

## Testimony of Robert C. Babkowski, MD

### Re: Opposition to HB 5476

I am also here today in support of the current law governing billing for anatomic pathology services. In addition to the pathologists present here today, 50 Pathologists at 13 Connecticut hospitals have petitioned this Committee to reject this legislation and support the current law. **The pathologist position is that no patient awaiting a biopsy result should be exploited by a marked-up pathology charge by a physician who has not performed any work to actually justify the charge—it is ethically wrong and financially exploitative.** Similarly, no patient should have to wonder or question whether the number of biopsies taken by a physician that orders such services is driven by good medical practice or his/her greed. In fact, in 2006, two physicians at the University of Connecticut Medical Center, neither of whom were pathologists, in an AMA ethics journal article on pathology markups stated that “such behavior corrupts the profession, impairs patient trust, and most importantly may cause patient harm.” This law effectively prohibits the practice of “markup” and is therefore beneficial to patients and society as a whole because it insulates medical judgment regarding biopsy specimens and laboratory referrals from profit considerations. Ultimately, this law protects the patient and helps promote quality in pathology.

It is our understanding that urologists in Connecticut are driving this effort to repeal this law. The Committee should be aware that nationally urologists have also attempted to thwart the closing of Medicare loopholes that permitted markups on lab services in limited situations. Urologists sued the federal Center for Medicare and Medicaid Services in January 2008 to block the

tightening of the federal regulations to close these markup loopholes in Medicare. The Urologists' lawsuit was dismissed by the US District Court of the District of Columbia in May 2008. If urologists in Connecticut claim this law has adversely impacted quality, the legislature should demand evidence that shows how quality of urology care is inferior in New York or inferior in California, or Massachusetts, Iowa, Ohio, or Rhode Island, because all of these states have laws similar to the current Connecticut law –15 states in all. In fact, urologists' efforts to repeal the current law commenced days after the law went into effect. Any argument regarding patients or quality concern is a pretext motivated by greed and nothing more.

Urologists have argued for the legitimacy of the “markup” and the appropriateness of billing for services they do not provide. The payors are waking up to this practice however. Massachusetts Blue Cross Blue Shield in October 2009 reminded physicians that: “Pass-through billing [by physicians that do not perform the service] **contributes to rising healthcare costs and results in significant increased premiums for employers and individual members.**” Incidentally, Massachusetts enacted its direct billing law for pathology services in 2006 and there was no urologist outcry in that state.

Connecticut urologists claim that the law establishes a monopoly for pathologists. That is a lie. Any physician that truly performs the anatomic pathology service – including for example any dermatologist – can bill for the service under this law. The law prohibits only those physicians from billing for pathology services when they have not provided *any* component of the service. Physicians urging repeal of this law have a transparent motive— the protection of the “markup”. By eliminating this profit motive in 2009 the

Legislature justly served the people of Connecticut and protected them from abusive medical practice. There is no reason to change this law. Thank you.

## Virtual Mentor

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### Clinical case

#### Dermatology lab referrals: cash cow or ethical trap?

Commentary by Jane M. Grant-Kels, MD, and Barry D. Kels, MD, JD

Dr. Adam Vinaver emerged from an exam room at the Metro Dermatology Group's downtown office and spoke to Joan, a lab technician. "Would you see that this biopsy sample gets on the fast track, please? It's from a local lifeguard, and I think he's got a problem here, maybe a serious one. We need results fast."

"OK, I'll send it off. Did you hear about the new lab we're going to be using?" said Joan.

"New lab?" he asked.

"It's one of the boss's bright ideas," she said.

Dr. Vinaver soon learned that the clinic was about to contract with a giant out-of-state lab and would start sending its pathology samples there because the fee schedule was more favorable to the clinic. With a volume discount, the clinic could pay the lab \$40 per sample and get the lab pathologists' interpretation of the path slide promptly. Since most patients' insurers were reimbursing at close to \$120 for lab analysis, Metro could conceivably collect \$80 on every test.

Dr. Vinaver foresaw some problems, not least an ethical conflict of interest. He knew he'd have to confront the group's senior partner on this one, because if there's one thing Jim Swoboda was serious about, it was the cash flow that made the clinic a going concern and a leading group practice in the region.

Dropping by Jim's office, Adam spoke up. "I think we're asking for trouble with this lab referral deal. It almost looks like a kickback to me."

Dr. Swoboda countered, "Well, Adam, it's not illegal if we set it up right—I'm running it by our lawyer today at lunch. He'll look at all the angles for me. We have to work the system and this is one way to do it. There's decent money in this."

"You're not worried that we'll be tempted to do more tests to get the volume discount and make more money?" Dr. Vinaver asked.

"I'm not telling you to do something a patient doesn't need, but when the opportunity arises, take it."

"Jim, I know you're a good businessman, so look at the risk. We could be getting into a serious conflict of interest here. How will it look? Besides, what happens when the insurers get wind of this? We know our local lab is fast and accurate. Who are these other guys? I'm asking you to wait until we can think it through."

### **Commentary**

We would encourage the Metro Dermatology Group to continue to utilize the local laboratory in which the group partners have confidence, due to its proven track record of speed, accuracy, service and availability for discussion of problematic cases. Large regional and national laboratories may have a roster of pathologists with indeterminate reputations and uncertain credentials. In addition, a switch to pathologists in a large regional or national laboratory might result in less-than-optimal pathologist-to-clinician communication and require clinicians to adapt to a new and unfamiliar terminology.

We would also caution Dr. Swoboda to insure that the Metro Dermatology Group will not run afoul of the federal "Anti-Kickback Statute" which states in relevant part:

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program...shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both [1].

### **Obligations of the dermatologists**

The ethical obligation of the dermatologists is to choose the lab in which they have the greatest confidence. We are aware of situations in which certain dermatologists use a cookie-cutter lab for some or all of their patients due to financial incentives but then consult with a high-quality laboratory for biopsies performed on their close friends and family members. This almost certainly represents unethical behavior and perhaps illegal behavior if the offending dermatologist realizes financial gain from the arrangement [1].

### **Obligation of the pathologists**

The ethical obligation of the laboratory pathologists is to demand working conditions that permit them to perform within, or to even surpass, the standard of care. Therefore, if laboratory management were to request volume or speed inconsistent with accurate diagnosis, its pathologists would be ethically obligated either to

demand amelioration of the situation or to terminate their employment with the lab. In addition, the pathologist requires a quiet work area that is conducive to concentration as well as the ability, for example, to order as many “deeper” (deeper cuts into the paraffin-embedded specimen block to ensure the absence of additional material pathology) and specials (various stains that highlight additional diagnostic clues) as he or she deems necessary. Finally, group conferences during which cases are shared and reviewed by several pathologists enhance the quality of the sign-out process (sending slides out for microscopic examination and differential diagnosis) on more challenging cases.

### **Profit vs. patient care?**

When physicians are required to see more patients per hour than they feel they can examine thoroughly or sign out more slides per day than they feel they can evaluate accurately, the need for profit has compromised patient care. If the work day extends beyond the time when the physician feels alert, profit motives may have compromised patient care. Unfortunately, we believe that 21st-century American medicine has probably reached the point at which the need for profit seriously threatens patient care.

As much as we disapprove of the course Dr. Swoboda wants to pursue, we understand his predicament. It is the rare clinician who can offer patients all the time and compassion they need and deserve while still producing sufficient revenue to service ever-expanding practice costs and meet personal income requirements. Moreover, the era of fee-for-service medicine is essentially at an end except for rare “boutique” or “conciierge” practices. Therefore, many providers in their late 50s and early 60s may choose to leave the ethically challenging, pressure-cooker environment that managed care and governmental controls have created. This situation does not augur well for American medicine or Americans who require the ministrations of the healing arts.

### **Critique of options**

The solution is not finding legal ways to cheat insurers. A better solution would be a return to fee-for-service medicine or hourly reimbursement similar to that demanded by attorneys. In that way, ever-expanding practice overhead could be transferred to the purchaser of the service. The CPT coding system has contributed to a business environment in which revenue is dependent upon volume rather than quality. Yet we seriously doubt that insurers or the government will ever allow physicians either to charge an hourly fee like experienced litigators or to return to fee-for-service medicine with a transparent disclosure of astronomical practice costs. Unfortunately, even if a single-payer system were to be adopted, the increasing overhead costs and medical-legal pitfalls inherent in the practice of medicine would not necessarily be adequately addressed.

Nevertheless, unethical behavior must be avoided because such behavior corrupts the profession, impairs patient trust and, most importantly, may cause patient harm. Disciplines such as internal medicine and pediatrics continue to struggle financially

because of the meager value placed upon face-to-face, doctor-to-patient time. Those physicians in subspecialty fields such as dermatology are more fortunate because of their ability to include cosmetic and procedural “profit centers” in their practices, thereby allowing them the luxury of providing moral, ethical and legal—as well as reasonably compensated—care.

**Reference**

1. 42 USC §1320a-7b.

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