(33)

STATE OF FLORIDA
BOARD OF MEDICINE

Final Order No. DOH-97-022 Date 7-11-97
FILED
Department of Health
AGENCY CLERK
By: Stephanie J. Dix
Deputy Agency Clerk

IN RE: THE PETITION FOR
DECLARATORY STATEMENT
OF ALAN LEVIN, M.D., and
AMERIPATH, INC.
_____/

FINAL ORDER

THIS CAUSE came before the Board of Medicine (hereinafter "Board") pursuant to Section 120.565, Florida Statutes, and Rule 28-105, Florida Administrative Code, on June 6, 1997, for the purpose of considering the Petition for Declaratory Statement filed on behalf of Alan Levin, M.D., and Ameripath, Inc. (hereinafter "Petitioners"). The Agency for Health Care Administration (hereinafter "AHCA") appeared before the Board for the purpose of participating in the resolution of the Petition. Having considered the Petition, the argument submitted by counsel for the Petitioners, the position set forth by AHCA, and otherwise being fully advised in the premises, the Board makes the following findings and conclusions.

FINDINGS OF FACT

1. Petitioner, Alan Levin, M.D., is a pathologist licensed to practice medicine in the State of Florida. Dr. Levin serves as Chief Operating Officer of Ameripath, Inc. In that capacity, Dr. Levin has regulatory compliance responsibilities for Ameripath and the activities of Ameripath's employed pathologists.

2. Petitioner, Ameripath, Inc., is a Florida corporation which, through employed pathologists, who hold licenses to practice medicine in the State of Florida, provides pathology services to patients and to Florida health care providers. Ameripath's address is 7289 Gardens Road, Suite 200, Riviera Beach, Florida 33404. This is the same address used by Dr. Levin.

3. Ameripath, through its employed pathologists, has opportunities to enter into certain business relationships with certain physician groups. The physician groups specialize in and offer only dermatology services, and consist of two or more physician/dermatologists legally organized as business entities (hereinafter "group"). The group would secure (by independent contract or employee leasing) from Ameripath the services of an Ameripath employed pathologist. The Ameripath employed pathologist would then provide surgical pathology services to the group and its patients on a part-time basis. Through these services rendered to the group, and pursuant to the laboratory work and billing arrangements described below, the group would then offer clinical laboratory services to its patients. The physician owners of the group would then refer patients to the Ameripath employed pathologist for surgical specimen interpretation.

4. The surgical specimen would be referred to an independent laboratory which prepares the specimen on a slide for diagnosis (the "technical" component). No member of the group would be immediately and physically present on the premises of the independent laboratory to directly supervise the technical component. The Ameripath employed pathologist would then interpret the slide specimen and report his or her findings to the referring dermatologist in the group.

5. The independent laboratory will bill Medicare directly for the technical component if the referral involves a Medicare patient. For non-Medicare patients, the independent laboratory will bill the group for the technical component. At all times, the group will be solely and exclusively responsible for setting the charges for the professional component and for the non-Medicare technical component, and for billing and collection of those charges. Such charges, on an aggregate basis, could exceed the group's actual cost to provide these services. The

contracted amount of the consideration paid to Ameripath by the group, for the part-time services of the Ameripath employed pathologist, would be less than the amount the group is entitled to bill for the professional component.

6. In the role as a part-time member of the group, the Ameripath employed pathologist would not be providing the full range of services he or she routinely provides in professional activities outside the group. For example, examination of skin surgical specimens constitutes only 1.7% of the entire range of microscopic examination units of service found under CPT Code Nos. 88302, 88304, 88305, 88307, and 88309. In at least some of the possible arrangements, the addition of a pathologist as a part-time member of a group comprised of dermatologists could result in less than 75% of the total patient care services[1] of the group members being furnished through the group and being billed in the name of the group with the amounts received being treated as receipts of the group. For example, if the group of dermatologists has two full-time members, and adds a part-time Ameripath employed pathologist, who devotes 10% of his or her patient care time to the group as a part-time member of the group, only 70% of the group's total patient care services will be furnished, billed, and collected through the group.

7. Patients regularly served by the group include patients for whom services are reimbursed under the Medicare, Medicaid, and other Federally funded reimbursement programs.

8. AHCA did not dispute any of the factual assertions set forth by Petitioners. Neither Petitioners, nor AHCA, or any other interested person has requested a hearing pursuant to

---

[1] As used herein, "patient care services" means any task performed by a member of the group that addresses the medical needs of specific patients, regardless of whether they involve direct patient encounters. They include, for example, the services of physicians who do not directly treat patient, time spent by a physician consulting with other physicians, or time spent reviewing laboratory tests.

Section 120.57, Florida Statutes.

9. This Petition was noticed by the Board in Volume 23, No. 21, dated May 23, 1997, of the Florida Administrative Weekly (p. 2635).

CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter pursuant to Section 120.565, Florida Statutes, and Rule 28-105, Florida Administrative Code. The Board is aware of the prohibition against using a declaratory statement as a vehicle for the adoption of broad agency policies as discussed in *Florida Optometric Association v. DPR, Board of Opticianry*, 567 So. 2d 928 (Fla. 1st DCA 1990). However, the Board is unable to readily envision a set of circumstances under the statute at issue in this cause that would be so unique as not to apply to any other licensee or group of licensees. Furthermore, the statute clearly directs the Board to encourage and answer declaratory statement petitions precisely like that pending in this matter for the purpose of clarifying the application of this statute. The Board therefore finds itself compelled by the specific mandate in Section 455.236(4)(b)4., Florida Statutes, to accept and answer the Petition filed in this matter.

2. The Petition filed in this cause is in substantial compliance with the provisions of Section 120.565, Florida Statutes, and Rule 28-105, Florida Administrative Code.

3. Section 455.236(3)(k)3.f., Florida Statutes, provides an exclusion from the definition of a "referral" prohibited by the Self-Referral Act a referral:

> By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients and that are provided or performed by or under direct supervision of such referring health care provider or group practice.

4. Section 455.236(3)(f), Florida Statutes, defines a "group practice as follows:

> 'Group practice' means a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association:
>
> 1. In which each health care provider who is a member of the group provides substantially the full range of services which the health care provider routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel;
>
> 2. For which substantially all of the services of the health care providers who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; . . .

5. Section 455.236(3)(f)1., Florida Statutes, requires that to qualify as a "group practice," the groups described in the petition that have an Ameripath employed pathologist as a part-time member, would have to have that pathologist provide "substantially the full range of services which the [pathologist] routinely provides." The Board finds that the type of business arrangement described by Petitioners would not qualify as a "group practice" under this provision because within the described groups, the pathologist would only be examining skin surgical specimens, and such activity would not constitute the full range of services routinely provided by that pathologist outside of his or her part-time work with the group. Therefore, referrals to the part-time pathologist, that are then billed by and for the group, would be prohibited.

6. Furthermore, Section 455.236(3)(f)2., Florida Statutes, requires that to be considered a "group practice" the members of the group must render "substantially all" of their services through the group. The Self-Referral Act does not specifically define "substantially all." At the Federal level, the "Stark Bill" sets forth physician self-referral prohibitions applicable to

Medicare, Medicaid and certain other governmental reimbursement for patient care. The Stark Bill contains the definition of a "group practice" which, in part, is virtually identical to the language found in Section 455.236, Florida Statutes. Given the magnitude of Medicare and Medicaid services rendered by Florida physicians and the relatively similar language and intent set forth in both the state and federal regulations, it is reasonable for the Board to look to the federal standards implementing the Stark Bill when interpreting the provisions of Florida's Self-Referral Act, where it would not be inconsistent with the plain meaning of and legislative intent of the Florida Act. The federal regulations implementing the Stark Bill define "substantially all" to require that at least 75% of the total patient care services of the group practice members are furnished through the group and billed in the name of the group with the amounts received being treated as receipts of the group. *See* Section 42 C.F.R. 351. This federal regulation defines "patient care services" in the same manner as that term is defined above. Accordingly, the Board finds that the business arrangement described by Petitioners would not be a "group practice" because the group members would not render "substantially all" of their services through the group. Therefore, referrals to the Ameripath employed pathologist, who is a part-time member, that are then billed by and for the group would be prohibited.

7. Section 458.331(1)(I), Florida Statutes, provides the following grounds for disciplinary action by the Board:

> Paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services, including, but not limited to, hospitals, nursing homes, clinical laboratories, ambulatory surgical centers, or pharmacies. The provisions of this paragraph shall not be construed to prevent a physician from receiving a fee for professional consultation services.

8. The Board finds that the business arrangement described in the Petition would involve referrals by an entity that is not within the "group practice" exemption of Section 455.236(3), Florida Statutes, and as such these referrals would not be protected by the safe harbor provided in Section 455.236, Florida Statutes. Therefore, to the extent that such referrals would involve splitting professional fees between the referring entity of physicians and the Ameripath employed pathologist,[2] such arrangement would result in a violation of Section 458.331(1)(i), Florida Statutes, because it would entail a split-fee arrangement.

WHEREFORE, the Board hereby finds that under the specific facts of the Petition, as set forth above, the business arrangement described by Petitioners is prohibited pursuant to Sections 455.236 and 458.331(1)(I), Florida Statutes.

DONE AND ORDERED this 30 day of June, 1997.

BOARD OF MEDICINE

Edward A. Dauer

EDWARD A. DAUER, M.D.
CHAIRMAN

NOTICE OF RIGHT TO JUDICIAL REVIEW

---

[2] As set forth in the Petition and accepted as a finding of fact above, the group would be billing and collecting for the professional component and for the non-Medicare technical component of all services provided by the Ameripath employed pathologist. Such charges could exceed the group's actual cost to provide these services to its patients.

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW PURSUANT TO SECTION 120.68, FLORIDA STATUTES. REVIEW PROCEEDINGS ARE GOVERNED BY THE FLORIDA RULES OF APPELLATE PROCEDURE. SUCH PROCEEDINGS MAY BE COMMENCED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE CLERK OF THE AGENCY FOR HEALTH CARE ADMINISTRATION AND A SECOND COPY, ACCOMPANIED BY THE FILING FEES REQUIRED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE PARTY RESIDES OR THE FIRST DISTRICT COURT OF APPEAL. THE NOTICE OF APPEAL MUST BE FILED AS SET FORTH ABOVE AND WITHIN THIRTY (30) DAYS OF RENDITION OF THIS FINAL ORDER.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been furnished by U.S. Mail to Michael J. Cherniga, Attorney at Law, Counsel for Petitioners, P.O. Drawer 1838, Tallahassee, Florida 32302, and by interoffice delivery to Larry G. McPherson, Jr., Chief Medical Attorney, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308, this _____ day of _____, 1997.

_____

AMENDED CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Order has been provided by certified mail to Alan Levin, M.D., 7289 Gardens Road, Sutie 200, Riviera Beach, FL 33404, Michael J. Cherniga, Esquire, Post Office Box Drawer 1838, Tallahassee, FL 32302, and interoffice delivery to Larry McPherson, Jr., Chief Attorney, 2727 Mahan Drive, Tallahassee, Florida 32308-5403, at or before 5:00 p.m., this _____ day of _____, 1997.

_____

STATE OF FLORIDA
BOARD OF MEDICINE

DRAFT

RE: Petition for Declaratory Statement by

CASE NO. _____

AMERIPATH, INC. and
ALAN LEVIN, M.D.,

Petitioners.
_____/

PETITION FOR DECLARATORY STATEMENT

Petitioners, AmeriPath, Inc. and Alan Levin, M.D., pursuant to Section 120.565, Florida Statutes, seek a declaratory statement form the Board of Medicine as follows and upon the following grounds:

I. Introduction and Factual Background

1. Petitioner, AmeriPath, Inc., is a Florida corporation which, through employed pathologists (hereinafter "AmeriPath employed pathologist") who hold licenses to practice medicine in the State of Florida, provides pathology services to patients and to Florida health care providers. AmeriPath's address is 7289 Gardens Road, Suite 200, Riviera Beach, Florida 33404.

2. Petitioner, Alan Levin, M.D., is a pathologist who is licensed to practice medicine in the State of Florida. Dr. Levin serves as AmeriPath's Chief Operating Officer. In that capacity, Dr. Levin has regulatory compliance responsibilities for

AmeriPath and the activities of AmeriPath's employed pathologists. Dr. Levin's business address is that of AmeriPath.

3. The activities of Petitioners are subject to regulation under Section 455.236, Florida Statutes, known as the "Patient Self-Referral Act of 1992", (hereinafter "Self-Referral Act"), attached as **Exhibit A**. Petitioner's activities are also subject to provisions of Section 458.331(1)(i), (hereinafter "Anti Split-Fee Statute"), found in the attached **Exhibit B**.

4. The Board, as part of its jurisdiction over the licensure of physicians in Florida, has responsibility for imposing disciplinary action upon AmeriPath's pathologists for any violations of the Self-Referral Act and/or the Anti Split-Fee Statute.

5. Petitioners' substantial interests are affected by the following **"Proposed Arrangement"**:

a. AmeriPath has opportunities to enter into certain business relationships with certain physician groups. These physician groups specialize in and offer only dermatology services, and consist of two or more physicians/dermatologists legally organized as a partnership, professional corporation, or similar association, (hereinafter "group practice"). The group practice would secure (by independent contract or employee leasing) from AmeriPath the services of an AmeriPath employed

pathologist, who would then provide surgical pathology services to the group practice and its patients on a part-time basis, (described herein as "retained AmeriPath pathologist" when referring to part-time work within the group practice). Through the services rendered to the group practice by the retained AmeriPath pathologist the group practice would then be offering clinical laboratory services for its patients, a "designated health service" as defined at Section 455.236(3)(c) of the Self-Referral Act.

b. The physician owners of the group practice, (i.e., those who hold an "investment interest" in the group practice as defined at Section 455.236(3)(i)), would then refer patients to this designated health service for surgical specimen interpretation to be performed by the retained AmeriPath pathologist. These internal group practice referrals would be based upon the premise that the self-referral prohibition contained in the Self-Referral Act, as found at Section 455.236(4), would not be applicable because a "referral" thereunder does not include a referral:

> By a . . . member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such . . . group practices on patients, and that are provided or performed by or under the direct

> supervision of such referring . . . group practice.

See Section 455.236(k)3.f.

c. The surgical specimens would be referred to an independent laboratory which prepares the specimen on a slide for diagnosis (the "technical component"). No member of the group practice would be immediately and physically present on the premises of the independent-laboratory to directly supervise the technical component.

d. The retained AmeriPath pathologist would then interpret the slide specimen and report his or her findings to the referring group practice dermatologist (the "professional component").

e. The independent laboratory would bill Medicare directly for the technical component if the referral involves a Medicare patient. For non-Medicare patients, the independent laboratory would bill the group practice for the technical component.

f. At all times the group practice would be solely and exclusively responsible for setting the charges for the professional component and for the non-Medicare technical component, and for billing and collection of those charges. These charges, on an aggregate basis, could exceed the group practice's actual cost to provide these services. Thus, as to

referrals to clinical laboratories, under the **Proposed Arrangement** the group practice could gain additional revenue which would not be realized in the absence of the **Proposed Arrangement**.

g. In order to avoid the prohibition against self-referral contained in the Self-Referral Act, among other things, Section 455.236(3)(f), Florida Statutes, requires the group practice to satisfy the requirement that through the group "each healthcare provider who is a member of group provide substantially the full range of services which the healthcare provider routinely provides, including medical care, consultation, diagnosis, or treatment . . . ." The retained AmeriPath pathologist's part-time role in the group practice would not result in the pathologist providing as a group member substantially the full range of services he or she routinely provides as a pathologist and as an AmeriPath employed pathologist. That full range of routinely provided services is described in the attached **Exhibit C**.

h. **Exhibit C** is a copy of a procedure code list reflecting the full range of surgical pathology specimens, or units of service, routinely diagnosed through microscopic examination by a pathologist. As a member of the group practice, the retained AmeriPath pathologist would only examine skin surgical specimens. These examinations constitute only 3 of the total 173 units of

service on the list involving microscopic examination, or 1.7% of the entire range of microscopic examination services routinely provided by a pathologist.

6. Petitioners' substantial interests are also affected by the following "Alternative Proposal Arrangement":

a. Paragraph 5 is incorporated by reference.

b. In order to avoid the prohibition against self-referral contained in the Self-Referral Act, among other things, Section 455.236(3)(f), Florida Statutes, requires the group practice to be able to demonstrate that "substantially all the services of the healthcare providers who are members of the group are provided through the group and are billed in the name of group and amounts so received are created as receipts of the group." In at least some of the Proposed Arrangements, the addition of a retained AmeriPath pathologist as a member of the group practice would result in less than 75% of the total patient care services of the group practice members being furnished through the group practice and being billed in the name of group practice with the amounts received being treated as receipts of the group practice.

c. As used above, "patient care services" means any tasks performed by a group practice member that address the medical needs of specific patients, regardless of whether they involve direct patient encounters. They include, for example, the

services of physicians who do not directly treat patients, time spent by a physician consulting with other physicians, or time spent reviewing laboratory tests.

d. As used above, the percentage determination of total patient care services is measured by the total patient care time each member spends on these services. For example, if the group practice has 2 full time members, and if the retained AmeriPath pathologist devotes only 10% of his or her patient care time to the group practice, only 70% of the group's total patient care services would be furnished, billed, and collected through the group practice:

2 x 100%	=	200%
+1 x 10%	=	10%
		210%
divided by 3 members		
	=	70%

7. Petitioners have contemplated taking advantage of the opportunities to enter into such Proposed Arrangements and Alternative Proposed Arrangements with various group practices. However, Petitioners have not done so because Petitioners believe that such business relationships violate the Self-Referral Act and Anti Split-Fee Statute. However, due to doubt over the correctness of their interpretation of the law, Petitioners seek a declaratory statement from the Board on the issues as more particularly described in the following parts of this Petition.

II Prohibitions Under the Self-Referral Act

8. Section 455.236(3)(f) of the Self-Referral Act defines a "group practice" as follows:

> 'Group practice' means a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association:
>
> 1. In which each healthcare provider who is a member of the group provide substantially the full range of services which the healthcare provider routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel;
>
> 2. For which substantially all the services of the healthcare providers who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; . . .

9. At the Federal level, the "Stark Bill" is similar to Florida's Self-Referral Act in setting forth self-referral prohibitions applicable to Medicare, Medicaid, and certain other governmental reimbursed patient care. The Stark Bill contains definitional language for a "group practice" which, in part, is virtually identical to the above-quoted language found in Florida's Self-Referral Act.

10. HCEA regulations (42 C.F.R., Section 411.351) which implement the Stark Bill define "substantially all" (see Section

455.236(3)(f)2. above) to require that at least 75% of the total patient care services of the group practice members are furnished through the group and billed in the name of the group with the amounts received are treated as receipts of the group. This regulation defines "patient care services" in the same manner as that term is used in paragraph 5(h) above. Further, this regulation requires that patient care services be measured by the total patient care time each member spends on those services, according to the methodology demonstrated in paragraph 5(j) above.

11. Given the magnitude of Medicare and Medicaid services rendered by Florida physicians, it would appear logical and reasonable for the Board to apply the Federal standard found at 42 C.F.R. Section 411.351 as a matter of policy in interpreting the "substantially all" language contained in Section 455.236(3)(f)2. As demonstrated in paragraphs 5(h)(i) and (j) of this Petition, the Alternative Proposed Arrangement does not satisfy this Federal standard.

12. Accordingly, Petitioner's request a declaration from the Board that the Alternative Proposed Arrangement would be in violation of the Self-Referral Act on the basis of a failure to meet the "group practice" definition criterion found at Section 455.236(3)(f)2., Florida Statutes, because the Alternative

Proposed Arrangement would not satisfy the "substantially all" requirement of the statute.

13. Alternatively, if the Board does not desire to apply the Federal definition of "substantially all", then the Petitioners request a declaration identifying the criteria to be relied upon by the Board to interpret whether the "substantially all" language in Section 455.236(3)(f)2. is satisfied.

14. Section 455.236(3)(f)1. of the Self-Referral Act would require the group practice's retained AmeriPath pathologist to provide as a member of the group practice "substantially the full range of services which the [pathologist] routinely provides". As demonstrated in paragraph 5(g) of this Petition, the retained AmeriPath pathologist in both the Proposed Arrangement and Alternative Proposed Arrangement would not satisfy this criterion because within the group practice he or she would only be examining skin surgical specimens. Such activity would not constitute the full range of services routinely provided by that pathologist outside of his or her part-time group practice work.

15. Accordingly, Petitioners request a declaration from the Board that the Proposed Arrangement and the Alternative Proposed Arrangement would be in violation of the Self-Referral Act on the basis of a failure to meet the "group practice" definition criterion found at Section 455.236(3)(f)1., Florida Statutes,

because the Proposed Arrangement and Alternative Proposed Arrangement would not satisfy the "full range of services" requirement of that statute.

16. As set forth in paragraph 5(b) of this Petition, as under the Proposed Arrangement and the Alternative Proposed Arrangement the group practice would rely upon Section 455.236(k)3.f. of the Self-Referral Act which provides exception for referrals solely for the group practice's patients. That exception applies as long as those designated services are provided under the "direct supervision" of the group practice.

17. The HCFA regulations implementing the Stark Bill define "direct supervision" to mean "supervision by a physician who is present in the office suite and immediately available to provide assistance and direction throughout the time the services are being performed". See 42 C.F.R. 411.315. This Board has adopted a similar definition for the term "direct supervision and control" as used in Section 458.303(2), Florida Statutes, to mean:

> The physical presence of the supervising physician on the premises so that the supervising physician is immediately available when needed.

See Florida Administrative Code Rule 59R-2.001.

18. Based on these circumstances, it would be logical and reasonable for the Board to adopt the "immediate presence" requirement in construing the meaning of "direct supervision" as contained in Section 455.236(3)(k)3.f.

19. The Proposed Arrangement and Alternative Proposed Arrangement is for the purpose of allowing the group practice to offer a designated health service and to refer its patients to that service. The technical component provided by the independent laboratory provided by the independent laboratory is an integral part of that designated health service. As demonstrated in paragraph 5(c) of this Petition, The direct supervision requirement of Section 455.236(k)3.f. is not satisfied by the Proposed Arrangement or the Alternative Proposed Arrangement.

20. Accordingly, Petitioner's request a declaration from the Board that the Proposed Arrangement and the Alternative Proposed Arrangement would be in violation of the Self-Referral Act on the basis of a failure to satisfy the referral exception for group practice found at Section 455.236(3)(k)f., because the Proposed Arrangement and the Alternative Proposed Arrangement would not satisfy the requirement that a member of the group must directly supervise the designated health service.

21. Alternatively, if the Board does not desire to apply the definition of "direct supervision" set forth in paragraph 17 above, the Petitioner's request a declaration as to the criteria to be relied upon by the Board to determine whether the direct supervision" language in Section 455.236(3)(k)f. is satisfied.

III. Prohibition Under the Anti Split-Fee Statute

22. Section 458.331(1)(i) provides the following ground for disciplinary action:

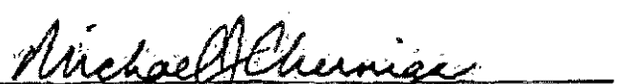
> Paying or receiving any commission, bonus, kick-back, or rebate, or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services, including, but not limited to, hospitals, nursing homes, clinical laboratories, ambulatory surgical centers, or pharmacies. The provisions of this paragraph shall not be construed to prevent a physician from receiving a fee for professional consultation services.

23. The Proposed Arrangement and Alternative Proposed Arrangement would allow the group practice to profit form offering and billing for a designated health service and, therefore, from the referral of its patients to that service. To the extent that any part of the Proposed Arrangement and Alternative Proposed Arrangement above is in violation of the Self-Referral Act, then they would be in violation of the Anti Split-Fee Statute as well. Because the owners of the group

practice can not refer their own patients to the designated health service in which they have an investment interest, the act of billing and collecting for the professional component and for the non-Medicare part of the technical component would constitute a split-fee arrangement with another provider of health services.

24. Accordingly, Petitioners request a declaration from the Board that the Proposed Arrangement and the Alternative Proposed Arrangement would be in violation of the Anti-Split Fee statute because they would allow the group practice to share in fees for service for which it could not legally provide, and because the fees received by the group practice do not otherwise have any relation to the cost of services provided by the group practice.

GREENBERG, TRAURIG, HOFFMAN,
LIPOFF, ROSEN & QUENTEL, P.A.
101 East College Avenue
Post Office Drawer 1838
Tallahassee, FL 32302
904/222-6891



MICHAEL J. CHERNIGA
Florida Bar Id. 328014

Attorney for Petitioners

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that original and one copy of the foregoing has been furnished by Hand Delivery to **Marm Harris**, Executive Director, Board of Medicine, 1940 North Monroe Street, Tallahassee, Florida 32399-0700 and by U.S. Mail to **Allen Grossman**, Deputy Assistant Attorney General, Room 308, Ervin Building, 2020 Capital Circle, Tallahassee, Florida 32399 and to **Larry G. McPherson, Jr.**, Chief Medical Attorney, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308 on this 13th day of March, 1997.

Michael J. Cherniga

Michael J. Cherniga

TALL/CHERNIGA/10615/29v801*.DOC/3/13/97

WEST'S FLORIDA STATUTES ANNOTATED
TITLE XXXII. REGULATION OF PROFESSIONS AND OCCUPATIONS
CHAPTER 455. REGULATION OF PROFESSIONS AND OCCUPATIONS: GENERAL PROVISIONS

Current through End of 1995 1st Regular Session

455.236. Financial arrangements between referring health care providers and providers of health care services

(1) Short title.--This section shall be known and may be cited as the "Patient Self-Referral Act of 1992."

(2) Legislative intent.--It is recognized by the Legislature that the referral of a patient by a health care provider to a provider of health care services in which the referring health care provider has an investment interest represents a potential conflict of interest. The Legislature finds these referral practices may limit or eliminate competitive alternatives in the health care services market, may result in overutilization of health care services, may increase costs to the health care system, and may adversely affect the quality of health care. The Legislature also recognizes, however, that it may be appropriate for providers to own entities providing health care services, and to refer patients to such entities, as long as certain safeguards are present in the arrangement. It is the intent of the Legislature to provide guidance to health care providers regarding prohibited patient referrals between health care providers and entities providing health care services and to protect the citizens of Florida from unnecessary and costly health care expenditures.

(3) Definitions.--For the purpose of this section, the word, phrase, or term:

(a) "Board" means any of the following boards relating to the respective professions: the Board of Medicine as created in s. 458.307; the Board of Osteopathic Medicine as created in s. 459.004; the Board of Chiropractic as created in s. 460.404; the Board of Podiatric Medicine as created in s. 461.004; the Board of Optometry as created in s. 463.003; the Board of Pharmacy as created in s. 465.004; and the Board of Dentistry as created in s. 466.004.

(b) "Comprehensive rehabilitation services" means services that are provided by health care professionals licensed under part I or part III of chapter 468 or chapter 486 to provide speech, occupational, or physical therapy services on an outpatient or ambulatory basis.

(c) "Designated health services" means, for purposes of this section, clinical laboratory services, physical therapy services, comprehensive rehabilitative services, diagnostic-imaging services, and radiation therapy services.

(d) "Entity" means any individual, partnership, firm, corporation, or other business entity.

(e) "Fair market value" means value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes, not taking into account its intended use, and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(f) "Group practice" means a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association:

1. In which each health care provider who is a member of the group provides substantially the full range of services which the health care provider routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel;

2. For which substantially all of the services of the health care providers who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; and

3. In which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group.

(g) "Health care provider" means any physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or any health care provider licensed under chapter 463 or chapter 466.

(h) "Immediate family member" means a health care provider's spouse, child, child's spouse, grandchild, grandchild's spouse, parent, parent-in-law, or sibling.

(i) "Investment interest" means an equity or debt security issued by an entity, including, without limitation, shares of stock in a corporation, units or other interests in a partnership, bonds, debentures, notes, or other equity interests or debt instruments. Except for purposes of s. 455.239 the following investment interests shall be excepted from this definition:

1. An investment interest in an entity that is the sole provider of designated health services in a rural area;

2. An investment interest in notes, bonds, debentures, or other debt instruments issued by an entity which provides designated health services, as an integral part of a plan by such entity to acquire such investor's equity investment interest in the entity, provided that the interest rate is consistent with fair market value, and that the maturity date of the notes, bonds, debentures, or other debt instruments issued by the entity to the investor is not later than October 1, 1996.

3. An investment interest in real property resulting in a landlord-tenant relationship between the health care provider and the entity in which the equity interest is held, unless the rent is determined, in whole or in part, by the business volume or profitability of the tenant or exceeds fair market value; or

4. An investment interest in an entity which owns or leases and operates a hospital licensed under chapter 395, or a nursing home facility licensed under chapter 400.

(j) "Investor" means a person or entity owning a legal or beneficial ownership or investment interest, directly or indirectly, including, without limitation, through an immediate family member, trust, or another entity related to the investor within the meaning of 42 C.F.R. s. 413.17, in an entity.

(k) "Referral" means any referral of a patient by a health care provider for health care services, including, without limitation:

1. The forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies designated health services or any other health care item or service;

or

2. The request or establishment of a plan of care by a health care provider, which includes the provision of designated health services or other health care item or service.

3. Except for the purposes of s. 455.239, the following orders, recommendations, or plans of care shall not constitute a referral by a health care provider.

a. By a radiologist for diagnostic-imaging services.

b. By a physician specializing in the provision of radiation therapy services for such services.

c. By a medical oncologist for drugs and solutions to be prepared and administered intravenously to such oncologist's patient, as well as for the supplies and equipment used in connection therewith to treat such patient for cancer and the complications thereof.

d. By a cardiologist for cardiac catheterization services.

e. By a pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician.

f. By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice.

g. By a health care provider for services provided by an ambulatory surgical center licensed under chapter 395.

h. By a health care provider for diagnostic clinical laboratory services where such services are directly related to renal dialysis.

i. By a urologist for lithotripsy services.

j. By a dentist for dental services performed by an employee of or health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member.

k. By a physician for infusion therapy services to a patient of that physician or a member of that physician's group practice.

l. By a nephrologist for renal dialysis services and supplies.

(l) "Rural area" means a county with a population density of no greater than 100 persons per square mile, as defined by the United States Census.

(4) Prohibited referrals and claims for payment.--Except as provided in this section:

(a) A health care provider may not refer a patient for the provision of designated health services to an entity in which the health care provider is an investor or has an investment interest.

(b) A health care provider may not refer a patient for the provision of any other health care item or service to an entity in which the health care provider is an investor unless:

1. The provider's investment interest is in registered securities purchased on a national exchange or over-the-counter market and issued by a publicly held corporation:

a. Whose shares are traded on a national exchange or on the over-the-counter market; and

b. Whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million; or

2. With respect to an entity other than a publicly held corporation described in subparagraph 1., and a referring provider's investment interest in such entity, each of the following requirements are met:

a. No more than 60 percent of the value of the investment interests are held by investors who are in a position to make referrals to the entity.

b. The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are no different from the terms offered to investors who are not in a position to make such referrals.

c. The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are not related to the previous or expected volume of referrals from that investor to the entity.

d. There is no requirement that an investor make referrals or be in a position to make referrals to the entity as a condition for becoming or remaining an investor.

3. With respect to either such entity or publicly held corporation:

a. The entity or corporation does not loan funds to or guarantee a loan for an investor who is in a position to make referrals to the entity or corporation if the investor uses any part of such loan to obtain the investment interest.

b. The amount distributed to an investor representing a return on the investment interest is directly proportional to the amount of the capital investment, including the fair market value of any preoperational services rendered, invested in the entity or corporation by that investor.

4. Each board and, in the case of hospitals, the Department of Health and Rehabilitative Services, shall encourage the use by licensees of the declaratory statement procedure to determine the applicability of this section or any rule adopted pursuant to this section as it applies solely to the licensee. Boards shall submit to the Department of Health and Rehabilitative Services the name of any entity in which a provider investment interest has been approved pursuant to this section, and the Department of Health and Rehabilitative Services shall adopt rules providing for periodic quality assurance and utilization review of such entities.

(c) No claim for payment may be presented by an entity to any individual, third-party payor, or other entity for a service furnished pursuant to a referral prohibited under this section.

(d) If an entity collects any amount that was billed in violation of this section, the entity shall refund such amount on a timely basis to the payor or individual, whichever is applicable.

(e) Any person that presents or causes to be presented a bill or a claim for service that such person knows or should know is for a service for which payment may not be made under paragraph (c), or for which a refund has not been made under paragraph (d), shall be subject to a civil penalty of not more

than $15,000 for each such service to be imposed and collected by the appropriate board.

(f) Any health care provider or other entity that enters into an arrangement or scheme, such as a cross-referral arrangement, which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil penalty of not more than $100,000 for each such circumvention arrangement or scheme to be imposed and collected by the appropriate board.

(g) A violation of this section by a health care provider shall constitute grounds for disciplinary action to be taken by the applicable board pursuant to s. 458.331(2), s. 459.015(2), s. 460.413(2), s. 461.013(2), s. 463.016(2), or s. 466.028(2). Any hospital licensed under chapter 395, found in violation of this section shall be subject to the rules adopted by the Department of Health and Rehabilitative Services pursuant to s. 395.0185(2). [FN1]

(h) Any hospital licensed under chapter 395, that discriminates against or otherwise penalizes a health care provider for compliance with this act.

(i) The provision of paragraph (a) shall not apply to referrals to the offices of radiation therapy centers managed by an entity or subsidiary or general partner thereof, which performed radiation therapy services at those same offices prior to April 1, 1991, and shall not apply also to referrals for radiation therapy to be performed at no more than one additional office of any entity qualifying for the foregoing exception which, prior to February 1, 1992, had a binding purchase contract on and a nonrefundable deposit paid for a linear accelerator to be used at the additional office. The physical site of the radiation treatment centers affected by this provision may be relocated as a result of the following factors: acts of God; fire; strike; accident; war; eminent domain actions by any governmental body; or refusal by the lessor to renew a lease. A relocation for the foregoing reasons is limited to relocation of an existing facility to a replacement location within the county of the existing facility upon written notification to the Office of Licensure and Certification.

(j) A health care provider who meets the requirements of paragraphs (b) and (i) must disclose his investment interest to his patients as provided in s. 455.25.

CR01

[FN1] Section 395.0185(2), as amended by Laws 1992, c. 92-289, § 10, provides for adoption of rules by the Agency for Health Care Administration rather than the Department of Health and Rehabilitative Services.

CREDIT(S)

1996 Interim Update

CR01 Laws 1992, c. 92-178, § 7, eff. April 8, 1992. Amended by Laws 1994, c. 94-218, § 89, eff. May 20, 1994; Laws 1995, c. 95-144, § 60, eff. July 10, 1995; Laws 1995, c. 95-146, § 35, eff. July 10, 1995. < < For additional credits, if any, see Historical Note field. > >

< General Materials (GM) - References, Annotations, or Tables >

HISTORICAL AND STATUTORY NOTES

1996 Interim Update

Laws 1992, c. 92-178, § 15, eff. April 8, 1992, as amended by Laws 1993, c. 93-129, § 55, eff. Oct. 1,

(a) Upon such suit being filed, the court shall conduct a hearing, with notice to the department, the board, and all interested parties, at the earliest practicable time. If the plaintiff makes a showing that a violation of subsection (1) is in progress or that there is a clear, real, and present danger that such a violation is about to commence, the court shall issue a temporary injunction enjoining such violation. Upon final hearing, the court shall either make the injunction permanent or dissolve it.

(b) A physician found to be in contempt of court for violating such an injunction shall be fined an amount considered appropriate by the court, but not less than $5,000. In determining the appropriate fine, the court shall objectively consider the extent of services lost to the hospital and its patients.

(3) A violation by a physician of subsection (1) constitutes ground for disciplinary action against him by the board, including the suspension or revocation of his license, and subjects him to liability for any damages that the hospital or any patient therein sustains as a result of the violation.

History. s. 24, ch. 88-1; s. 9, ch. 88-277; s. 1, ch. 89-296; s. 1, ch. 91-429.

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(a) Attempting to obtain, obtaining, or renewing a license to practice medicine by bribery, by fraudulent misrepresentations, or through an error of the department or the board.

(b) Having a license or the authority to practice medicine revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of any jurisdiction, including its agencies or subdivisions. The licensing authority's acceptance of a physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the physician's license, shall be construed as action against the physician's license.

(c) Being convicted or found guilty of, or entering a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of medicine or to the ability to practice medicine.

(d) False, deceptive, or misleading advertising.

(e) Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules of the department or the board. A treatment provider approved pursuant to s. 455.261 shall provide the department or consultant with information in accordance with the requirements of s. 455.261(3), (4), (5), and (6).

(f) Aiding, assisting, procuring, or advising any unlicensed person to practice medicine contrary to this chapter or to a rule of the department or the board.

(g) Failing to perform any statutory or legal obligation placed upon a licensed physician.

(h) Making or filing a report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall include only those which are signed in the capacity as a licensed physician.

(i) Paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services, including, but not limited to, hospitals, nursing homes, clinical laboratories, ambulatory surgical centers, or pharmacies. The provisions of this paragraph shall not be construed to prevent a physician from receiving a fee for professional consultation services.

(j) Exercising influence within a patient-physician relationship for purposes of engaging a patient in sexual activity. A patient shall be presumed to be incapable of giving free, full, and informed consent to sexual activity with his physician.

(k) Making deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine.

(l) Soliciting patients, either personally or through an agent, through the use of fraud, intimidation, undue influence, or a form of overreaching or vexatious conduct. A solicitation is any communication which directly or implicitly requests an immediate oral response from the recipient.

(m) Failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

(n) Exercising influence on the patient or client in such a manner as to exploit the patient or client for financial gain of the licensee or of a third party, which shall include, but not be limited to, the promoting or selling of services, goods, appliances, or drugs.

(o) Promoting or advertising on any prescription form of a community pharmacy unless the form shall also state: "This prescription may be filled at any pharmacy of your choice."

(p) Performing professional services which have not been duly authorized by the patient or client, or his legal representative, except as provided in s. 743.064, s. 766.103, or s. 768.13.

(q) Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his intent.

(r) Prescribing, dispensing, or administering any medicinal drug appearing on any schedule set forth in chapter 893 by the physician to himself, except one prescribed, dispensed, or administered to the physician by

Surgical Pathology

Services 88300 through 88309 include accession, examination, and reporting. They do not include the services designated in codes 88311 through 88365 and 88399, which are coded in addition when provided.

The unit of service for codes 88300 through 88309 is the specimen. A specimen is defined as tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. Two or more such specimens from the same patient (eg, separately identified endoscopic biopsies, skin lesions, etc.) are each appropriately assigned an individual code reflective of its proper level of service.

Service code 88300 is used for any specimen that in the opinion of the examining pathologist can be accurately diagnosed without microscopic examination. Service code 88302 is used when gross and microscopic examination is performed on a specimen to confirm identification and the absence of disease. Service codes 88304 through 88309 describe all other specimens requiring gross and microscopic examination, and represent additional ascending levels of physician work. Levels 88302 through 88309 are specifically defined by the assigned specimens.

Any unlisted specimen should be assigned to the code which most closely reflects the physician work involved when compared to other specimens assigned to that code.

88300 Level I - Surgical pathology, gross examination only

88302 Level II - Surgical pathology, gross and microscopic examination

Appendix, Incidental
Fallopian Tube, Sterilization
Fingers/Toes, Amputation, Traumatic
Foreskin, Newborn
Hernia Sac, Any Location
Hydrocele Sac
Nerve
Skin, Plastic Repair
Sympathetic Ganglion
Testis, Castration
Vaginal Mucosa, Incidental
Vas Deferens, Sterilization

88304 Level III - Surgical pathology, gross and microscopic examination

Abortion, Induced
Abscess
Aneurysm - Arterial/Ventricular
Anus, Tag
Appendix, Other than Incidental
Artery, Atheromatous Plaque
Bartholin's Gland Cyst
Bone Fragment(s), Other than Pathologic Fracture
Bursa/Synovial Cyst
Carpal Tunnel Tissue
Cartilage, Shavings
Cholesteatoma
Colon, Colostomy Stoma
Conjunctiva - Biopsy/Pterygium
Cornea
Diverticulum - Esophagus/Small Bowel
Dupuytren's Contracture Tissue
Femoral Head, Other than Fracture
Fissure/Fistula
Foreskin, Other than Newborn
Gallbladder
Ganglion Cyst
Hematoma
Hemorrhoids
Hydatid of Morgagni
Intervertebral Disc
Joint, Loose Body
Meniscus
Mucocele, Salivary
Neuroma - Morton's/Traumatic
Pilonidal Cyst/Sinus
Polyps, Inflammatory - Nasal/Sinusoidal
Skin - Cyst/Tag/Debridement
Soft Tissue, Debridement
Soft Tissue, Lipoma
Spermatocele
Tendon/Tendon Sheath
Testicular Appendage
Thrombus or Embolus
Tonsil and/or Adenoids
Varicocele
Vas Deferens, Other than Sterilization
Vein, Varicosity

88305 Level IV - Surgical pathology, gross and microscopic examination

Abortion - Spontaneous/Missed
Artery, Biopsy
Bone Marrow, Biopsy
Bone Exostosis
Brain/Meninges, Other than for Tumor, Resection
Breast, Biopsy
Breast, Reduction Mammoplasty

Bronchus, Biopsy
Cell Block, Any Source
Cervix, Biopsy
Colon, Biopsy
Duodenum, Biopsy
Endocervix, Curettings/Biopsy
Endometrium, Curettings/Biopsy
Esophagus, Biopsy
Extremity, Amputation, Traumatic
Fallopian Tube, Biopsy
Fallopian Tube, Ectopic Pregnancy
Femoral Head, Fracture
Fingers/Toes, Amputation, Non-traumatic
Gingiva/Oral Mucosa, Biopsy
Heart Valve
Joint, Resection
Kidney, Biopsy
Larynx, Biopsy
Leiomyoma(s), Uterine Myomectomy - without Uterus
Lip, Biopsy/Wedge Resection
Lung, Transbronchial Biopsy
Lymph Node, Biopsy
Muscle, Biopsy
Nasal Mucosa, Biopsy
Nasopharynx/Oropharynx, Biopsy
Nerve, Biopsy
Odontogenic/Dental Cyst
Omentum, Biopsy
Ovary with or without Tube, Non-neoplastic
Ovary, Biopsy/Wedge Resection
Parathyroid Gland
Peritoneum, Biopsy
Pituitary Tumor
Placenta, Other than Third Trimester
Pleura/Pericardium - Biopsy/Tissue
Polyp, Cervical/Endometrial
Polyp, Colorectal
Polyp, Stomach/Small Bowel
Prostate, Needle Biopsy
Prostate, TUR
Salivary Gland, Biopsy
Sinus, Paranasal Biopsy
Skin, Other than Cyst/Tag/Debridement/Plastic Repair
Small Intestine, Biopsy
Soft Tissue, Other than Tumor/Mass/Lipoma/Debridement
Spleen
Stomach, Biopsy
Synovium
Testis, Other than Tumor/Biopsy/Castration
Thyroglossal Duct/Brachial Cleft Cyst
Tongue, Biopsy
Tonsil, Biopsy
Trachea, Biopsy
Ureter, Biopsy
Urethra, Biopsy
Urinary Bladder, Biopsy
Uterus, with or without Tubes & Ovaries, for Prolapse
Vagina, Biopsy
Vulva/Labia, Biopsy

88307 Level V - Surgical pathology, gross and microscopic examination

Adrenal, Resection
Bone - Biopsy/Curettings
Bone Fragment(s), Pathologic Fracture
Brain, Biopsy
Brain/Meninges, Tumor Resection
Breast, Mastectomy - Partial/Simple
Cervix, Conization
Colon, Segmental Resection, Other than for Tumor
Extremity, Amputation, Non-traumatic
Eye, Enucleation
Kidney, Partial/Total Nephrectomy
Larynx, Partial/Total Resection
Liver, Biopsy - Needle/Wedge
Liver, Partial Resection
Lung, Wedge Biopsy
Lymph Nodes, Regional Resection
Mediastinum, Mass
Myocardium, Biopsy
Odontogenic Tumor
Ovary with or without Tube, Neoplastic
Pancreas, Biopsy
Placenta, Third Trimester
Prostate, Except Radical Resection
Salivary Gland
Small Intestine, Resection, Other than for Tumor
Soft Tissue Mass (except Lipoma) - Biopsy/Simple Excision
Stomach - Subtotal/Total Resection, Other than for Tumor
Testis, Biopsy
Thymus, Tumor
Thyroid, Total/Lobe
Ureter, Resection
Urinary Bladder, TUR
Uterus, with or without Tubes & Ovaries, Other than Neoplastic/Prolapse

88309 Level VI - Surgical pathology, gross and microscopic examination

Bone Resection
Breast, Mastectomy - with Regional Lymph Nodes
Colon, Segmental Resection for Tumor
Colon, Total Resection
Esophagus, Partial/Total Resection
Extremity, Disarticulation
Fetus, with Dissection
Larynx, Partial/Total Resection - with Regional Lymph Nodes

Lung - Total/Lobe/Segment Resection
Pancreas, Total/Subtotal Resection
Prostate, Radical Resection
Small Intestine, Resection for Tumor
Soft Tissue Tumor, Extensive Resection
Stomach - Subtotal/Total Resection for Tumor
Testis, Tumor
Tongue/Tonsil - Resection for Tumor
Urinary Bladder, Partial/Total Resection
Uterus, with or without Tubes & Ovaries, Neoplastic
Vulva, Total/Subtotal Resection

(For fine needle aspiration, preparation, and interpretation of smears, see 88170-88173)

88311 Decalcification procedure (List separately in addition to code for surgical pathology examination)

88312 Special stains (List separately in addition to code for surgical pathology examination); Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), each

88313 Group II, all other, (eg, iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each

(For immunocytochemistry and immunoperoxidase tissue studies, use 88342)

88314 histochemical staining with frozen section(s)

(88316 has been deleted. To report, use 99070)

(88317 has been deleted)

88318 Determinative histochemistry to identify chemical components (eg, copper, zinc)

88319 Determinative histochemistry or cytochemistry to identify enzyme constituents, each

88321 Consultation and report on referred slides prepared elsewhere

88323 Consultation and report on referred material requiring preparation of slides

88325 Consultation, comprehensive, with review of records and specimens, with report on referred material

88329 Pathology consultation during surgery;

88331 with frozen section(s), single specimen

88332 each additional tissue block with frozen section(s)

88342 Immunocytochemistry (including tissue immunoperoxidase), each antibody

(88345 has been deleted. To report, use 88346)

88346 Immunofluorescent study, each antibody; direct method

88347 indirect method

88348 Electron microscopy; diagnostic

88349 scanning

88356 Morphometric analysis; skeletal muscle

88358 nerve

88358 tumor

When semi-thin plastic-embedded sections are performed in conjunction with morphometric analysis, only the morphometric analysis should be coded; if performed as an independent procedure, see codes 88300-88309 for surgical pathology.

(88360 has been deleted. To report, use 88399)

88362 Nerve teasing preparations

(For physician interpretation of peripheral blood smear, use 85060)

88365 Tissue in situ hybridization, interpretation and report

(88370 has been deleted. To report, use 88342)

88371 Protein analysis of tissue by Western Blot, with interpretation and report

88372 immunological probe for band identification, each

88399 Unlisted surgical pathology procedure

Other Procedures

(Basal metabolic rate has been deleted. If necessary to report, use 89399)