IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

NEIGHBORHOOD CLINICS, L.L.C., Plaintiff, v. PATHOLOGY CHP S.C., *et al.*, Defendants.	)))))))))	No. 05 CH 2692 Honorable Sophia H. Hall

BRIEF OF *AMICI CURIAE*
COLLEGE OF AMERICAN PATHOLOGISTS AND
AMERICAN MEDICAL ASSOCIATION
IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

INTEREST OF *AMICI CURIAE*

The College of American Pathologists is a professional association consisting of over 16,000 physicians who practice the medical specialty of pathology. The College is the largest association in the world comprised entirely of pathologists. Over 700 of its pathologist members practice in the State of Illinois.

The American Medical Association ("AMA") is the largest medical association in the United States with approximately 240,000 physicians, residents, and medical students. Its members practice in every state, including Illinois. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. Its members practice in pathology and in all other fields of medical specialization[1].

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[1] The AMA joins this brief in its own person and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts.

This case arises out of the decision of plaintiff Neighborhood Clinics, L.L.C. to refuse to pay the pathologists at Pathology CHP S.C. for services provided to commercial, non-Medicare patients. These services, commonly known as the "professional component of clinical pathology services," are critical for ensuring that the results of each laboratory test for each individual patient are timely, medically reliable, and clinically useful. The professional component of clinical pathology laboratory services involves medical supervision, quality control, and clinical consultation. It includes "setting up test protocols, calibrating the equipment and supervising the testing, and, if necessary, interpreting the results and consulting with treating physicians." *Central States v. Pathology Labs. of Ark.*, 71 F.3d 1251, 1252 (7th Cir. 1995).

As numerous courts in Illinois and elsewhere have recognized, the professional component of clinical pathology services is a valuable and necessary medical service for which pathologists should be paid. *See Pathology Laboratories*, 71 F.3d at 1253; *Health Options, Inc. v. Palmetto Pathology Services, P.A.*, 983 So. 2d 608 (Fla. App. 2008); *Martis v. Pekin Mem. Hosp.*, No. 05 L 23 (Ill. Cir. Ct. 2007) (App. C); *Smith v. Peoria-Tazewell Pathology Group*, No. 94-L-245 (Ill. Cir. Ct. 1994) (App. D); *Ark. Soc'y of Pathologists v. Harris* [1980 Transfer Binder] CCH Medicare & Medicaid Guide ¶ 30,546 (E.D. Ark. 1980) (App. E). Based on the erroneous premise that the professional component of clinical pathology represents mere administrative overhead, plaintiff maintains that it has no obligation to pay for these services. Plaintiff's position fails to recognize the value of the medical services that pathologists perform each day for patients in Illinois and throughout the nation.

Amici curiae and their members thus have a keen interest in this appeal. To assist the Court in understanding the nature of the professional medical services provided by

pathologists, the importance of those services to sound medical care, and the threat of harm posed by plaintiff's position, *amici* respectfully submit this brief.

BACKGROUND

I. PATHOLOGISTS' SERVICES IN THE CLINICAL LABORATORY

Pathologists are physicians who specialize in the study of human tissues, fluids, and waste products for the purpose of diagnosing disease. Pathologists must graduate from medical school and complete post-graduate training that generally lasts four to five years.

The medical specialty of pathology has two branches, anatomic pathology and clinical pathology. Anatomic pathology consists of the analysis of human tissue that has been biopsied or otherwise removed from the body in order to determine the presence of absence of disease, and, if present, the nature of the disease. Anatomic pathology includes surgical pathology and cytopathology (disease at the cellular level).

Clinical pathology – at issue in this case – involves the testing and analysis of human fluids such as blood and urine. These fluids are analyzed to determine the presence or concentration of specific indicators (or analytes) – information which is critical to making a proper diagnosis of disease and determination regarding treatment. Clinical pathology procedures are generally performed on complex, highly sensitive laboratory equipment.

A number of clinical pathology procedures (for example, coagulation procedures and protein electrophoreses) require a pathologist's personal examination of a specific specimen, slide, or test result. Other procedures do not necessarily require a pathologist's individual review. Hundreds of procedures may be performed in a laboratory on any given day, and technicians often handle the specimens and operate the equipment on which the tests are run. However, the pathologist supervises, and is responsible for, the timeliness and accuracy of every one of these tests. Thus, the pathologist provides a distinct medical input for every test performed in the laboratory.

For example, as medical knowledge and technology advance, the pathologist must re-evaluate existing methodology and make a series of decisions to ensure that the procedures utilized in the laboratory are effective and generate timely, accurate, and useful results for the attending physicians. The pathologist must evaluate or design new testing protocols and procedures, evaluate the normal range of test results in light of the specific patient population, and work with treating physicians on the sequencing of test ordering and evaluation of test results.

Once a test is operational, the pathologist is responsible for quality assurance and quality control in the clinical laboratory on an ongoing basis. The pathologist is also responsible for assuring that the highly sensitive equipment used to conduct the tests is properly calibrated and functioning at all times. Even small inaccuracies can lead to inappropriate diagnoses and treatment. Likewise, the pathologist must supervise the technologists and technicians who work in the laboratory. If a result falls outside of ranges determined by the pathologist or otherwise seems unusual to the technologist, the pathologist must review the result to determine whether it is attributable to laboratory error and should therefore be disregarded – or whether it accurately reflects the patient's condition.

Pathologists who direct medical laboratories must be available 24 hours a day, 7 days a week to address questions raised by treating physicians about specific results for specific patients. They must be available to discuss with the treating physicians the medical significance of a patient's results that are difficult to evaluate or seem inconsistent with clinical findings. They must be prepared to suggest follow up testing. And they may need to do additional medical research or follow up in order to interpret particularly unusual results. These services can take anywhere from a few minutes to several hours.

Collectively, the services of pathologists in directing the medical laboratory to assure the timeliness, reliability, and usefulness of test results for patients are known as the "professional component of clinical pathology services." These services directly benefit each individual patient for whom a clinical laboratory examination is performed. Without accurate clinical test results, treating physicians would be unable to make accurate diagnoses and informed decisions regarding proper and effective treatment of their patients.

II. HOW PATHOLOGISTS ARE COMPENSATED FOR THEIR SERVICES

Pathologists are compensated for professional clinical pathology laboratory services in a few different ways. Some pathologists receive a fixed salary from a hospital at which they are employed. However, most pathologists have an independent contractual relationship with the hospitals at which they practice. These pathologists may bill the patient – or the patient's insurer – for the work they perform.

A. Billing in the Private Sector

Outside of the Medicare context (discussed below), professional component billing is one recognized way for pathologists to bill and receive payment for their services for patients whose specimens are analyzed in the laboratory. In this form of billing, the pathologist charges the patient or the patient's insurer a relatively small amount (the "professional component") for every clinical pathology procedure performed for a patient. The hospital bills a separate amount (the "technical component") for providing space, equipment, and the services of technicians. *See Central States v. Pathology Laboratories of Arkansas*, 71 F.3d 1251, 1252 (7th Cir. 1995). Professional component billing reflects the role of the pathologist in assuring timely and reliable results for each test for each patient. Importantly, the pathologist does not charge an

additional amount for those tests that require particularly close attention. *See Pathology Laboratories,* 71 F.3d at 1253.

Both the American Medical Association ("AMA") and the College of American Pathologists ("CAP") have formally recognized the legitimacy of professional component billing. In its publication, CPT Assistant, which provides guidance on appropriate medical coding, the AMA found that "[p]rofessional component billing is one valid method of billing for the professional services of pathologists in the clinical laboratory." AMA, CPT Assistant, Vol. 15, Issue 8, at 9 (Aug. 2005) (Appendix A). In so finding, the AMA relied in part on CAP policies. *Id.* (citing CAP Public Policy HH: "Pathologist Professional Component Billing for Clinical Pathology Services" (2002)) (Appendix B). Among the professional component services for which pathologists may properly bill, according to the AMA and CAP, are the following:

- Ensuring that tests, examinations, and procedures are properly performed, recorded and reported;
- Interacting with members of the medical staff regarding issues of laboratory operations, quality, and test availability;
- Designing protocols and establishing parameters for performance of clinical testing;
- Recommending appropriate follow-up diagnostic tests, when appropriate;
- Supervising laboratory technicians and advising technicians regarding aberrant results;
- Selecting, evaluating, and validating test methodologies;
- Directing, performing, and evaluating quality assurance and control procedures; and
- Evaluating clinical laboratory data and establishing a process for review of test results prior to issuance of patient reports.

AMA, CPT Assistant, Vol. 15, Issue 8, at 9-10; CAP, Public Policy HH, at HH-1.

In the private sector context (such as commercial health insurance, HMOs, PPOs, and Blue Cross Blue Shield plans), professional component billing is a widely accepted practice.

Indeed, professional component billing has been characterized as "not only the established billing practice of pathologists in Florida, but also the established practice in the majority of other states." *Am. Med. Intern., Inc. v. Scheller*, 590 So.2d 947, 949 (Fla. 4th DCA 1991).

B. Billing Under Medicare

Unlike the private sector, the federal Medicare program does not utilize professional component billing. Instead, the Medicare statutes and regulations specify a unique method for paying pathologists for their services in the laboratory. Rather than paying pathologists directly, Medicare includes payment for professional component services in the fixed amount that Medicare pays to the hospital for each patient. Under the Medicare system, each hospital in-patient is assigned a "diagnosis related group," or "DRG." By law, the amount paid to the hospital for each patient in a DRG is deemed to cover a variety of services for the patient. Pathologists' services in the clinical laboratory are included among the services covered in these Medicare payments.[2]

Although professional component services are not billed separately for Medicare patients, pathologists are still paid for these services. Medicare requires hospitals to pay pathologists for the professional component out of the payments made by Medicare to the hospital. *See* 42 U.S.C. § 1395xx(a)(1)(b). Hospitals that fail to make the professional component payments to pathologists are subject to prosecution for violation of the Medicare "fraud and abuse" provisions. *See* Department of Health and Human Services, Office of Inspector General, Management Advisory Report: *Financial Arrangements Between Hospitals*

[2] When Medicare moved to a DRG-based reimbursement system, it expressly included in the hospital's Medicare payment the value of pathologists' services in the clinical laboratory. Final Rule, "Payment for Physician Services Rendered in Hospitals," 48 Fed. Reg. 8901, 8909 (March 2, 1983). By contrast, plaintiff's payments to hospitals makes no allowance for the value of the professional component of clinical pathology services.

and Hospital-Based Physicians, at 3-4 (Jan. 31, 1991); *see also* Department of Health and Human Services, Office of Inspector General, *Supplemental Compliance Guidance for Hospitals,* 70 Fed. Reg. 4858, 4866-67 (Jan. 31, 2005).

The Medicare billing system is based on the unique rules of the Medicare program, and is inapplicable to services provided outside the context of Medicare. For non-Medicare patients, however, professional component billing is one of the most common methods of compensating pathologists for their services in a clinical laboratory.

ARGUMENT

I. PATHOLOGISTS' SERVICES IN THE CLINICAL LABORATORY ARE MEDICAL SERVICES FOR PATIENTS AND SHOULD BE REIMBURSED AS SUCH

Plaintiff alleges that the professional component of clinical pathology does not represent a "specific service" for patients. Based on this erroneous position, plaintiff maintains that it has no legal obligation to pay pathologists for the professional component services. Plaintiff's position is incorrect both as a matter of fact and law.

A. Pathologists Bear Legal and Medical Responsibility for Timely and Accurate Clinical Pathology Laboratory Testing

Pathologists have a physician-patient relationship with patients who submit specimens to the laboratory. As a result, pathologists are legally and medically responsible for any result that is misreported or untimely reported from their laboratories. *See e.g.*, *Walters v. Rinker*, 520 N.E.2d 468, 472 (Ind. App. 1988); *Peterson v. St. Cloud Hosp.*, 460 N.W.2d 635 (Minn. App. 1990). This is so even when the pathologist's involvement in a particular patient's test is limited to oversight and supervision of the laboratory. *See e.g., Dougherty v. Gifford*, 826 S.W.2d 668 (Tex. App. 1992). To hold otherwise would be fundamentally unfair. If pathologists have a sufficient physician-patient relationship with patients whose laboratory

specimens they examine to give rise to malpractice liability, they must also have the right to bill for their services.

B. Professional Clinical Pathology Laboratory Services are Valuable and Necessary Medical Services

The vast majority of cases that have dealt with professional component billing have concluded that the professional component of clinical pathology is a valuable medical service for which the patient or the patient's insurer must pay.

The leading federal case to consider the issue is *Central States v. Pathology Laboratories of Arkansas*. 71 F.3d 1251 (7th Cir. 1995). In *Pathology Laboratories*, an insurer claimed that a pathology group had charged for services not rendered, and sought to recoup the payments it had made to the pathologists over the course of several years. *Id.* at 1253. The Seventh Circuit rejected the insurer's argument that pathologists "do not render medical services to the hospital's patients." *Id.* at 1253. To the contrary, the court of appeals found: "Pathology Laboratories provides supervisory services of value to all patients, and interpretation services of value to some." *Id.* Because of the value of these services, the pathologists have an "honest claim" to reimbursement. *Id.* at 1255. The court suggested that an insurer could prospectively negotiate a change in its policy regarding professional component billing, but indicated that "[b]y refusing to pay [the pathologists'] bills, [the insurer] disabled itself from extracting a quid pro quo such as an end to supplemental direct billing." *Id.* at 1254. The court concluded with this blunt assessment:

> Pathology Laboratories claim to compensation is honest; the only question (from its perspective) was whether to bill [the insurer] or the patients.... The real conflict is between the insurer and its participants; one or the other should pay Pathology Laboratories' bill, but [the insurer] wants to achieve a state in which neither has paid. Why should we leave physicians holding the bag?

Id. at 1255.

Pathology Laboratories is squarely on point. Here, as in that case, plaintiff has sought to deprive pathologists of payment for professional clinical pathology laboratory services on the false premise that pathologists render no service for individual patients in the clinical laboratory. As that court found, however, pathologists provide valuable services for which they have an "honest claim" to reimbursement. *Id.* at 1255. Further, as in *Pathology Laboratories*, plaintiff's position would leave the pathologists entirely without compensation for their professional clinical laboratory services.

Like the insurer in *Pathology Laboratories*, plaintiff could have negotiated a different contractual arrangement for payment of professional clinical pathology laboratory services. However, plaintiff "disabled itself" from such an alternate arrangement through its decision to unilaterally stop paying the pathologists' bills. *Id.* at 1255. The evidence shows that plaintiff is not paying either the pathologists or the hospital for the professional component of clinical pathology. Plaintiff's actions thus unfairly left the pathologists "holding the bag."

Other courts have agreed with the reasoning and holding of the Seventh Circuit in *Pathology Laboratories*. In 1980, before Congress enacted specific revisions to the Medicare Act to require indirect payment for the professional component of clinical pathology services, *see supra* at 9 & n.1, a federal court in Arkansas enjoined the Secretary of Health and Human Services from denying the Medicare payment for the professional component. *Arkansas Society of Pathologists v. Harris* [1980 Transfer Binder] CCH Medicare & Medicaid Guide ¶ 30,546 (E.D. Ark. 1980). As here, the payer had argued that the pathologists did not directly perform services for patients. The court disagreed, stating that clinical pathology services represent "professional services … performed for the direct benefit of identifiable, individual patients …

whether or not the pathologist sees the patient and whether or not he or she looks through the microscope." *Id.* at 10,118.[3]

Likewise, a state court in Illinois summarily dismissed fraud claims brought against a pathology group, stating that "the Pathologists provide medical services of value to all patients who have laboratory tests performed at the hospitals at which the Pathologists practice." *Smith v. Peoria Tazewell Pathology Group*, No. 94-L-245 (Ill. Cir. Ct. 1997) (unpublished) (Appendix C). The court held that pathologists are "entitled to bill patients" on a per-test basis for "establishing test protocols, performing quality and assurance, and remaining available to consult with laboratory technicians and treating physicians" regardless of "whether the pathologists personally perform the test or review its results." *Id.*; *see also Martis v. Pekin Mem. Hosp.*, No. 05 L 23 (Ill. Cir. Ct. 2007) (plaintiffs' claims "have intertwined within them allegations concerning the professional component billing practice, which has been upheld in [*Central States*]. The Court finds said practice not to be actionable.") (unpublished) (Appendix D).

Most recently, a Florida appellate court upheld the appropriateness of professional component billing in *Health Options, Inc. v. Palmetto Pathology Services, P.A.*, 983 So. 2d 608 (Fla. App. 2008). There, a payer denied payment for the professional component of clinical pathology on the ground that these services were not "patient-specific" and therefore were "essentially ... an element of overhead." 983 So. 2d at 611. The court of appeals rejected this position, finding that the pathologists had "rendered medically necessary tests and services" for which they should be paid. *Id.* at 615.

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[3] *See also Sander v. Geib, Elston, Frost Prof'l Ass'n*, 506 N.W. 2d 107, 114 (S.D. 1993); *Montgomery v. South County Radiologists, Inc.*, 2000 WL 1846432 (Mo. App. 2000).

An Arizona appellate court reached a similar conclusion in *Arizona Society of Pathologists v. AHCCCS,* 38 P.3d 1218 (Ariz. App. 2002). The final judgment in that case provides that the "practice of billing for indirect services (or 'professional component billing') whereby pathologists bill a nominal fixed fee for each laboratory test...is an appropriate billing practice." *Id.* at 1219. The court specifically rejected the argument that professional clinical pathology laboratory services were "services not rendered." *Id.* at 1222.

At a minimum, these cases confirm that a professional component bill is a valid claim for professional services rendered to patients. In light of these decisions, plaintiff cannot reasonably claim that Pathology CHP S.C. did not render medical services for its patients, or that plaintiff has no legal obligation to pay for these services.

* * *

The professional component of clinical pathology represents an essential medical service for patients. Plaintiff's position is contrary to a long line of precedents in Illinois and elsewhere in which the legitimacy of professional component billing was fully litigated and upheld. Plaintiff's position, if adopted by this court, threatens to disrupt the settled expectations of pathologists and patients in Illlinois and around the nation. *Amici* therefore respectfully urge this Court to affirm the decision of the court below.

CONCLUSION

For the foregoing reasons, *amici curiae* respectfully request that the Court of Appeal affirm the decision of the court below.

Respectfully submitted,

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Appendix A

Coding Communication: Professional Component for Clinical Laboratory Services (CPT codes 80048-89356)

Although the use of modifier *26, Professional Component*, and clinical laboratory services has been previously addressed in the *CPT Assistant* (May 1999), the discussion continues to surface as an area of great interest among our members and subscribers. Building upon the May 1999 foundation, this coding update further expands upon the role of the pathologist with respect to their capacity in the clinical laboratory setting.

The use of modifier *26, Professional component*, is required for CPT codes 80048-89356 in those instances when the physician is only billing for the professional component of the laboratory tests (eg, medical direction, supervision or interpretation). This method of reporting is appropriate when the technical and professional components are performed by different providers. A written report for an individual patient is not a requirement for having performed a professional component service.

Pathologists often report the professional component of clinical laboratory tests because they oversee the clinical laboratory and are responsible for the results. As stated in the College of American Pathologists *Professional Relations Manual* (pages 151-152 under the section Pathologist Professional Component Billing for Clinical Pathology Services):

> Professional component billing is one valid method of billing for the professional services of pathologists in the clinical laboratory. In many communities, the standard practice is for the pathologist to direct bill patients for the professional component of clinical laboratory services. When the pathologist bills a professional component to a non-Medicare patient, no payment is made by the hospital to the pathologist for this service. The hospital's bill for the technical component covers hospital costs for laboratory equipment, supplies and non-physician personnel—it does not include the professional services of the pathologist.

Pathologists in their capacity as medical directors of hospital clinical laboratories provide valuable, necessary medical services for patients. These services and responsibilities, often called *clinical pathology professional component services*, include:

- Ensuring that tests, examinations, and procedures are properly performed, recorded and reported
- Interacting with members of the medical staff regarding issues of laboratory operations, quality, and test availability
- Designing protocols and establishing parameters for performance of clinical testing
- Recommending appropriate follow-up diagnostic tests, when appropriate
- Supervising laboratory technicians and advising technicians regarding aberrant results
- Selecting, evaluating, and validating test methodologies
- Directing, performing, and evaluating quality assurance and control procedures
- Evaluating clinical laboratory data and establishing a process for review of test results prior to issuance of patient reports
- Ensuring the hospital laboratory's compliance with state licensure laws, Medicare conditions, Joint Commission on Accreditation of Healthcare Organizations standards, the College of American Pathologists Laboratory Accreditation Program,and federal certification standards

continued on bottom of page 10

Neurostimulator, continued from page 8

increments may vary. In addition, history, physical examination, and medical decision making are provided concerning the patient's medication regimen to address concurrent medical problems and to counsel the patient and family about psychosocial difficulties encountered in coping with moderately advanced Parkinson's disease.

When separately identifiable evaluation and management (E/M) services are provided, they are coded separately. The time included in the E/M service is exclusive of any time used to determine the coding of 95978 and 95979. The services provided on the same day can include both E/M services as well as reprogramming. The reprogramming time is inclusive of the several stages of that service, including the initial system analysis, initial reprogramming time, initial time waiting for stabilization, subsequent cycles of reprogramming and waiting for stabilization, and final counseling and instructions.

Glossary

anode: The positive pole of a galvanic battery or the electrode connected with it.

cathode: The negative pole of a galvanic battery or the electrode connected with it.

dystonia: A state of abnormal (either hypo or hyper) tonicity in any of the tissues.

neurostimulator: A device for electrical excitation of the central or peripheral nervous system.

Parkinson's disease: A progressive degenerative disease of unknown etiology characterized by rhythmic tremor of the limbs, stooped posture, slowness of voluntary movements, and mask-like facial expression.

parkinsonian: Relating to or the suffering from parkinsonism. ■

Professional, continued from page 9

In closing, when reporting the professional or technical component of a procedure or service, it is important to familiarize yourself with the various reporting requirements of individual insurance companies in your area. These reporting and reimbursement policies may vary from one insurance company to another.

The book *Medicare RBRVS: The Physicians' Guide* can be ordered by contacting the American Medical Association's Customer Service department at (800) 621-8335.

For information regarding the College of American Pathologist (CAP) manual, contact the CAP at (800) 323-4040.

References:

American Medical Association. *Medicare RBRVS: The Physicians' Guide 2005*. Chicago, Ill: AMA; 2005.

College of American Pathologists. *Professional Relations Manual*. 12th ed. Northfield, Ill: CAP; 2003: 151-152. ■

Appendix B

HH. Pathologist Professional Component Billing for Clinical Pathology Services

Policy Synopsis
Pathologists perform professional services as well as technical services. The variety of billing arrangements for pathologists' services includes professional component billing. In professional component billing, while the hospital might bill the patient for the pathologist's technical services, the pathologist can bill the patient, the patient's insurer, or the hospital directly for professional services.

Policy
Quality laboratory services are essential to the diagnosis and treatment of patients. Pathologist directors of hospital laboratories spend a significant amount of time and effort in fulfilling their responsibility to the patient for quality laboratory services. The pathologist is professionally responsible and legally accountable for laboratory results. To prepare for this responsibility the pathologist must complete a lengthy medical residency program. Moreover, Federal certification standards and Joint Commission on Accreditation of Healthcare Organizations standards require certain professional, organizational and administrative services be provided in the clinical laboratory to assure quality laboratory services to patients. The pathologist-director of a hospital clinical laboratory provides professional services in:

- Assuring that tests, examinations, and procedures are properly performed, recorded and reported;
- Interacting with members of the medical staff regarding issues of laboratory operations, quality, and test availability;
- Designing protocols and establishing parameters for performance of clinical testing;
- Recommending appropriate follow-up diagnostic tests, when appropriate;
- Supervising laboratory technicians and advising technicians regarding aberrant results;
- Selecting, evaluating, and validating test methodologies;
- Directing, performing, and evaluating quality assurance and control procedures;
- Evaluating clinical laboratory data and establishing a process for review of test results prior to issuance of patient reports;
- Assuring the hospital laboratory's compliance with state licensure laws, Medicare conditions, Joint Commission on Accreditation of Healthcare Organizations standards, the College of American Pathologists Laboratory Accreditation Program and federal certification standards.

A variety of valid and accepted methods for payment for the above professional services of the pathologist in the hospital clinical laboratory are available.

These physician services may be billed by the pathologist to the patient (or the patient's insurer) or to the hospital as the pathologist and hospital may agree. Medicare rules require pathologists to seek payment from the hospital for the professional component of clinical pathology services to Medicare patients because the hospital's Medicare payment rate includes payment for these physician services. Pathologists and hospitals often negotiate a different billing arrangement for the pathologist's professional services for non-Medicare patients. The pathologist may bill a professional component for clinical laboratory services to the patient, and the hospital may bill the technical component.

Professional component billing is one valid method of billing for the professional services of pathologists in the clinical laboratory. In many communities the standard practice is for the pathologist to direct bill patients for the professional component of clinical laboratory services. When the pathologist bills a professional component to a non-Medicare patient, no payment is made by the hospital to the pathologist for this service. The hospital's bill for the technical component covers hospital costs for laboratory equipment, supplies and non-physician personnel; it does not cover the professional services of the pathologist.

Revision history

Adopted February 1991
Reaffirmed December 1992
Reaffirmed February 1996
Revised February 1999
Reaffirmed February 2002

Appendix C

STATE OF ILLINOIS
IN THE CIRCUIT COURT OF THE TENTH JUDICIAL CIRCUIT
TAZEWELL COUNTY

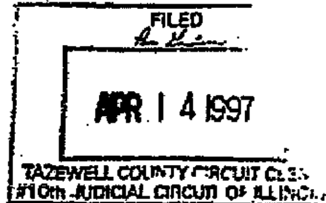
GALE J. SMITH, DONALD E. LIGHTER, and WILMA I. GARBER,

Plaintiffs and Class Representatives,

vs.

PEORIA-TAZEWELL PATHOLOGY, PEKIN MEMORIAL HOSPITAL, PATHOLOGY ASSOCIATES OF PEORIA, S.C., OSF HEALTHCARE SYSTEMS a not for profit corporation d/b/a ST. FRANCIS MEDICAL CENTER, and CENTRAL ILLINOIS PATHOLOGY, S.C.,

Defendants.



Case No. 94-L-245

Hon. Donald C. Courson

ORDER

This matter coming to be heard on the motion for summary judgment filed by Peoria-Tazewell Pathology Group, S.C. ("PTPG"), Pathology Associates of Peoria, S.C. ("Pathology Associates"), and Central Illinois Pathology, S.C. (collectively, the "Pathologists"), the Court being duly advised in the premises, and due notice having been given:

The Court makes the following findings of fact and conclusions of law:

(1) This case involves bills sent by the Pathologists for the professional component of clinical pathology services. Plaintiffs Donald E. Lighter and Gale J. Smith allege that these bills, and the practice of professional component billing generally, represent common law fraud and a violation of the Illinois Consumer Fraud and Deceptive Business Practices Act. Plaintiffs also seek restitution for unjust enrichment. The

Court has previously dismissed plaintiffs' claims for violation of the Illinois Antitrust Act, the Illinois Medical Practice Act, and RICO.

(2) On March 11, 1988, Pathology Associates sent a bill for $9.75 to plaintiff Lighter for the professional component of three clinical pathology tests: Routine Admission Profile, CBC, and RPR. Lighter received a separate bill from St. Francis Medical Center for the technical component of these tests.

(3) On April 8, 1992, PTPG sent a bill for $392.50 to plaintiff Smith for the professional component of four clinical tests (HCG-Beta Pregnancy, Urinalysis, CBC with Differential, and 18 Channel Chemistry), and two anatomic tests (Cervix-Conization and Endometrium-Curretings/ biopsy). The professional component charges for the four clinical tests totaled $38.80. The charges for the two anatomic tests totaled $353.70. Smith received a separate bill from Pekin Memorial Hospital for the technical component of these tests.

(4) There is no genuine issue of material fact that the Pathologists provide medical services of value to all patients who have laboratory tests performed at the hospitals at which the Pathologists practice. These services include establishing test protocols, performing quality control and assurance, and remaining available to consult with laboratory technicians and treating physicians. The Pathologists are entitled to bill patients, including plaintiffs Smith and Lighter, for these services -- regardless of whether the pathologists personally perform the test or review its results. Accord Central States, Southeast and Southwest Areas Health & Welfare Fund v. Pathology Laboratories of Arkansas, P.A., 71 F.3d 1251 (7th Cir. 1995).

(5) The statements on the bills from PTPG and Pathology Associates were not the proximate cause of, nor were they material to, any decision by plaintiff Smith or Lighter to pay -- or have paid on their behalf -- the Pathologists' bills.

(6) Pathology Associates sent plaintiff Lighter a bill for the professional component of his clinical laboratory tests in March 1988, but Lighter did not file this lawsuit until over six years later in November 1994. Accordingly, all of plaintiff Lighter's claims are time-barred by the applicable statutes of limitation.

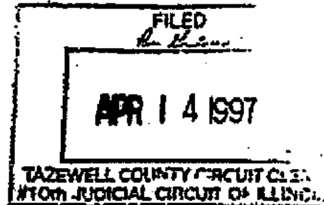
Based on the foregoing findings and conclusions, **IT IS HEREBY ORDERED THAT** the Pathology Defendants' motion for summary judgment is **GRANTED**. All counts directed at Peoria-Tazewell Pathology Group, S.C., Pathology Associates of Peoria, S.C., and Central Illinois Pathology, S.C., in the First Amended Complaint are hereby dismissed with prejudice.

ENTERED at Pekin, Illinois this 4th day of April, 1997.

Donald C. Courson
Circuit Judge

Appendix D

STATE OF ILLINOIS
IN THE CIRCUIT COURT OF THE TENTH JUDICIAL CIRCUIT
TAZEWELL COUNTY



GALE J. SMITH, DONALD E. LIGHTER, and WILMA I. GARBER,

Plaintiffs and Class Representatives,

vs.

PEORIA-TAZEWELL PATHOLOGY, PEKIN MEMORIAL HOSPITAL, PATHOLOGY ASSOCIATES OF PEORIA, S.C., OSF HEALTHCARE SYSTEMS a not for profit corporation d/b/a ST. FRANCIS MEDICAL CENTER, and CENTRAL ILLINOIS PATHOLOGY, S.C.,

Defendants.

Case No. 94-L-245

Hon. Donald C. Courson

ORDER

This matter coming to be heard on the motion for summary judgment filed by Peoria-Tazewell Pathology Group, S.C. ("PTPG"), Pathology Associates of Peoria, S.C. ("Pathology Associates"), and Central Illinois Pathology, S.C. (collectively, the "Pathologists"), the Court being duly advised in the premises, and due notice having been given:

The Court makes the following findings of fact and conclusions of law:

(1) This case involves bills sent by the Pathologists for the professional component of clinical pathology services. Plaintiffs Donald E. Lighter and Gale J. Smith allege that these bills, and the practice of professional component billing generally, represent common law fraud and a violation of the Illinois Consumer Fraud and Deceptive Business Practices Act. Plaintiffs also seek restitution for unjust enrichment. The

Court has previously dismissed plaintiffs' claims for violation of the Illinois Antitrust Act, the Illinois Medical Practice Act, and RICO.

(2) On March 11, 1988, Pathology Associates sent a bill for $9.75 to plaintiff Lighter for the professional component of three clinical pathology tests: Routine Admission Profile, CBC, and RPR. Lighter received a separate bill from St. Francis Medical Center for the technical component of these tests.

(3) On April 8, 1992, PTPG sent a bill for $392.50 to plaintiff Smith for the professional component of four clinical tests (HCG-Beta Pregnancy, Urinalysis, CBC with Differential, and 18 Channel Chemistry), and two anatomic tests (Cervix-Conization and Endometrium-Curretings/ biopsy). The professional component charges for the four clinical tests totaled $38.80. The charges for the two anatomic tests totaled $353.70. Smith received a separate bill from Pekin Memorial Hospital for the technical component of these tests.

(4) There is no genuine issue of material fact that the Pathologists provide medical services of value to all patients who have laboratory tests performed at the hospitals at which the Pathologists practice. These services include establishing test protocols, performing quality control and assurance, and remaining available to consult with laboratory technicians and treating physicians. The Pathologists are entitled to bill patients, including plaintiffs Smith and Lighter, for these services -- regardless of whether the pathologists personally perform the test or review its results. Accord Central States, Southeast and Southwest Areas Health & Welfare Fund v. Pathology Laboratories of Arkansas, P.A., 71 F.3d 1251 (7th Cir. 1995).

(5) The statements on the bills from PTPG and Pathology Associates were not the proximate cause of, nor were they material to, any decision by plaintiff Smith or Lighter to pay -- or have paid on their behalf -- the Pathologists' bills.

(6) Pathology Associates sent plaintiff Lighter a bill for the professional component of his clinical laboratory tests in March 1988, but Lighter did not file this lawsuit until over six years later in November 1994. Accordingly, all of plaintiff Lighter's claims are time-barred by the applicable statutes of limitation.

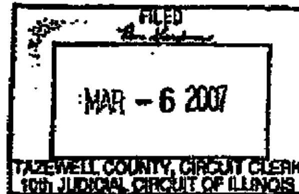
Based on the foregoing findings and conclusions, IT IS HEREBY ORDERED THAT the Pathology Defendants' motion for summary judgment is GRANTED. All counts directed at Peoria-Tazewell Pathology Group, S.C., Pathology Associates of Peoria, S.C., and Central Illinois Pathology, S.C., in the First Amended Complaint are hereby dismissed with prejudice.

ENTERED at Pekin, Illinois this 4th day of April, 1997.

Donald C. Courson
Circuit Judge

IN THE CIRCUIT COURT OF THE TENTH JUDICIAL CIRCUIT OF ILLINOIS
TAZEWELL COUNTY

Richard Martis, on behalf of himself and all others similarly situated,	)	
PLAINTIFF,	)	
vs.	)	**CASE NO. 05 L 23**
Pekin Memorial Hospital, et al.,	)	
DEFENDANTS.	)	



ORDER

The Court, having heard the arguments on the various motions to dismiss, enters the following findings and rulings:

As the Court mentioned during the arguments on said motions, the Court had great difficulty in preparing for said hearing for two reasons:

1. The complaint, the motions and various memorandum are replete with editorial comments that the Court had to wade through in order to get to the substance of said pleadings; and
2. Some of the motions to dismiss made it difficult to determine which arguments were based on 2-615 and which were based on 2-619.

The Court remedied the second shortcoming by informing all parties at the outset that it would hear arguments and rule only on the motions that were based on 2-615 challenging the sufficiency of the pleadings. The Court hopes to remedy the first shortcoming by informing the parties that it expects that all future pleadings will be based on statements of facts and good faith arguments as to the law, without any use of editorial comments.

The Court finds the following minimal deficiencies in the complaint as a matter of law as the basis for its final rulings on the pending motions.

1. All of the Part II counts have intertwined within them allegations concerning the professional component billing practice, which has been upheld in **Central States Health & Welfare Fund v. Pathology Labs of Arkansas**, 71 F.3d 1251 (7th Cir. 1995). The Court finds said practice not to be actionable. Therefore said allegations should not be a part of any cause of action.
2. All contract counts fail to allege that fees charged were not usual and customary.
3. All contract counts fail to allege that Richard Martis was damaged.
4. Since plaintiff pleads that some services were provided, plaintiff can not allege in the alternative that there was no express or implied contract. Therefore he can not plead unjust enrichment.

5. There is no duty or obligation for the hospital to inform the plaintiff of its charitable status or any perceived right the plaintiff may have to apply *for a* discount.
6. The plaintiff has failed to plead that he has any standing to challenge any status that the hospital may have as the result of any ruling by any governmental agency.
7. Since plaintiff has yet to plead a cause of action that meets the standards of 2-615, his other requests for equitable relief must also fail at this time.

The Court hereby strikes the entire complaint and amendments thereto, with leave to amend. The plaintiff is given 30 days to file an amended complaint. The Court recognizes that the complaint has been stricken partly because of practices and causes the Court has found not be actionable and partly because of the failure to allege necessary elements.

Plaintiff may replead, if he so chooses to protect the issues on appeal, those practices or counts the Court has found not to be actionable, as long as he does so in counts separate from those the Court found to be wanting necessary elements. The Court recognizes the desire to plead separately and in the beginning of the *complaint allegations that* may apply to *all* counts. *While*, the plaintiff may do so, he still must plead all the necessary elements for each count within that count. If any particular element is based on an allegation that applies to all counts, then he must within the particular count refer back to the specific general allegation when stating the basis for proving that particular element.

The defendants will be given 30 days after the plaintiff has filed an amended complaint to file an answer or a 2-615 motion to dismiss as to the various counts. The Court will not entertain any 2-619 motions at this time but will grant leave to file said 2-619 motions at the appropriate time in the future.

The Clerk shall mail a copy of the order to the attorneys listed below.

ENTERED 3-6-07

JOHN A. BARRA, CIRCUIT JUDGE

ATTORNEYS:

Donald Bimer
Jack Bierig
Thomas Ging
L. Lee Smith

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing has been furnished this 14th day of August, 2008, by U.S. Mail to the following:

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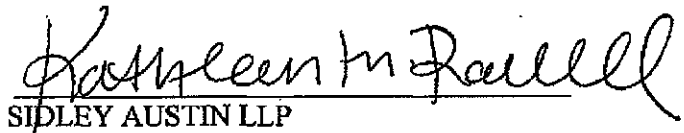

SIDLEY AUSTIN LLP