	Laboratory	918,469	\$146	9,099,801	\$15	\$134,274,458	1,745,989	\$176	18,667,522	\$16	\$307,258,215
	Imaging	526,758	\$250	2,041,972	\$64	\$131,481,652	871,795	\$330	4,382,377	\$66	\$287,721,179
	Average Costs					\$184					\$227
2013	Laboratory	527,740	\$173	5,151,551	\$18	\$91,284,773	2,028,152	\$181	23,200,020	\$16	\$366,513,034
	Imaging	325,429	\$274	1,283,733	\$69	\$89,193,330	1,036,250	\$323	4,872,994	\$69	\$335,178,366
	Average Costs					\$212					\$229
2014	Laboratory	574,223	\$169	5,247,523	\$18	\$97,032,565	1,964,443	\$179	22,153,416	\$16	\$352,178,238
	Imaging	343,702	\$254	1,338,326	\$65	\$87,451,579	992,037	\$314	4,851,690	\$117	\$311,462,316
	Average Costs					\$201					\$224
2015	Laboratory	471,609	\$178	4,551,846	\$18	\$83,813,502	2,179,544	\$176	24,133,140	\$16	\$382,542,401
	Imaging	288,245	\$248	1,126,862	\$64	\$71,615,898	1,084,604	\$310	6,114,186	\$55	\$336,528,737
	Average Costs					\$205					\$220
2016	Laboratory	472,475	\$175	4,231,236	\$20	\$82,683,910	2,393,056	\$180	24,674,410	\$17	\$431,230,466
	Imaging	265,585	\$250	1,109,690	\$60	\$66,527,944	882,259	\$376	4,244,154	\$78	\$331,376,726
	Average Costs					\$202					\$233
2017	Laboratory	398,027	\$146	2,967,663	\$20	\$58,256,492	2,580,670	\$198	25,719,264	\$20	\$511,017,873
	Imaging	210,777	\$238	801,599	\$63	\$50,103,591	964,648	\$373	4,494,102	\$80	\$359,554,455
	Average Costs					\$178					\$246

*See appendix for details

Data Source: Business Objects Query Ad hoc Query Platform (AHQP) Claims (FFS) and Best Picture Encounters (STAR, STAR Health, STAR Kids and STAR+PLUS) for dates of service 09/01/2011 - 08/31/2017. Prepared by Texas (TX) HHSC Center for Analytics and Decision Support (CADS) - Benefits Management Review Team; 08/30/2018 (MB and GWR).

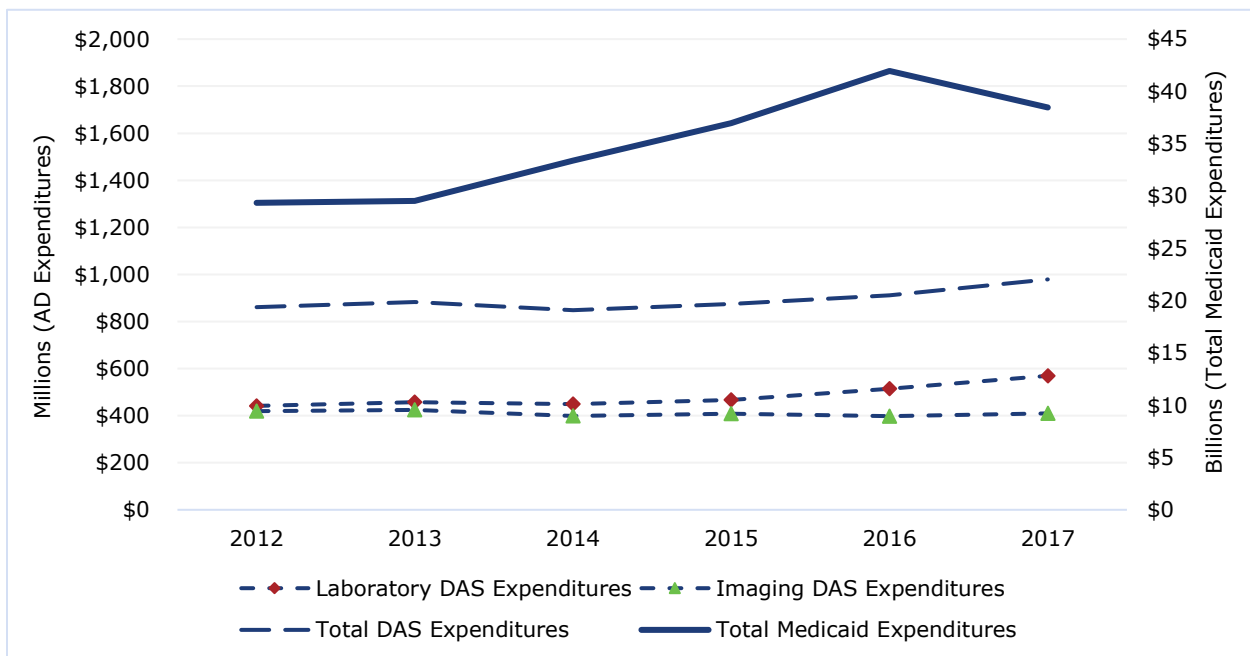
Figure 1: Medicaid Enrollment and Ancillary Diagnostic Utilization: FY 2012-2017



Data Source: Business Objects Query AHQP Claims (FFS) and Best Picture Encounters (STAR, STAR Health, STAR Kids and STAR+PLUS) for dates of service 09/01/2011 - 08/31/2017. Prepared by TX HHSC CADS - Benefits Management Review Team; 08/30/2018 (MB and GWR).

Medicaid total expenditures have increased 31 percent since fiscal year 2012. Overall DAS spending increased by less than 14 percent for the same period. Laboratory DAS expenditures followed laboratory utilization growing at a slightly lower rate than the Medicaid rate (29 percent) while Imaging DAS expenditures declined by 2.3 percent consistent with the decline of imaging utilization (Figure 2). These trends reiterate that spending on DAS services is growing at a slower rate than Medicaid spending in general.

Figure 2: Medicaid Expenditures and Ancillary Diagnostic Utilization: FY 2012-2017

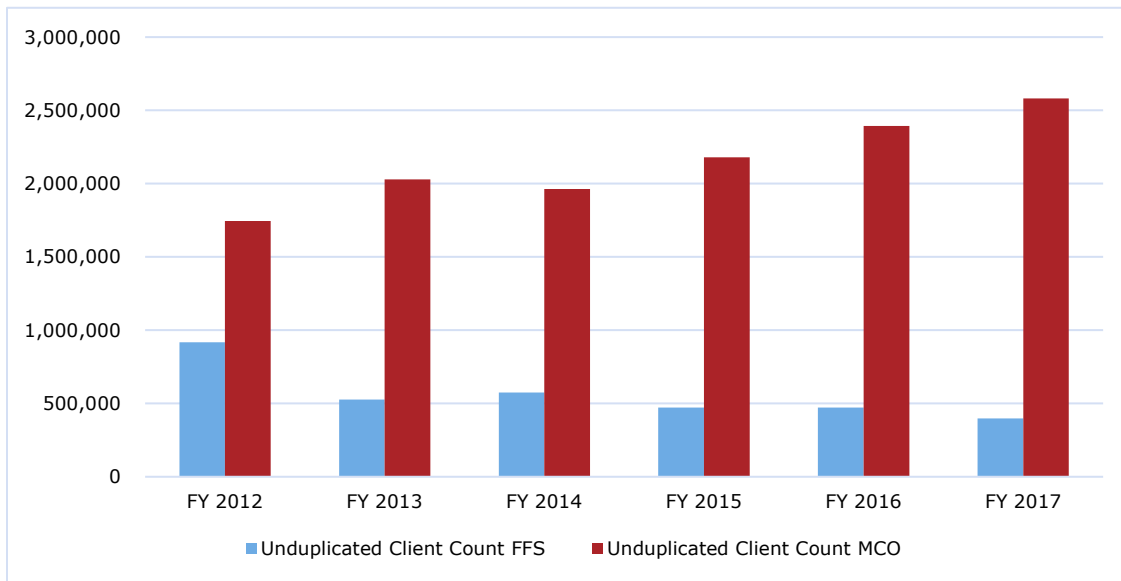


Data Source: Business Objects Query AHQP Claims (FFS) and Best Picture Encounters (STAR, STAR Health, STAR Kids and STAR+PLUS) for dates of service 09/01/2011 - 08/31/2017.
 Prepared by TX HHSC CADS - Benefits Management Review Team; 08/30/2018 (MB and GWR).

No other significant changes in utilization or costs for laboratory or imaging ancillary diagnostic were evident from fiscal years 2012 to 2017. However, because of the change to the MCO provider model from FFS in March 2012 increasingly larger fractions of laboratory and imaging utilization and expenditures continue to shift to the managed care model. Utilization and overall costs did not grow significantly as MCOs displaced FFS originated services (Figures 3-10).

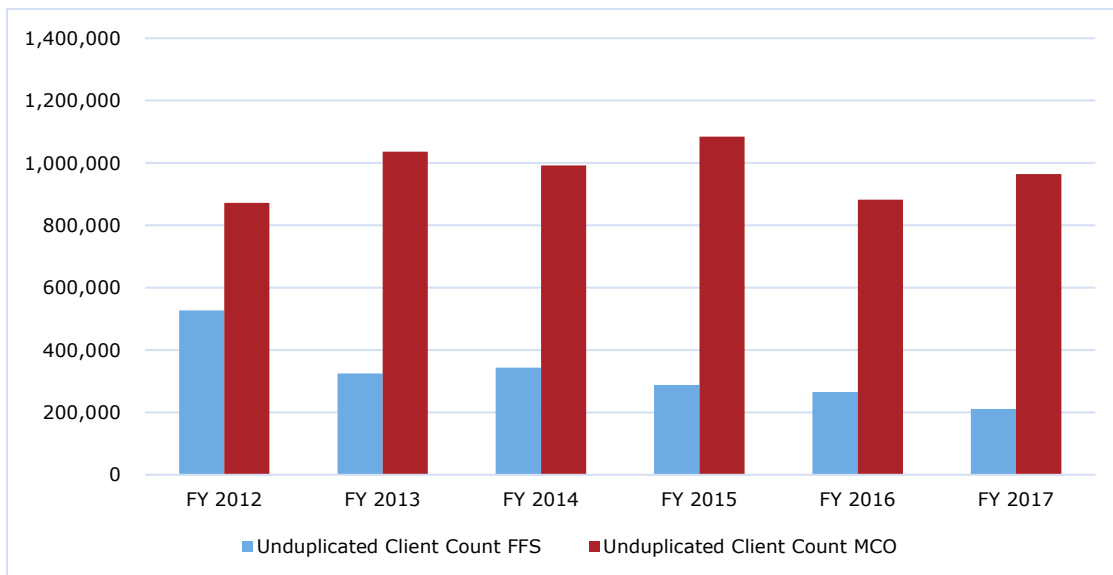
Despite the growth in total DAS expenditures and utilization, the average costs per client and the average number of units per client has not significantly increased since 2012. Figures 7 through 10 indicate that average costs per client and average units per clients have remained consistent since fiscal year 2012. These rates have fluctuated within narrow ranges (and insignificant at 2 standard deviations) since fiscal year 2012 and do not demonstrate clear increases or decreases through time.

Figure 3: Laboratory* Unduplicated Client Count



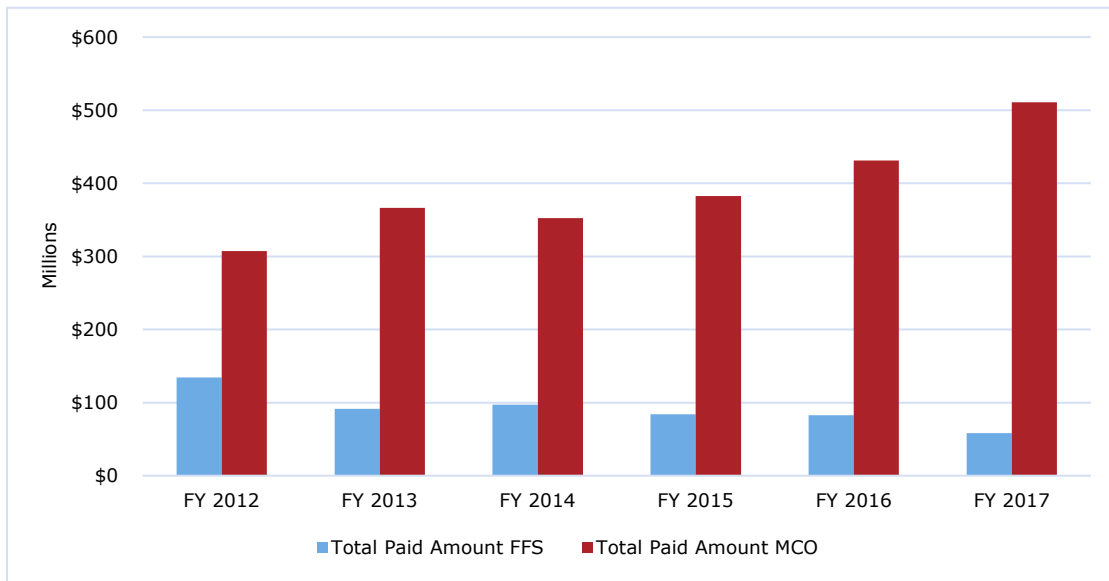
*- See Appendix for procedure codes used.
 Data Source: Business Objects Query AHQP Claims (FFS) and Best Picture Encounters (STAR, STAR Health, STAR Kids and STAR+PLUS) for dates of service 09/01/2011 - 08/31/2017. See Table 1 for actual values.
 Prepared by TX HHSC CADS - Benefits Management Review Team; 08/30/2018 (MB and GWR).

Figure 4: Imaging* Unduplicated Client Count



*- See Appendix for procedure codes used.
 Data Source: Business Objects Query AHQP Claims (FFS) and Best Picture Encounters (STAR, STAR Health, STAR Kids and STAR+PLUS) for dates of service 09/01/2011 - 08/31/2017. See Table 1 for actual values.
 Prepared by TX HHSC CADS - Benefits Management Review Team; 08/30/2018 (MB and GWR).

Figure 5: Laboratory* Total Amount Paid

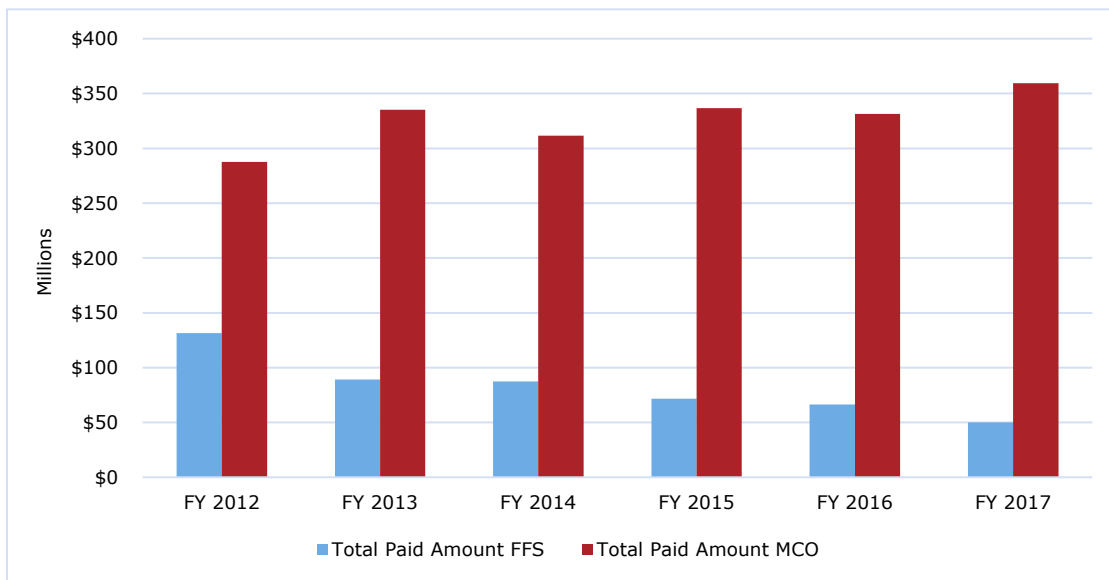


*- See Appendix for procedure codes used.

Data Source: Business Objects Query AHQP Claims (FFS) and Best Picture Encounters (STAR, STAR Health, STAR Kids and STAR+PLUS) for dates of service 09/01/2011 - 08/31/2017. See Table 1 for actual values.

Prepared by TX HHSC CADS - Benefits Management Review Team; 08/30/2018 (MB and GWR).

Figure 6: Imaging* Total Amount Paid

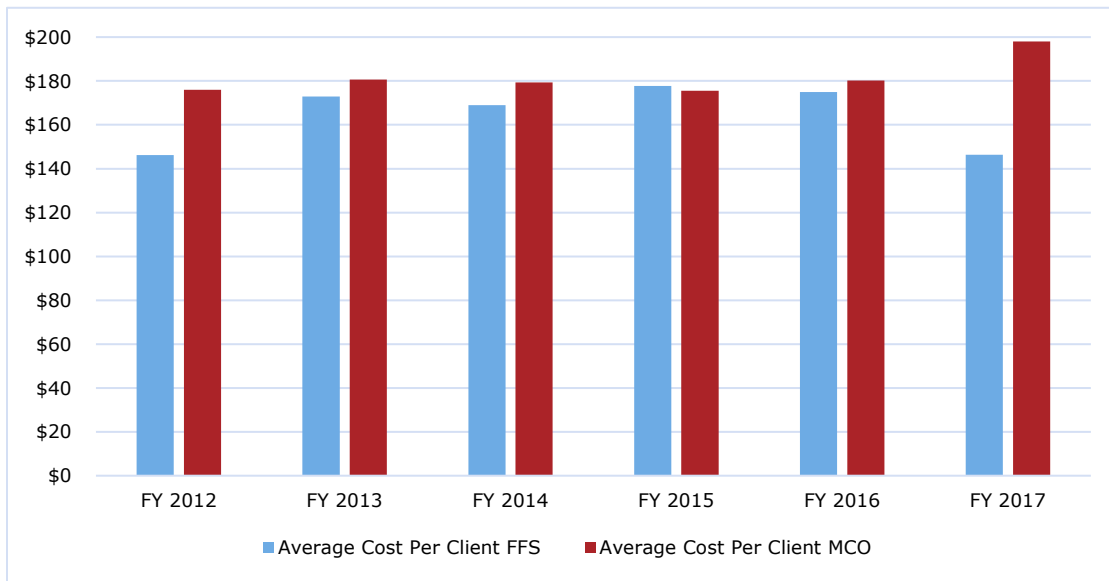


*- See Appendix for procedure codes used.

Data Source: Business Objects Query AHQP Claims (FFS) and Best Picture Encounters (STAR, STAR Health, STAR Kids and STAR+PLUS) for dates of service 09/01/2011 - 08/31/2017. See Table 1 for actual values.

Prepared by TX HHSC CADS - Benefits Management Review Team; 08/30/2018 (MB and GWR).

Figure 7: Laboratory* Average Cost/Client

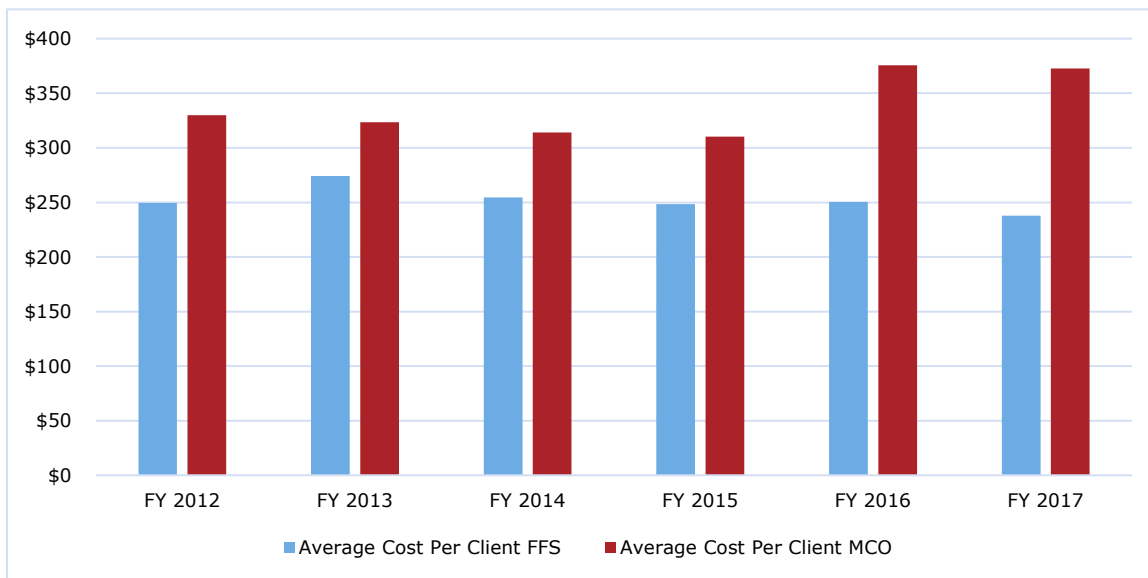


*- See Appendix for procedure codes used.

Data Source: Business Objects Query AHQP Claims (FFS) and Best Picture Encounters (STAR, STAR Health, STAR Kids and STAR+PLUS) for dates of service 09/01/2011 - 08/31/2017. See Table 1 for actual values.

Prepared by TX HHSC CADS - Benefits Management Review Team; 08/30/2018 (MB and GWR).

Figure 8: Imaging* Average Cost/Client

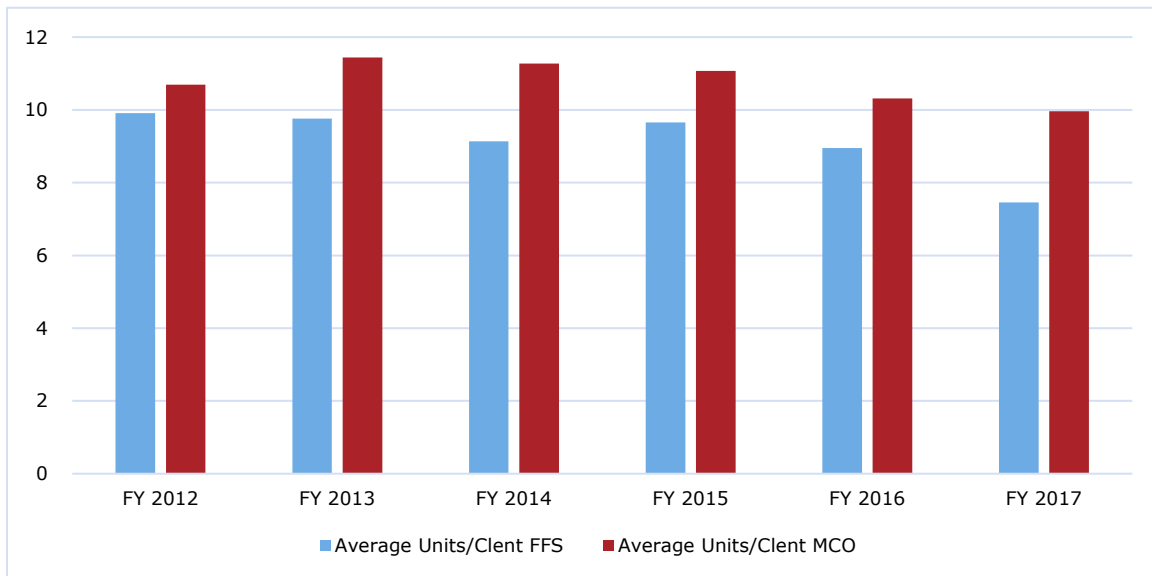


*- See Appendix for procedure codes used.

Data Source: Business Objects Query AHQP Claims (FFS) and Best Picture Encounters (STAR, STAR Health, STAR Kids and STAR+PLUS) for dates of service 09/01/2011 - 08/31/2017. See Table 1 for actual values.

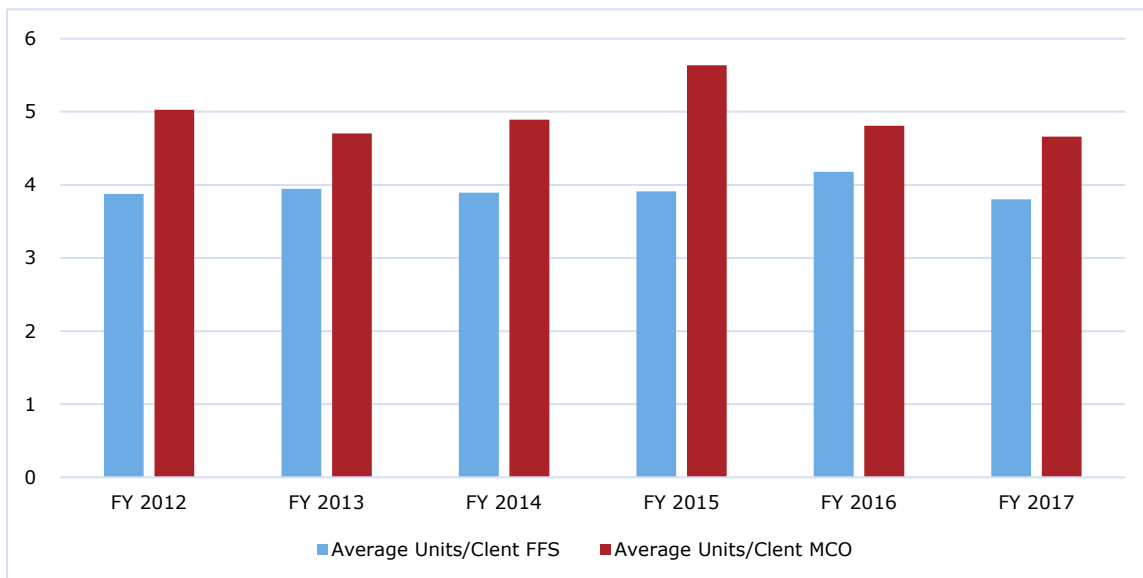
Prepared by TX HHSC CADS - Benefits Management Review Team; 08/30/2018 (MB and GWR).

Figure 9: Laboratory* Average Units/Client



*- See Appendix for procedure codes used.
 Data Source: Business Objects Query AHQP Claims (FFS) and Best Picture Encounters (STAR, STAR Health, STAR Kids and STAR+PLUS) for dates of service 09/01/2011 - 08/31/2017. See Table 1 for actual values.
 Prepared by TX HHSC CADS - Benefits Management Review Team; 08/30/2018 (MB and GWR).

Figure 10: Imaging* Average Units/Client



*- See Appendix for procedure codes used.
 Data Source: Business Objects Query AHQP Claims (FFS) and Best Picture Encounters (STAR, STAR Health, STAR Kids and STAR+PLUS) for dates of service 09/01/2011 - 08/31/2017. See Table 1 for actual values.
 Prepared by TX HHSC CADS - Benefits Management Review Team; 08/30/2018 (MB and GWR).

4. Conclusion

Overall laboratory and imaging services utilization and costs have not increased at the same rates that were found by the LBB from fiscal years 2008 to 2011.

Laboratory DAS MCO client growth and total costs increased significantly from fiscal year 2012 to 2017, with a spike in growth occurring between fiscal years 2015 and 2016.

Conversely, significant imaging DAS declines in cost among FFS clients were seen for the period from fiscal year 2012 to 2017.

Although HHSC is unable to distinguish specific practices that are utilizing in-office ancillary services, our overall results suggest that excessive referrals or utilization is not a significant Medicaid cost-driver at this time. Single year fluctuations in costs or utilization, such as the fiscal year 2016 peak in Medicaid expenditures, are not significantly different and would require additional years of data to detect any trend changes.

Until HHSC has provider information necessary to validate the completeness of billing, referral and the actual performing of services, a report as mandated by Rider 16 is not possible.

A requirement to mandate the collection of *referring* provider by MCOs was scheduled to take effect October 1, 2018. HHSC is currently working on a MCO requirement to submit the national provider identifier for *rendering* provider on institutional claims. However, the requirement will not provide complete information on the institutional claim form because the CMS-1450 does not have a discrete rendering provider field. Currently, a single field designated as attending provider is available to be used for the rendering provider. However, this is a significant limitation if multiple rendering providers were required for the encounter. An effective date for the requirement has not yet been set. It is unknown when the additional information will become available.

Obtaining these data will impose requirements on providers and claims and encounters administrators, as well as the Medicaid program that may be challenging to implement completely and consistently within a short time frame. These changes could also have budgetary impacts on the provider community and HHSC to accommodate the collection and monitoring of these data. If this timeline is successfully implemented as planned, based on previous experience the earliest

point the agency will have sufficient and complete referring provider data (at least one year of data to ensure their validity and two additional fiscal years trend data for analyses) would be approximately March 2022. Because a policy is not yet implemented for collecting rendering provider information, we are unable to project when sufficient data would be available to carry out the requested analyses.

Ensuring completeness of the rendering and referring provider fields could potentially enable HHSC to examine if patterns exist, by provider, of potential abuses of the in-office diagnostic waiver. However, by requiring these fields to be completed, HHSC and MCOs would necessarily deny claims from providers where the rendering and referring fields were not specified, even if that content was not needed to pay the claim. In addition, HHSC and MCOs would need to make system changes to ensure that content is submitted and validated, which could result in an increased cost for administration of the Medicaid program.

APPENDIX A: List of Acronyms

Acronym	Full Name
AHQP	Ad hoc Query Platform
CADS	Center for Analytics and Decision Support
CHIP	Children’s Health Insurance Plan
DAS	Diagnostic Ancillary Services
FFS	Fee-for-Service
GEER	Government Effectiveness and Efficiency Report
HHSC	Health and Human Services Commission
LBB	Legislative Budget Board
MCO	Managed Care Organization
STAR	State of Texas Access Reform Program

Appendix A

Procedure Codes Used to Identify Table 1 Diagnostic Ancillary Services

FY 2012 through FY 2015 Utilization is based on the following procedure codes:

Laboratory Procedure Codes

Types of Service: 5/I/T

Procedure Codes: 80000 - 89999, 92550, - 92553, 92555 - 92557, 92562 - 92565, 92567, 92568, 92570 - 92572, 92575 - 92577, 92579, 92582 - 92588, 93000, 93005, 93010, 93561, 93562, 93701, 93724, 93740, 93770, 93784, 93786, 93788, 93790, 93797 - 93799, 93922, 94010, 94014 - 94016, 94060, 94070, 94150, 94200, 94250, 94375, 94400, 94450, 94452, 94453, 94620, 94621, 94680, 94681, 94690, 94726 - 94729, 94750, 94760 - 94762, 94770, 94772, 94799, 95782, 95783, 95803, 95805, 95807, 95808, 95810, 95811 - 95813, 95816, 95819, 95822, 95824, 95827, 95829, 95831 - 95834, 95851, 95852, 95857, 95860, 95861, 95863 - 95870, 95872 - 95875, 95885 - 95887, 95905, 95907 - 95913, 95921 - 95930, 95933, 95937 - 95941, 95943, 95950, 95951, 95953 - 95958, 95970 - 95975, 95978 - 95982, 95999, G0306, G0307, G0328, G0477 - G0483.

Radiology Procedure Codes

Types of Service: 4/I/T

Procedure Codes: 70000 - 79999, 91110 - 91112, 93278, 93303, 93304, 93307, 93308, 93312, 93313, 93315, 93316, 93318, 93350, 93355, 93880, 93882, 93886, 93888, 93890, 93892, 93893, 93923 - 93926, 93930, 93931, 93965, 93970, 93971, 93975, 93976, 93978 - 93982, 93990, 95965 - 95967, 96000 - 96003, G0365, G0106, G0120, G0130, G0389, Q0035.

Updated FY 2016 through FY 2017 Utilization is based on the following procedure codes:

Laboratory Procedure Codes

Types of Service: 5/I/T

Procedure Codes: 78267, 78268, 80000 - 89999, 91022, 92531, 92533, 92534, 92537, 92538, 92540 - 92542, 92544, 92546, 92547, 92550 - 92553, 92555 - 92557, 92563 - 92565, 92567, 92568, 92570 - 92572, 92575 - 92577, 92579, 92582 - 92588, 92590, 92592 - 92595, 93000, 93005, 93010, 93015, 93016, 93024, 93025, 93040 - 93042, 93224, 93228, 93268, 93270, 93271, 93279 - 93289, 93291 - 93296, 93298, 93299, 93306, 93351, 93561, 93562, 93701, 93724, 93740, 93770, 93784, 93786, 93788, 93790, 93797 - 93799, 93922, 94010, 94014 - 94016, 94060, 94070, 94150, 94200, 94250, 94375, 94400, 94450, 94452, 94453, 94617, 94618, 94621, 94680, 94681, 94690, 94726 - 94729, 94750, 94760 - 94762, 94770, 94772, 94799, 95012, 95782, 95783, 95803, 95805, 95807, 95808, 95810 - 95813, 95816, 95819, 95822, 95824, 95827, 95829, 95831 - 95834, 95851, 95852, 95857, 95860, 95861, 95863 - 95870, 95872 - 95875, 95885 - 95887, 95905, 95907 - 95913, 95921, 95922 - 95930, 95933, 95937 - 95941, 95943, 95950, 95951, 95953 - 95958, 95970 - 95972, 95974, 95975, 95978 - 95982, 95999, 96101, 96105, 96110, 96111, 96116, 96118, G0306, G0307, G0328, G0398 - G0400, G0433, G0475, G0480 - G0483, G0499, G0659, Q3031, S3722, S3800, S3840 - S3842, S3846.

Radiology Procedure Codes

Types of Service: 4/I/T

Procedure Codes 70000 - 79999, 91110 - 91112, 93278, 93303, 93304, 93307, 93308, 93312 - 93318, 93320, 93321, 93325, 93350, 93355, 93880, 93882, 93886, 93888, 93890, 93892, 93893, 93922 - 93926, 93930, 93931, 93970, 93971, 93975, 93976, 93978 - 93981, 93990, 95965 - 95967, 96000 - 96003, C9744, G0106, G0120, G0122, G0130, G0365, Q0035, R0070, R0075.