A pathologist's observations about in-office AP labs

September 2013—*With the GAO reporting that self-referral of anatomic pathology and other services costs Medicare millions, and with legislation introduced Aug. 1 that would prohibit such self-referrals, physician groups are fighting back, arguing that the exemptions allow for more integrated care. Not so, says pathologist Matthew Foster, MD, who shared what he's observed about in-office AP labs in an Aug. 8 CAP online panel discussion. He is with Pathology Consultants of Central Virginia, an independent lab that provides services to Centra Health, a nonprofit hospital system serving a community of about 350,000. He is also associate medical director of the Alan B. Pearson Regional Cancer Center in Lynchburg. Dr. Foster's edited remarks follow.*

Dr. Foster

In this era of declining reimbursement, physicians are searching for creative ways to maintain revenue in a volume-based fee-for-service world. This is not unique to anatomic pathology; it reflects a wider practice of providing a greater level of in-office services that are justified as being convenient for the patient or leading to care that is more integrated. At their root, however, they serve as alternative revenue streams.

I have listened to many discussions centering on the cost, legality, policy, and technical angles of in-office anatomic pathology labs. I have heard passionate arguments on both sides, and I hope those who support in-office pathology labs would agree that despite there being strong feelings about this issue, its importance calls for civil discussion. Let me also acknowledge that pathologists are not immune to the temptations of overutilization, in both self-referral and non-self–referral arrangements.

To understand where we are now we must look at how we got started. When the in-office exemption to the Stark Law was enacted I believe the intent was to allow for in-office services that would provide an immediate benefit to the patient at the time of the visit. A rapid strep test, for example, provides immediate and actionable information that allows for timely, efficient, and appropriate care. Thus, a legitimate argument can be made in favor of the in-office clinical lab: Actionable information can be obtained at the time of service and therefore the lab does provide a tangible benefit to the patient. In-office anatomic pathology labs are fundamentally different because they cannot routinely provide actionable results at the time of the biopsy and therefore do not meet the same level of patient convenience as an in-office clinical laboratory.

As health care providers we enjoy a standard of living higher than that of many other professionals. With that comes a high level of societal trust and responsibility that the advice and opinions we give to our patients are based on sound medical evidence and experience and not at all related to what we stand to gain financially. We have a responsibility to be stewards of that trust. Practicing medicine is not equivalent to manufacturing widgets. If we are true to our calling as physicians, then we are duty bound to be our patients' advocates. What is in the patient's best interest seems to have been lost in the wider discussion of in-office pathology laboratories. I offer my observations on in-office labs and the impact they have had in my community. I suspect my situation is far from unique.

Clinician advocates of in-office anatomic pathology labs will tell you that the labs result in better, more direct communication with the pathologist and easy access to reports and images. In my experience, the opposite is true. These labs are not equivalent to non-self–referral arrangements. They erect barriers to integrated multidisciplinary quality care that did not exist before the in-office laboratory was established.

Here is what I've observed about in-office anatomic pathology labs:

- They do not provide a higher level of service to patients.
- They do not fundamentally change clinician-pathologist interactions.
- They do not provide faster turnaround time.
- They are not more convenient for the patient and, in most cases, patients are unaware of the existence of an in-office lab or the implications of its presence.
- They may not allow for 24/7 availability for pathologist consultation.
- They do not allow for independent verification of accessioning and specimen identification by a master's degree level pathologist assistant.
- They do not allow for rapid peer consultations on difficult cases.

As associate medical director of the Alan B. Pearson Regional Cancer Center and chairman of the center's cancer committee, I have witnessed how the introduction of an in-office laboratory has affected the multidisciplinary delivery of care to cancer patients in our community. In-office labs result in care that is more fractured, not less fractured, and perpetuate the practice of silo medicine wherein one provider may not know what the other is doing or has done. Though we are working at one of the 'most wired hospitals' in the country, since the opening of an in-office AP lab, we as a medical community have lost the ability to seamlessly integrate outpatient pathology reports from in-office pathology labs into a patient's hospital electronic medical record. One oncologist, upon hearing of the opening of an in-office anatomic pathology lab, called it a "step backward" for integrated care.

We do not practice pathology in a vacuum and all of us recognize the value of a second opinion. This is how difficult surgical pathology cases are often handled and it's the bedrock upon which many experts have built their careers. There are seven pathologists in my group, all with different areas of expertise and fellowship training. We share cases daily and meet around a multi-headed scope as part of a highly valued departmental consensus conference. These timely intradepartmental consults remain an invaluable part of daily quality surgical pathology practice. The value of immediate consultation from a colleague down the hall is generally lost in the world of in-office laboratories, which may be staffed by lone pathologists, signing out cases in isolation.

I do not believe that the overall diagnostic acumen of pathologists working in an in-office lab is substandard. I do believe that in-office laboratories do not have the means to provide the same level of service as a multispecialty pathology group with subspecialty pathologists and master's level pathology assistants who are integrated into a larger medical system.

In-office pathology labs exist because no one has said they can't. In my experience, the motivations of the clinicians interested in starting these labs are not altruistic but about enhancing revenue. Their evolution is a consequence of focusing too much on the business side of medicine (I've seen it described as the 'easiest and safest way to add new ancillary revenues to your practice') and losing sight of the potential impact on patient care. A successful business model does not always translate into better patient care.

We cannot serve two masters—this being nothing new, of course, but it's especially true in regard to in-office anatomic pathology labs. Physicians cannot stand at the proverbial bedside and make decisions about what is in the best interests of their patients at the same time they are making decisions about what is in the best interest of their bottom line. It is time to choose.

I believe the business model of a non-pathologist earning money on the professional component of pathology services is wrong and unethical. Further, it could not have been the intent of third-party payers when their fee schedules were established or of the in-office exemption of the Stark Law to allow non-pathologists to profit on the backs of anatomic pathologists who do the work. The best medical care results from the pathologist being an equal but independent partner in the care of a patient and not a subservient employee whose professional work serves

to enhance a clinician’s income.

It is time to close the loophole.

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