Re: UnitedHealthcare Laboratory Benefit Management Program

Dear Ms. Stewart:

On behalf of the Florida Society of Dermatology and Dermatologic Surgery (FSDDS) and the American Academy of Dermatology Association (AADA), we are writing to share our concern regarding the Laboratory Benefit Management Program planned to take effect in Florida on October 1, 2014. Specifically, AADA and FSDDS are concerned that the Laboratory Benefit Management Program will prevent dermatologists from performing their own pathology, impacting the delivery of high quality and cost effective care.

Dermatopathology

The Laboratory Benefit Management Program raises significant concerns from the AADA and FSDDS because it does not acknowledge a dermatologist’s extensive training in pathology or the ability to perform their own dermatopathology. Moreover, it would limit board-certified dermatopathologists’ ability to perform their own dermatology without unreasonable encumbrance.

The AADA and FSDDS believe that dermatologists being able to perform their own dermatopathology serves a critical role in delivering high-quality and affordable dermatologic care for our patients across the country. Your proposed policy would impact dermatologists’ ability to deliver timely, high-quality, and cost effective care.

This policy impacts dermatology patients in two ways. First, when a patient has a skin biopsy, many dermatology practices provide their own dermatopathology services to ensure optimal patient care through delivery of timely and accurate diagnoses relating to a variety of skin conditions—including skin cancers. Specifically, clinicopathologic correlation in dermatopathology is essential for generating the most accurate histopathologic diagnosis. Thus, in the office setting, the immediate availability of clinical data from the patient chart, including clinical photographs, allows for instant correlation of the clinical presentation with the histology. Unlike other specialists, dermatologists receive extensive instruction in dermatopathology as part of their residency training. In fact, dermatologists receive substantially more training in dermatopathology during their residency than do general pathologists. This includes
demonstrating proficiency in dermatopathology by passing a challenging dermatopathology section as part of the American Board of Dermatology’s (ABD) Certifying Examination in order to receive ABD’s certification in dermatology. There are harmful consequences to patient care when ignoring the quality and reliable diagnosis dermatologists and dermatopathologists can provide.

Prompt availability of a skin biopsy reading is particularly important for patients to be accurately diagnosed. Below are brief examples where a delay in biopsy results impacts the quality of care patients receive. Further, these examples display the need for a rapid and reliable diagnosis that could impact acute and long term patient health.

- **Psoriasis versus eczematous reaction** – The clinician wants to use systemic steroids as soon as possible and needs to rule out psoriasis.
- **Exfoliative erythroderma** – The physician needs to establish the underlying diagnosis as soon as possible so the physician can institute the correct treatment.
- **Dysplastic nevus versus melanoma** – The physician needs to establish the correct diagnosis as soon as possible to correctly identify the right plan of action for treatment.
- **Blistering eruption** – The patient is uncomfortable and the physician needs to establish the correct diagnosis as soon as possible so the physician can choose the best drug and plan of action for treatment.

The interpretation of a skin biopsy specimen is not a screening technique analogous to a cytology smear. It is a component of the diagnostic process as important as the physical examination for the dermatologist who reads their own pathology slides or the consultative process whereby a board-certified specialist renders an opinion to another physician. As you can see from the examples above, on-site and local pathology should continue to remain an option since it can improve care for patients and prevent unnecessary health care spending.

Coverage and payment policies that undermine the practice of dermatopathology go against the best interests of patients and run counter to the Academy’s policies addressing dermatopathology and choice of consultant. We invite you to review our attached policies and we would welcome a chance to discuss your perspective on this critical component of dermatologic care.

This clinicopathologic correlation is often necessary for optimal diagnosis and treatment during patient care. Eliminating dermatologists’ ability to function within their scope of practice as dermatopathologists is not in patients’ best interests.

Secondly, if UnitedHealthcare requires an additional reading from a second board-certified dermatopathologist for malignant dermatologic cases, a majority of board-certified dermatologists would, in practical terms, be prevented from routinely performing their own pathology. Indeed, even most dermatology practice groups that include a board-certified dermatopathologist have only one such physician, thus rendering it impractical to obtain a second read. The requirement of a second review for dermatologists is unnecessary, onerous, unfounded, and would routinely delay or even prevent appropriate patient care.

Further, AADA and FSDDS would like to understand the following issues regarding the Laboratory Benefit Management Program pilot:
1. Which pathologist is reimbursed for the pathology and which physician inherits the medical liability risk?
2. What will the processing time be for specimens sent to LabCorp that require two dermatopathology readings? Will this cause a delay in patient care?

AADA and FSDDS strongly believe that dermatopathology services should be performed only when appropriate, and only by physicians qualified to perform them. Board-certified dermatologists are inherently qualified and trained. Rereading of slides initially read by a dermatologist should be confined to cases when complex or ambiguous cases warrant this based on technical medical considerations.

AADA and FSDDS struggle to see how quality of patient care is improved by requiring onerous standards that will delay patient treatment because of a need to have a specimen read by a second dermatopathologist or an outside company like LabCorp. Further, we request documentation from UnitedHealthcare that justifies how quality of care will be improved by this pilot program before it is implemented more broadly. This pilot program appears to prevent Dermatologists – who are accepting the medico-legal risks of their trade – from performing tasks that are within their scope of practice and could potentially be a restraint of trade by limiting the marketplace of eligible dermatopathologists.

**Conclusion**

While AADA and FSDDS understand your concerns with responsibly managing medical costs, we advise against creating an environment in which dermatopathology becomes a commodity provided only by pathologists who are chosen based solely on price and not on quality or clinical accuracy. Specifically, this situation arises when dermatologists are forced to send their pathology to distant laboratories about whom they know nothing except that the patient will not get reimbursed for the service if they do not comply. The pathology reports issued by high-volume labs that rank cost-containment as a priority are below the standard of quality expected by practicing dermatologists and dermatopathologists, who deliver significantly more complete and helpful reports. This is particularly true of general pathologists who may complete their residency program without the extra training in the field of dermatopathology that is necessary for rendering the very best care.

Denying full access to payer networks to qualified dermatology practices, dermatopathologists, and dermatopathology laboratories will result in delays in diagnosis, incorrect work-ups, unnecessary imaging, and patient harm when erroneous diagnoses are made. The medicolegal liability risk is also substantial when analysis of biopsy tissue is substandard in quality.

In summary, dermatologists are nearly unanimous in their belief that their “right to read one’s own slides” and/or to refer to a dermatopathology “consultant of choice” should be preserved. AADA and FSDDS support preserving these choices, and welcome the opportunity to establish a dialogue so we can provide you with the dermatologist and dermatopathologist experience and perspective on this critical, but often misunderstood issue. Further, we believe widespread implementation of the Laboratory Benefit Management Program would only lead to increased costs and fail to provide a higher standard of care than a dermatologist already delivers due to their extensive training in dermatopathology. AADA and FSDDS welcome the opportunity for
Re: UnitedHealthcare Clinical Laboratories Network Reconfiguration and Laboratory Benefit Management Program

further dialogue. Please contact David Brewster, Assistant Director for Practice Advocacy at 202-609-6334 or dbrewster@aad.org to set up a mutually agreeable time to meet and discuss these issues.

Sincerely,

Brett Coldiron, MD, FAAD
President
American Academy of Dermatology Association

Oliver M. Reed, MD, FAAD
President
Florida Society of Dermatology and Dermatologic Surgery

cc:
Richard Justman, MD, UnitedHealthcare, National Medical Officer
Elaine Weiss, JD, AADA, Chief Executive Officer
Barbara Greenan, Senior Director, Government Affairs
Leslie Stein Lloyd, JD, AADA, Director, Regulatory and Payment Policy
David W. Brewster, AADA, Assistant Director, Practice Advocacy

Attachments:
1. Position Statement on Pathology Billing
   (http://www.aad.org/Forms/Policies/Uploads/PS/PS-Pathology%20Billing.pdf)
2. Position Statement on Choice of Consultant for Interpretation of Skin Biopsy Specimens
   (http://www.aad.org/Forms/Policies/Uploads/PS/PS-Physician%20Choice%20of%20Consultant%20for%20Interpretation%20of%20Skin%20Biopsy%20Specimens.pdf)
As part of their dermatology residency program, dermatologists receive extensive medical, surgical, and dermatopathology training. Dermatopathology is a critical component of dermatologic care, which ensures that skin biopsy specimens receive accurate, reliable, and timely diagnosis for the purpose of delivering quality patient care. Clinical-pathological correlation is part of the unique training of all dermatologists.

1. The Association supports the right to bill for one’s own work:
   a. A board-certified dermatologist and board-certified dermatopathologist must continue to have the ability to bill for both the technical and professional components of pathology work (global fee) if they have their own physician office lab where they supervise the preparation of and interpret their own dermatopathology slides.
   b. A board-certified dermatologist must continue to have the ability to bill for the professional component of pathology work if they interpret their own slides but rely on an outside reference lab to prepare their slides outside the office. This outside reference lab would then bill for the technical work they provide.

2. The Association supports the principle of freedom of choice of dermatopathology consultants:
   a. Dermatologists must retain the right to use a dermatopathologist of their choosing, even if/when that dermatopathologist works in the same group practice as the referring dermatologist. This should be true even for small single-specialty groups (not just multi-specialty groups). The dermatologist and dermatopathologist work together to deliver the best care for the patient and it is necessary for the dermatologist to be able choose the dermatopathologist with whom they work best based upon their confidence in that dermatopathologist’s ability and the ability to communicate with each other.

3. The Association supports the principle of dermatology office labs:
   a. It is acceptable for board-certified dermatologists to have their own physician office labs where they can rely on in-office histology slide processing so that they are able to either read their own slides or refer their slides to their own in-house dermatopathologists for interpretation. For purposes of practice integration and clinic-diagnostic nexus, this model should be preserved, especially as dermatology group practices grow. However, practices that adopt such a model must ensure that the quality of the services they provide matches or exceeds that available from outside vendors, as the model is inherently suspect to payers and regulators who perceive it as a method of income maintenance in the face of other payment cuts. Dermatologists should be mindful that this practice may bring significant scrutiny.
b. Any change in supervision or certification requirements for preparing dermatopathology slides must not impede the ability of dermatologists to run their own physician office labs without unreasonable new hurdles, as long as those labs have and maintain high quality standards and practices.

4. The Association cautions against the risks associated with certain physician office lab models:

a. Technical component (TC)/professional component (PC) arrangements that involve splitting the services between a dermatology practice performing the TC and/or the outside reference pathology lab performing the PC, or any combination or permutation thereof should not be designed primarily for the financial gain of the dermatology practice. This may endanger patient safety, undermine quality of care, raise medico-legal risks/compliance red flags, and invite ethical concerns.

b. The Association urges against purchased service arrangements for ancillary dermatopathology lab tests provided by an outside pathology lab to a dermatology practice that then inappropriately marks up the cost and bills for work not performed by the billing dermatology practice. This arrangement results in a lowering of the level of resources available for providing pathology services to patients, invites scrutiny from state regulators, and is clearly unethical.

c. Dermatology practices purchasing the TC and/or PC of dermatopathology services from an outside lab have been notified by the Association that, where permitted by law, client billing is appropriate ONLY when necessary to ensure access to high-quality dermatopathology services. Any mark-up can only cover the administrative cost incurred by the dermatology practice. Marking up purchased services solely for profit is unethical and is considered egregious and unacceptable by the Association.

Dermatologists and their staff need to be aware of, and comply with, the full scope of complex federal and state laws and regulations governing the provision and billing of pathology laboratory services. They should also be mindful that, in certain instances, private payers may impose restrictive payment policies governing the provision of professional and/or technical dermatopathology lab services.
The American Academy of Dermatology strongly supports the rights of patient access to care and choice of a physician. As an extension of these rights, physicians have the responsibility to choose consultants in the best interests of their patients. Specifically this requires that clinicians choose a physician with expertise in dermatopathology or cutaneous immunopathology to interpret skin biopsy specimens taken from their patients. Dermatologists and pathologists are trained in the interpretation of skin biopsy specimens and many have maintained competency in this field through continued education and practical experience. The Residency Review Committees for both Dermatology and Pathology require that residency training programs emphasize dermatopathology in their curricula.

A dermatology residency program devotes approximately 25% of its curriculum to dermatopathology and an equal percentage of the dermatology certifying examination evaluates proficiency in dermatopathology. This level of expertise is recognized at the Federal level as evidenced by applicable CLIA regulations published in the February 28, 1992 Federal Register (Vol. 57, No. 40, page 7179 (1) (2) (B) (3)), which attest to the qualifications of dermatologists for interpretation of dermatopathology tests.

Many dermatologists prefer to refer skin biopsy specimens obtained from their patients to specialized dermatopathology laboratories directed and staffed by dermatologists and/or pathologists with special expertise in dermatopathology and immunopathology. Besides the education obtained during residency training, these physicians have acquired specific training leading to certification of special qualification in dermatopathology by the American Board of Dermatology and the American Board of Pathology. This additional training is a one or two year program approved by the Accreditation Council for Graduate Medical Education. Also included under the general category of dermatopathology are physicians with further training leading to special certification in cutaneous immunopathology.

Dermatopathology is a professional or consultation service rather than a quantitative laboratory test. Dermatopathologic interpretation is an integral part of a dermatologist’s service to his or her patients. Accurate interpretation of skin biopsies requires an ability to recognize and record the details of the specimen, and to synthesize these findings with the clinical situation. Failure to interpret skin biopsy specimens correctly can mislead the clinician, can interfere with institution of appropriate medical or surgical therapy, and may thus potentially cause harm to the patient. Certain managed care
programs mandate that the treating physician send skin biopsy specimens to laboratories with exclusive contracts for pathology.

These laboratories may lack a physician, or lack sufficient numbers of physicians, with a high level of training and experience in dermatopathology or immunopathology. Sometimes the treating physician must send skin biopsy specimens to multiple different laboratories in multiple locations, depending upon the mandates of various insurance plans. This dissemination of specimens results in interpretations by a variety of individuals whose expertise may be unknown to the treating physician, and whose terminology may be unfamiliar to the treating physician. Often no working relationship has been established between the clinician and the managed care pathologist. This subjects the patient to a likelihood of having the skin biopsy specimen misinterpreted.

Quality medical care demands that physicians have the right and responsibility to use an acknowledged expert in the histopathologic diagnosis of skin diseases. Sometimes this expert will be the treating physician. In other cases the treating physician will choose a local or regional expert. Patients deserve routine access to this expertise, especially when the physician highly trained in dermatopathology is willing to accept a competitive reimbursement.

In summary, the American Academy of Dermatology supports the principles of freedom of choice of consultants, free access to any qualified physician, and the right of any qualified physician to negotiate a competitive reimbursement.

This Position Statement is provided for educational and informational purposes only. It is intended to offer physicians guiding principles and policies regarding the practice of dermatology. This Position Statement is not intended to establish a legal or medical standard of care. Physicians should use their personal and professional judgment in interpreting these guidelines and applying them to the particular circumstances of their individual practice arrangements.