Position Statement
on
Pathology Billing
(Approved by the Board of Directors: March 2, 2013; Revised August 9, 2014; Revised March 11, 2024)

Dermatologists receive extensive medical, surgical, and dermatopathology instruction during their residency training. Dermatopathology is a critical component of dermatologic care, ensuring that skin biopsy specimens receive expert, accurate, and timely diagnosis for the purpose of delivering quality patient care. Clinicopathological correlation (CPC) is critical to accurate diagnosis and treatment of patients.

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 and interpretation of 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 for small single-specialty groups as well as larger multi-specialty groups alike. This should also be true if the dermatologist chooses to send outside of the group practice. The dermatologist and dermatopathologist work together to deliver the best care for the patient, and it is necessary for the dermatologist to be able to choose the dermatopathologist with whom they work best based upon their professional expertise and their ability to effectively communicate with that dermatopathologist.

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 or a dermatopathologist that the clinician chooses. 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 if those labs have and maintain high-quality standards and practices. Recognizing that a discussion of what constitutes both quality and efficiency continues to evolve, the Association disagrees with the notion that quality is equivalent to accreditation by one or more of a limited number of organizations and that efficiency can be determined by reimbursement rates alone.

4. The Association cautions against the risks associated with certain physician practice and 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.

   d. Arrangements in which a dermatologist owns shares in a laboratory and receives dividends based on the volume of services they send to the laboratory creates financial incentives that may not be in the best interest of patient care. This raises both ethical and medicolegal/compliance concerns.

   e. Practice models in which a dermatologist reviews a digital version of a dermatopathology report (after a specimen is sent to a laboratory for processing, digitizing and digital diagnosis) and then confirms the diagnosis may result in the dermatologist capturing revenue for confirming the report. Such arrangement does not enhance patient care and invites scrutiny.

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, including Stark Law, anti-kickback statutes, and false claims acts. 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. It is important that any practice expend appropriate efforts to understand and use proper CPT coding for the services it provides and that its coding is verified by an authoritative entity such as the local Medicare carrier or relevant private payer. Furthermore, the Association expects its members to uphold the ethics of the physician medical profession. The AADA does not support unethical practices, such as payment models whose sole purpose is to increase compensation and that are not in the best interest of patient care.