



Issue Brief: Direct Billing of Anatomical Pathology

*AAFP State Government Relations
and Division of Socioeconomics*

The purpose of AAFP State Government Relations Issue Briefings is to provide background information to state constituent chapters in order to facilitate discussion and determine policy or legislative positions. This issue briefing concerns Anatomical Pathology Billing Legislation

Background

The 2005 state legislative session included efforts by several groups to pass legislation that would otherwise prohibit physicians from billing for services that they did not provide in their practice. That is, the legislation would mandate direct billing for services provided by outside reference labs rather than allowing physicians to continue to purchase laboratory services and bill for them under the physician practice's provider number. This differs from non-physician providers attempting to expand their scope of practice as the legislation consists of restricting the business practice explicitly to a singular specialty. Legislation was filed in Georgia, Iowa, Massachusetts, and North Carolina in 2005. In 2006, legislation has been filed in Missouri, Oklahoma and Utah along with a petition for findings with the Minnesota Attorney General.

Issue

The rationale for the legislation offered by pathologists is centered on disclosure of billing practices. Representatives for pathologists contend that *primary care physicians* send patient samples to a pathologist for analysis and then bill the patient for pathology services in an amount that exceeds the pathology charge without informing or disclosing a mark-up to the patient. In the Minnesota case, the Minnesota Society of Pathologists contends that primary care physicians are engaging in the unethical conduct of fee splitting and abusive and/or fraudulent business practices.

Outlined in the arguments on the side of pathologists is the contention that the physician ordering the analysis instructs the pathologist to bill the physician rather than the patient for the purpose of marking up the fee charged for the analysis with the intent to profit off the professional work done by the pathologist. Supporters of legislation contend patient billing sometimes exceeds "three or even four times what a pathologist charges." In order to prevent abusive and/or fraudulent billing practices, pathologists are taking a legislative and regulatory approach to solving this problem.

Physician Billing of Purchased Diagnostic Tests

Medicare and other payers have long acknowledged the practice of physicians purchasing such services as laboratory testing and pathology services from vendors and billing the third party payer and/or patient for these costs. However, Medicare and many payers require that the physician billing for purchased diagnostic testing indicate this by appending modifier -90 and in field 20 of the CMS 1500 form including the price paid for the test.

Medicare will allow the lesser of the purchase price or the fee schedule amount for the test. The physician may not bill the patient more than the allowed amount even if non-participating.

The regulations requested by the pathologists do indicate that some physicians may be adding a surcharge to the cost of the tests to cover services which by CPT principles would not be separately billed or would be appropriately reported by a code separate from that of the test.

A physician group in Iowa indicates that not adding a surcharge to the cost of the pathology for PAP smear collections resulted in lost revenue intended to cover the cost of collecting the PAP smear. The *AMA CPT Assistant* issue (Winter 1994) stated, "The services to obtain the PAP smear or throat culture are inherent in the procedure being performed and are not reported separately." The *1997 Evaluation and Management Guidelines* confirm this by including "pelvic examination (with or without specimen collection for smears and cultures)" in the elements of a female genitourinary exam. Medicare does reimburse for obtaining, preparing and conveyance of cervical or vaginal smear to a laboratory separately with code Q0091. This is because of the limited preventive services which Medicare covers. Some private payers have also adopted the policy of reimbursing this service separately when not part of a comprehensive preventive service.

Other physicians may add a surcharge in an effort to cover expenses related to preparing and conveying the specimen to the laboratory. This is a separately billable service which is to be reported with CPT code 99000. There are payers who do not reimburse this code as they consider this expense to be included in the practice expense portion of other services. However, unless a payer has provided written instruction that the costs may be added to the amount billed for the test, a physician may be open to charges of fraud and/or abuse in not following CPT guidelines. Payers often reimburse charges only to later determine that the payment was in error due to incomplete information from the physician.

AAFP Policy

The AAFP has stated in its Policy on Coding and Reimbursement: *Given this recognition, the Academy believes that it is important for both physicians and health plans to abide by the principles of CPT.* For physicians, this means selecting the code that accurately identifies the service performed and documented. By adding a surcharge to the price of a test for the cost of collection and/or preparation and conveyance to the laboratory, a physician would fail to abide by the principles of CPT and/or select the code that accurately identifies the service performed and documented.

No coding or compliance issues seem to arise when there is no surcharge added to the cost of the test by a physician. While this may be merely a convenience to the party paying for the service who receives only one bill for two services, this unnecessarily brings the physician added billing compliance liability for services provided by the laboratory. The charges could come into question should services of the laboratory be found to be noncompliant with accepted standards. Such practice would also increase the practice expense of the physician due to added work to his/her billing staff.

Even if no CPT principle were in question with the surcharge, there may be anti-kickback issues as noted in the rule-making decision by the office of the Minnesota Attorney General. If the laboratory is giving a discounted fee to the physician, this could certainly be seen as an incentive for referrals. State laws may already exist which prohibit this.

Both the Minnesota pathologists and Minnesota Attorney General state that this practice is unethical, per AMA CEJA opinion 6.10*. The AMA Code of Ethics also serves as the AAFP's Code of Ethics (with rare exception). *AAFP legal counsel is reviewing the code to determine if the interpretation for AAFP members is the same.*

The Minnesota Attorney General notes that this practice could be construed as fee splitting since the ordering physician collects a fee and passes part of it on to the pathologist. While we are not sure that this arrangement is fee splitting, the AAFP does have a policy opposed to fee splitting (see <http://www.aafp.org/x6816.xml>.) Also, our policy on "Fees, Excessive" (found at the same URL) states, in part, "Each physician should make his/her own charges and be compensated for services rendered." The practice in question would seem to be contrary to the intent of the statement.

Policy Implications for Constituent Chapters

The regulatory and legislative impact of legislation that restricts billing to a specialty should not be taken lightly. While representatives of the pathologists contend that such billing practices are taking place and the associated mark-ups for services are "three to four times" higher than those charged by a pathologist, there is no empirical evidence provided in support. The allegations could be overstated and supported only by anecdotal information. These services are paid for under fee schedules established by insurance carrier. Increasing the cost of service will not increase the reimbursement as no payer (government or fee for service) will pay in excess of the standardized established fee for service schedules. It would make sense that if the practice is as egregious as represented, providing fee disclosure to patients would eliminate the perceived need for legislative and regulatory remedy.

Legislation filed in the states mentioned as well as the regulatory relief sought in Minnesota include severe reprimands for physicians who bill for services up to and including revocation or non-renewal of license. Legislative and regulatory solutions should not be punitive in nature in regard to licensure. Constituent chapters can provide education to members on the appropriate use of CPT codes specific to the collection of specimens for pathology analysis.

Enactment of this type of legislation may create a legislative and/or regulatory demand from other specialties (e.g., radiologists) to mandate direct billing for their services or otherwise restrict primary care physicians' ability to bill for services purchased from such specialties.

*[See the AMA Code of Ethics](#)

[AMA Policy No. E-6.10; http://www.ama-assn.org/apps/pf_new/pf_online]

Additional Background Documents Available Online

Minnesota Physicians Service Network Letter

http://www.aafp.org/PreBuilt/stateadvocacy_MN_PSN_Letter.pdf

Minnesota Attorney General Opinion

http://www.aafp.org/PreBuilt/stateadvocacy_MN_AG_Opinion.pdf

Minnesota Society of Pathologists Petition for Rulemaking

http://www.aafp.org/PreBuilt/stateadvocacy_MN_Pathology_Petition.pdf