

Amendment No. 1 to HB2367

Harwell  
Signature of Sponsor

AMEND Senate Bill No. 1204\*

House Bill No. 2367

by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section:

56-7-1015.

(a) No patient, insurer, or third party payor shall be required to reimburse any licensed practitioner for charges or claims submitted in violation of this part.

(b) A clinical laboratory or physician, located in this state, or in another state, providing anatomic pathology services for patients in this state, shall present or cause to be presented a claim, bill or demand for payment for these services only to the following:

(1) The patient directly;

(2) The responsible insurer or other third-party payor;

(3) The hospital, public health clinic, or nonprofit health clinic

ordering such services;

(4) The referring laboratory or a referring physician provided that:

(A) A physician in the referring laboratory is performing or supervising the professional component of the anatomic pathology service for the patient; or

(B) A referring physician has provided a written confirmation to the physician or laboratory providing the anatomic pathology service that the patient is not covered under any health care benefit program.

(5) Governmental agencies and/or their specified public or private agent, agency, or organization on behalf of the recipient of the services.

(c) Except for a physician billing for a referring laboratory's services pursuant to subsection (h), no licensed practitioner in the state shall, directly or indirectly, charge, bill, or otherwise solicit payment for anatomic pathology services unless such services were rendered personally by the licensed practitioner or under the licensed practitioner's direct supervision in accordance with section 353 of the Public Health Service Act (42 U.S.C. 263a).

(d) Nothing in this section shall be construed to mandate the assignment of benefits for anatomic pathology services as defined in this section.

(e) For purposes of this section, the term "anatomic pathology services" means:

(1) Histopathology or surgical pathology, meaning the microscopic examination (professional component) and histologic processing of organ tissue (technical component) performed by a physician or under the supervision of a physician;

(2) Cytopathology, meaning the microscopic examination of cells from the following:

(A) Fluids;

(B) Aspirates;

(C) Washings;

(D) Brushings; or

(E) Smears, including the Pap test examination performed by a physician or under the supervision of a physician.

(3) Hematology, meaning the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician, or under the supervision of a physician, and peripheral blood smears when the

attending or treating physician, or technologist requests that a blood smear be reviewed by a pathologist;

(4) Sub-cellular pathology or molecular pathology, meaning the assessment of a patient specimen for the detection, localization, measurement, or analysis of one or more protein or nucleic acid targets;

(5) Blood-banking services performed by pathologists.

(f) For purposes of the section, the term “health care benefit program” means any public or private plan or contract under which any medical benefit, item or service is provided to any individual.

(g) A referring physician may bill a patient not covered under a health care benefit program for an anatomic pathology service if the referring physician was billed pursuant to § 56-7-1015(b)(4), provided that the referring physician complies with the disclosure requirement of § 63-6-214(b)(22) or § 63-9-111(b)(22) and does not, directly or indirectly, markup or increase the actual amount billed by the physician or clinical laboratory that performed the anatomic pathology service.

(h) This section does not prohibit a laboratory, physician, physician’s office or group practice directly performing the professional component of the anatomic pathology service from billing for a referring laboratory’s services in instances where a sample or samples must be sent to another physician or laboratory for consultation or histologic processing. For purposes of this subdivision the term “referring laboratory” means a laboratory that performs histologic processing or consultation on an anatomic pathology specimen.

(i) Nothing in this section shall be construed to mandate the billing of any patient not covered under a health care benefit program, or any referring physician who has ordered an anatomic pathology service for a patient not covered under a health care benefit program.

(j) Nothing in this section shall apply to anatomic pathology services billed by gastroenterologists on patients in this state until January 1, 2012. Following the enactment of this section, any gastroenterologist may request that the board of medical examiners evaluate their anatomic pathology billing, coding and referral practices including patient access to anatomic pathology services when such services are billed by the gastroenterologist, based upon voluntary submission of information in order to determine the continued need for exemption from the requirements of this section. The evaluation shall include a review of the ethics and coding policies of the American Medical Association that apply to billing for pathology services. The board shall accept comments from physicians on this matter at a regularly scheduled meeting and may render a recommendation to the general assembly by February 1, 2011 as to whether the exemption provided in this subsection should be extended

(k) The respective state licensing boards having jurisdiction over any practitioner who may request or provide anatomic pathology services may revoke, suspend or deny renewal of the license of any practitioner who violates the provisions of this section.

SECTION 2. Tennessee Code Annotated, Section 63-6-214(b)(22), is amended by deleting the language "practitioner discloses" and by substituting instead the language "practitioner is in compliance with the requirements of § 56-7-1015(g) and discloses."

SECTION 3. Tennessee Code Annotated, Section 63-9-111 (b) (22), is amended by deleting the language "practitioner discloses" and by substituting instead the language "practitioner is in compliance with the requirements of § 56-7-1015(g) and discloses."

SECTION 4. This act shall take effect July 1, 2010, the public welfare requiring it.