Position on preservation of dermatologists' ability to perform dermatopathology

Support:

- The use of dermatologists and pathologists who have the appropriate training and expertise in dermatopathology to interpret skin specimens
- The ability of dermatologists and dermatopathologists to bill and be reimbursed for their own work, as appropriate

Oppose:

- Efforts to eliminate the in-office ancillary services exception to the Stark Law
- Policies which prohibit direct billing for dermatologists and dermatopathologists who prepare and interpret their own slides

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 lead to misdiagnosis, co-morbidity, and fatality. Clinical-pathologic correlation can be a key component for a dermatologic diagnosis of skin disease.

Dermatopathology is an essential component of American College of Graduate Medical Education (ACGME) and Royal College of Physician and Surgeons of Canada (RCPSC) approved dermatology residencies. Twenty-five percent of the dermatology residency curriculum is devoted to dermatopathology, with a similar emphasis in the dermatology board-certifying examination.[1] Residents routinely examine stained histologic sections from the full spectrum of dermatologic disease. Training includes education relating to interpretation of direct immunofluorescence specimens, appropriate use and interpretation of immunohistochemistry (special stains, including immunoperoxidase) and electron microscopy.[2] On average, dermatology residents receive more training in dermatopathology than pathology residents.[3]

Dermatologic surgeons routinely read pathology slides as a part of Mohs Micrographic Surgery (MMS), as evidenced by the fact that pathology valuations are built directly into those CPT codes. MMS is a highly specialized and precise treatment for skin cancer in which the cancer is removed in stages, one tissue layer at a time. After each tissue layer is removed, pathology is performed on that area of tissue to see if skin cancer is present. Depending on the results, the physician may need to remove additional layers of skin or perform repair on the area where skin was removed. By definition, the MMS surgeon (a dermatologist) must also serve as the interpreting dermatopathologist in order to maintain the highest cure rate that this procedure provides.

According to the Appropriate Use Criteria for Mohs Micrographic Surgery, "As defined by the American Medical Association Current Procedural Terminology (American Medical Association, Chicago, IL),MMS is a technique for the removal of complex or ill-defined skin cancer with histologic examination of 100% of the surgical margins. It is a combination of surgical excision and surgical pathology that requires a

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[1]Hancox, J.G., et al. Interpretation of Dermatopathology Specimens Is within the Standard of Care of Dermatology Practice. Dermatol Surg 2005;31:306–309.

[2]American College of Graduate Medical Education. Program Requirements for Dermatology Residencies Currently in Effect. Retrieved July 27, 2016 from: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/080_dermatology_2016.pdf

[3] Singh S, Grummer SE, Hancox JG, Sangueza OP, Feldman SR. The extent of dermatopathology education: A comparison of pathology and dermatology. Journal of the American Academy of Dermatology. Volume 53, Issue 4, October 2005, Pages 694–697.

single physician to act in two integrated but separate and distinct capacities: surgeon and pathologist. If either of these responsibilities is delegated to another physician who reports the services separately, these codes should not be reported…"[4]

The elimination of the in-office ancillary services exception to the Stark Law, or any restrictions on our ability to read our own slides, would negatively impact dermatologic surgeons' ability to quickly and effectively diagnose and treat the epidemic growth in skin cancer. Specifically, it would diminish the ability of dermatologic surgeons to correlate microscopic findings into meaningful patient care decisions efficiently, potentially leading to unnecessary delays in treatment and treatment failures. Further, it would also compromise patient care by foregoing the clinicopathological correlation and dermatopathological expertise of the treating dermatologist.

Dermatologists and dermatopathologists should have the ability to bill for their work, as appropriate to the circumstance. If dermatologists and dermatopathologists have their own office laboratory in which they both supervise the preparation of their dermatopathology slides and interpret these slides, they should be permitted to bill for both the technical and professional components of the pathology. However, if dermatologists read their own slides but have their slides prepared by an outside reference lab, then the dermatologists should bill only for the professional components of the pathology, while the outside laboratory bills for the technical component of the pathology.

While many dermatopathology labs are accredited by the Clinical Laboratory Improvement Amendments (CLIA), the College of American Pathologists, or both, such accreditation should not be legally required as a condition for payment by third party payors. There is no research supporting claims that accredited laboratories are safer than unaccredited laboratories.

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[4]Connolly, S., et al. AAD/ACMS/ASDSA/ASMS 2012 Appropriate Use Criteria for Mohs Micrographic Surgery: A Report of the American Academy of Dermatology, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, and the American Society for Mohs Surgery. Dermatol Surg 2012;38:1582–1603