Dermatopathology in Clinical Practice: Avoiding Abuse of Self-referral and Client Billing

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Practice Points

- Self-referral and client billing for dermatopathology services are used to optimize patient care, but both are subject to real and perceived abuse.
- Additional restrictions on self-referral and client billing will limit dermatologists' ability to process and interpret slides or choose consulting dermatopathologists.
- Careful utilization of self-referral and client billing with emphasis on patient care over revenue will serve to maintain dermatopathology as an integral component of the dermatology practice.

You have of course entered the Profession of Medicine with a view of obtaining a livelihood; but in dealing with your patients let this always be a secondary consideration.

Sir William Osler, MD[1]

Dermatopathology is as important to the specialty of dermatology and the care of patients with skin disease as is any element of the specialty. The American Academy of Dermatology (AAD) has long supported the right of dermatologists to provide dermatopathology services and to choose their preferred dermatopathologists.[2] Physician self-referral and client billing exist, in theory and in practice, to ensure access to high-quality dermatopathology services; unfortunately, both also are subject to real or perceived financial, ethical, and professional abuse, and have attracted critical attention from other specialty societies and policymakers.[3,4] The dermatologist's ability to provide dermatopathology services and to bill clients is at risk because these practices are viewed as potential sources of increased utilization and cost. To protect our specialty and our patients, dermatologists must avoid business arrangements that prioritize revenue over patient care.

Federal law prohibits physicians from referring services to facilities in which the physicians have financial interests, a practice called self-referral.[5] However, there are exceptions for certain designated in-office ancillary services (eg, anatomic pathology) that allow physicians to own and operate pathology laboratories. Although the practice of dermatology has long included the interpretation of dermatopathology specimens, there has been a perceived increase in the number of dermatologist-owned dermatopathology laboratories.[3] Additionally, other specialists, primarily gastroenterologists and urologists, are establishing anatomic pathology laboratories within their practices. Unlike dermatologists, these practices must contract with surgical pathologists for the professional component of anatomic pathology services, but the practices can provide and bill for the technical component, thus increasing their revenue. A recent

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study funded by the American Clinical Laboratory Association in conjunction with the College of American Pathologists suggests that urologists who self-refer for pathology bill for more specimens and detect fewer prostate cancers than urologists who do not self-refer.[3] This study's methodology has been subject to criticism,[6,7] but it raises an important question: Do dermatologists who own pathology laboratories perform more biopsies than those who send their specimens elsewhere?

Although self-referral for designated in-office ancillary services is legal under federal law, the Patient Protection and Affordable Care Act requires physicians who self-refer for radiology services to provide written notice to patients indicating that imaging services can be received elsewhere.[8] This provision does not apply to dermatopathology services yet, but it may be applied to any or all designated services at the discretion of the secretary of the US Department of Health & Human Services. There also are those who call for federal legislation prohibiting self-referral altogether,[9] which would severely limit dermatologists' ability to interpret specimens in their own practice. Dermatologists do not need to be reminded that dermatopathology is an important component of dermatology residency training and certification by the American Board of Dermatology. This fact alone distinguishes dermatologists from other physicians whose training does not incorporate the interpretation of anatomic pathology specimens. It is not unusual or outside the scope of practice for a dermatologist to own and operate a dermatopathology laboratory. Despite that fact, dermatologists often are discussed together with other clinical specialists when physician self-referral is criticized. There are no published data documenting increased utilization of pathology services by dermatologists who own pathology laboratories, but we also lack data to prove otherwise.

For those dermatologists who send specimens for outside dermatopathology interpretation, the choice of a dermatopathologist is key to ensuring quality and clinicopathologic correlation. A dermatologist and his/her dermatopathology laboratory of choice may not contract with the same insurance companies, so the dermatologist is allowed to purchase pathology services from an outside laboratory for a fee and bill a patient's insurance company for the services, which is referred to as client billing. Client billing is not allowed in all states or by Medicare, and although it can be an effective tool for ensuring access to high-quality dermatopathology services, this practice invites scrutiny, as there is obvious potential for abuse involving the dermatologist's billing and collecting the total allowable fee for dermatopathology services while paying the laboratory only a fraction of that fee. Although this practice increases the dermatologist's revenue, it reduces the revenue available for dermatopathology services and would be appropriately interpreted as billing for work that the dermatologist did not perform.

A recent position statement on pathology billing issued by the AAD addresses both self-referral and client billing.[2] Importantly, the AAD strongly supports the right of dermatologists to provide dermatopathology services and supports the in-office ancillary exception that allows office-based pathology services. The position statement, however, also emphasizes that physician-owned laboratories "must ensure that the quality of the services . . . exceeds that available from outside venders, as the model is inherently suspect to payers and regulators."[2] In short, the decision to offer in-office pathology services must be made based on optimizing patient care and not on increasing revenue.

The AAD also supports the dermatologist's right to choose his/her consulting dermatopathologists,[2] a practice that may involve client billing. Client billing can involve the purchase of technical and/or professional components or the global service from an outside vendor. The AAD's statement makes clear that client billing should only be used when required to ensure that patients have access to high-quality dermatopathology services. The AAD also states that any markup should only cover administrative costs and cannot be used for profit; to do otherwise is "unethical and is considered egregious and unacceptable."[2]

The AAD's strong words reflect the concerns that abusing self-referral and client billing will lead to legislative, regulatory, and contractual restrictions on the dermatologist's ability to provide care to his/her patients. Dermatologists and dermatopathologists are uniquely trained to diagnose and manage skin diseases; among physicians, dermatologists often are the most satisfied with their chosen careers. Although health care reform will bring unpredictable changes to the practice of medicine, we can maintain our specialty's scope of practice by providing efficient, accurate, and cost-effective care, and always putting patients before profit. To do otherwise puts our specialty and by extension our patients at risk. By emphasizing our training, certification, and excellence in patient care, dermatologists can maintain dermatopathology as an integral component of our specialty.

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