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September 6, 2016

Acting Administrator Andrew Slavitt
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1654-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-1654-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Proposed Rule

Dear Administrator Slavitt,

On behalf of the American Society for Clinical Pathology (ASCP), I appreciate the opportunity to provide comments on the Calendar Year (CY) 2017 Medicare Physician Fee Schedule (PFS) Proposed Rule. The ASCP is a 501(c)(3) nonprofit medical specialty society representing more than 100,000 members. Our members are board certified pathologists, other physicians, clinical scientists (PhDs), certified medical laboratory scientists/technologists and technicians, and educators. ASCP is one of the nation's largest medical specialty societies and is the world's largest organization representing the field of laboratory medicine and pathology. As the leading provider of continuing education for pathologists and medical laboratory personnel, ASCP enhances the quality of the profession through comprehensive educational programs, publications, and self-assessment materials.

ASCP's comments focus on the following subjects addressed in the PFS Proposed Rule:

- Valuation of Work and Practice Expense Relative Value Units (RVUs) for:
 - Pathology Add-on Services
 - Immunohistochemistry (CPT Codes 88341, 88342, 88344, and 88350)
 - Morphometric Analysis (CPT Codes 88364, 88365, 88367, 88368, 88389, 88373)
 - Flow Cytometry Interpretation (CPT Codes 88184, 88185, 88187, 88188, and 88189)
 - Microslide Consultation (CPT Codes 88321, 88323, and 88325)
 - Prostate Biopsy, Any Method (HCPCS Code G0416)
 - Cytopathology Fluids, Washings or Brushings and Cytopathology Smears, Screening, and Interpretation (CPT Codes 88104, 88106, 88108, 88112, 88160, 88161, and 88162)
- Standardization of Clinical Labor Tasks
- Refinement Panel
- Diabetes Prevention Program
- Self-Referral

I. Valuation of Work and Practice Expense Relative Value Units

The following text outlines our comments on the valuation of work and practice expense Relative Value Units (RVUs) for services of interest to the specialty of pathology.

A. Work RVU Changes for Pathology Add-On Services

In the CY 2017 PFS Proposed Rule, CMS is proposing to further reduce a discount factor it has applied to the American Medical Association (AMA) Relative Value Scale Update Committee's (RUC) recommended physician work RVU amounts for Immunohistochemistry (IHC), Florescent *in Situ* Hybridization (FISH), and Morphometric Analysis *in Situ* Hybridization (ISH) add-on service codes. This discount initially appeared in the CY 2015 PFS Final Rule when CMS decided NOT to adopt the full RUC-recommended physician work RVU amounts for these add-on codes. In that Final Rule, CMS proposed to discount the work RVUs—arguing that this was necessary to identify the relative resources involved in performing these add-on services.

In the CY 2016 Proposed Rule, CMS proposed reducing the discount applied to these add-on codes from 40 percent of the base code work RVU to 24 percent. Now, for CY 2017 CMS proposes further reducing this discounting factor to 20 percent (from 24 percent). While we appreciate CMS's proposals to reduce the size of the discount factor, ASCP believes the Agency should eliminate entirely its discounting of these add-on services and utilize the RUC's recommended work RVUs.

In the CY 2017 Proposed Rule, CMS stated it was utilizing a RUC recommendation specific to these codes. It states, "the RUC recommended a work RVU for the add-on code (CPT code 88364) that was 60 percent of the base code (CPT code 88365)." This is incorrect. According to the CY 2015 Final Rule, the codes on which CMS based its discount are CPT codes 88334/88335 and 88177/88172. See below:

"For example, the RUC-recommended work RVU for CPT code 88334 (Pathology consultation during surgery; cytologic examination (for example, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure)) is 60 percent of the work RVU of the base CPT code 88333 (Pathology consultation during surgery; cytologic examination (for example, touch prep, squash prep), initial site). Similarly, the RUC-recommended work RVU for CPT code 88177 (Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)) is 60 percent of the recommended value for the base CPT code 88172 (Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site)." 79 FR 76668

The distinction between the codes cited in the CY 2015 Final Rule and the new add-on codes is important. In our comments in response to the CY 2015 Final Rule, we noted that the discount factor was specific to services for which a diagnosis has *already* been furnished. For the codes that CMS has applied this discount, no such corresponding interpretative diagnosis has been made. We note that for morphometric

codes, the pathologist is reviewing a second, unique and distinct probe with an entirely different signal than that of its base code. The work involved with these add-on services require the *same* level of intensity and time as their base codes. The pathology consultation and cytopathology evaluation codes are clinically different and are not valid proxies to identify efficiencies for the new add-on codes. As a result, ASCP argues that CMS is misapplying the RUC recommendation.

When the new add-on CPT codes were created in 2014, the RUC provided new, more relevant recommendations for this family of codes. The RUC recommended work RVUs for base codes 88365, 88367, and 88368 of 0.88, 0.88, and 0.86, respectively. The recommendations for the add-on codes match identically to their base codes; CPT codes 88364, 88369, and 88373 received recommended work RVUs of 0.88, 0.88., and 0.86, respectively. This data, illustrated in the table below, can be found in both the RUC database and CMS’s CY 2015 PFS Final Rule (See 79 FR 67659, published 11/13, 2014).

<u>CPT Code</u> <u>(base code or</u> <u>add-on to)</u>	Long Describer	RUC Review Date	RUC Recommended Work RVU	CMS Finalized Work RVUs
88364 (add-on for 88365)	In situ hybridization (eg, fish), per specimen; each additional single probe stain procedure (list separately in addition to code for primary procedure).	April 2014	0.88	0.53
88365 (base code to 88364)	In situ hybridization (eg, fish), per specimen; initial single probe stain procedure.	April 2014	0.88	0.88
88366	In situ hybridization (eg, fish), per specimen; each multiplex probe stain procedure.	April 2014	1.24	1.24
88367 (base code to 883730)	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure.	April 2014	0.86	0.73
88368 (base code to 88369)	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure.	April 2014	0.88	0.88
88369 (add-on to 88368)	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each additional single probe stain procedure (list separately in addition to code for primary procedure).	April 2014	0.88	0.53
88373 (add-on code to 88369)	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each additional single probe stain procedure (list separately in addition to code for primary procedure).	April 2014	0.86	0.43

Clearly, there is no RUC recommendation here suggesting the work RVUs should be valued at a lesser amount than the base codes. In fact, the RUC's recommendation is quite the opposite: the base and add-on codes should be valued with the same work RVU. We urge CMS to rescind the discount applied to these add-on codes and to value these services as recommended by the RUC.

The following comments pertain to specific code families to which CMS has applied the 20 percent discount.

1. Immunohistochemistry (CPT Codes 88341, 88342, 88344, and 88350)

For CY 2017, CMS is proposing a work RVU of 0.56 for CPT codes 88341, which would apply a twenty percent discount to the base code (88344) work RVU of 0.70. The agency is proposing a work RVU of 0.59 for CPT code 88350, which likewise would apply a 20 percent discount on the base code (CPT code 88346) work RVU of 0.74. For reasons stated above, the Society disagrees with these valuations as they still do not reflect the appropriate work involved compared to base codes 88342 and 88346. Moreover, they present a rank order anomaly in respect to other services.

ASCP also wishes to address CMS's comparison of these codes to intravascular ultrasound evaluation add-on services CPT codes 37252 (*Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation, initial non-coronary vessel (List separately in addition to code for primary procedure)*) and 37253 (*...each additional non-coronary vessel (List separately in addition to code for primary procedure)*), as this is not a meaningful or appropriate comparison. These codes describe the service of non-coronary intravascular ultrasound (IVUS) in a vessel during a single encounter, including the introduction and manipulation of the probe into the vessel, imaging guidance for the IVUS portions of the procedure, and radiologic supervision and interpretation for the IVUS. For CPT codes 88342, 88341, 88346, and 88350 the physician work involves the pathologists' verification of staining, examination of controls and specimen-specific staining, as well as interpretation of the staining patterns and intensities to determine histologic, cellular, significance, and location prior to composing and dictating a report. In addition, for additional immunohistochemistry services represented by add-on CPT codes 88341 and 88350, each antibody is evaluated on different slides separately.

For some medical procedures and services, efficiencies may be present through the lack of specific pre-, intra-, or post-service physician work or intensities and complexities between base and add-on services; however, this is not the case for 88342, 88341, 88346, and 88350. Each pathology service is unique and distinct from all other medical services within and outside the scope and specialty of pathology. Each pathology service has individual intensities and complexities that terminally compromise any attempt at rational comparison of the physician work with intravascular ultrasound services. ASCP urges the Agency to accept the RUC's recommended work values for 88342 and 88350 of 0.65 and 0.70, respectively.

Practice Expense

In the CY 2017 Proposed Rule, CMS states that "a stakeholder has suggested to us that an error was made in the implementation of direct PE inputs for code 88341 and several other related codes." The stakeholder's comments refer to equipment code EP112 (Benchmark ULTRA automated slide preparation

system) and EP113 (E-Bar II Barcode slide label system). The stakeholder suggested that when CMS reclassified equipment code EP112 and EP113 into a single equipment item, the equipment minutes from EP113 should have been added into the new equipment time. ASCP concurs with the stakeholder's comment that the equipment minutes of EP113 should be added into the new equipment time for EP112 for CPT codes 88341, 88342, 88360, and 88361.

2. Morphometric Analysis (CPT Codes 88364, 88365, 88367, 88368, 88389, 88373)

For CY 2017, CMS proposes a work RVU of 0.70 for CPT codes 88364 and 88369, which represents a 20 percent discount from the base codes (CPT codes 88365 and 88368). Additionally, the Agency proposes to revalue CPT code 88373 at 0.58 work RVUs, which also represents a 20 percent discount for add-on services from the base code.

The Society appreciates that CMS has responded to the physician community with this year's proposals to include the RUC's recommended base/add-on codes time relationships for pathology services. The Society appreciates the Agency's proposal to reduce its discount factor from 24 percent of the base code to 20 percent. However, as previously mentioned, ASCP does not support the application of a standard discount factor for pathology add-on services' work RVU amounts relative to the base code. Further, with these services, the pathologist is reviewing a second, unique and distinct probe with an entirely different signal than that of its base code—meaning that these codes require the same level of intensity and time as their base codes. As discussed previously in relation to immunohistochemistry services, the comparison of these services to coronary ultrasound services is inappropriate and not meaningful. Therefore, we urge the Agency to accept the RUC's recommended work RVUs of 0.88 for CPT codes 88364 and 88369.

With regard to CPT code 88373, we note that the RUC found that the use of computer-assisted technology does reduce slightly the physician work RVUs compared to CPT code 88369, which requires the pathologist to manually review the slide, by selecting the images the pathologist must review. However, this technology cannot distinguish between cancerous and non-cancerous cells and requires the pathologist to review and analyze these cells to render an interpretation. As a result, we urge the Agency to accept the RUC's recommended work RVUs of 0.88 for CPT codes 88364 and 88369 and 0.86 for CPT code 88373.

B. Flow Cytometry Interpretation (CPT Codes 88184, 88185, 88187, 88188, and 88189)

CMS disagreed with some of the RUC-recommended direct PE inputs for CPT codes 88184 and 88185. For these codes, the Agency solicited comments about either (1) creating a CPT coding change to consolidate the base code and the add-on code into a single code to describe the technical component of flow cytometry, or (2) imposing a number of refinements to the direct PE inputs. For CPT codes 88187 and 88189, CMS proposes to accept the RUC-recommended work RVUs. However, for CPT code 88188 CMS is proposing a work RVU of 1.2 rather than the RUC recommended value of 1.4.

As noted above for CPT code 88188, CMS has rejected the RUC-recommendation to value the work RVUs at 1.4. Instead, CMS recommends crosswalking this service to CPT code 88120 (*Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* (work RVU = 1.20)). In explaining its reason for rejecting the RUC's

recommendations for CPT code 88188, it states that there are “no comparable codes with no global period in the RUC database with intra-service time and total time of 30 minutes that had a work RVU higher than 1.20.” According to the RUC, however, *there are at least 10 such codes* with values exceeding 1.20. These codes range in value from 1.38 to 2.4 RVUs, with a median RVU of 1.67. CMS also states that “the RUC-recommended work RVU of 1.4 would go beyond the current maximum value (emphasis added) and establish a new high, which is not consistent with [CMS’s] estimation of the overall intensity of this service relative to others.” ASCP is troubled by this statement as we believe that CMS should value physician work based on the actual work and intensity involved and not up to an arbitrary cap that results in inaccurate assessments of the actual work and expenses involved.

With regard to the CMS proposals for CPT codes 88184 and 881854, ASCP is opposed to consolidating the base code and add-on service into one code. As for the proposed refinements to the direct PC inputs, we wish to note that we have reviewed and agree with the specialty society comments provided by the College of American Pathology. ASCP appreciates CMS’s approval of the RUC-recommended work RVUs for CPT codes 88187 and 8818.

C. Microslide Consultation (CPT Codes 88321, 88323, and 88325)

In the CY 2017 Proposed Rule, CMS is proposing to accept RUC-recommended restorations to slide preparation without refinement. For the clinical labor direct input PE, the Agency proposes to assign one minute of L037B clinical labor for “Complete workload recording logs, collate slides and paperwork, deliver to pathologist” for CPT codes 88323 and 88325; the Agency is maintaining the current value for CPT code 88323 and adding one minute to 88325. Additionally, CMS proposes to remove the clinical labor for “Assemble and deliver slides with paperwork to pathologists” from all three codes in this family as it believes it is redundant with the “Complete workload recording logs” clinical labor assignment. CMS similarly proposes removal of the clinical labor for “Clean equipment while performing service” from CPT codes 88323 and 88325, as it is believed to be redundant with “Clean room/equipment following procedure.”

ASCP agrees with all of the Agency’s proposed refinements, with one exception: CMS proposes to eliminate the clinical labor task, “Assemble and deliver slides with paperwork to pathologists” for CPT code 88321. This is a necessary task for this and many other codes. It is our understanding that this task was mistakenly left off the RUC’s April 2014 recommendations when it last evaluated this service. If CMS believes it is necessary to delete this input, then we urge the Agency to add one (1) minute for “complete workload recording logs. Collate slides and paperwork. Deliver to pathologist.”

D. Prostate Biopsy, Any Method (HCPCS Code G0416)

CMS notes in its Proposed Rule that the College of American Pathologists and the American Society of Cytopathology formed an expert panel to make recommendations at the October 2015 RUC meeting to determine an appropriate work RVU for HCPCS code G0416, as they felt that the recent survey results were invalid. The panel made several arguments to the RUC in recommending for a higher work RVU under the RUC’s “*compelling evidence*” standard. These arguments were: (1) That incorrect assumptions were made in previous valuations; (2) the value of HCPCS code G0416 remained constant while the code descriptors changed over the years; and (3) the “anomalous relationship” between HCPCS code G0416 and CPT code 88305 (Level IV—Surgical pathology, gross and microscopic examination). The expert panel recommended a work RVU of 4.00 based on a crosswalk from CPT code 38240 (Hematopoietic

progenitor cell (HPC); allogeneic transplantation per donor). Working within the constructs of the compelling evidence standard, the RUC agreed with the expert panel's recommendations.

CMS, however, did not accept the RUC's recommendation, arguing that HCPCS code G0416 should not be valued as a crosswalk to CPT code 38240. The Agency noted that using the RUC recommended RVU of 4.00 results in a higher intra-service work per unit of time (IWPUT), and that it does not believe there is a difference in work intensity between these codes. Instead, CMS proposed that G0416 should be tied to CPT code 88305. The Agency used the intra-service time ratio between HCPCS code G0416 and CPT code 88305 to arrive at a work RVU of 3.60. Additionally, the Agency noted that using the IWPUT of CPT code 88305 multiplied by the cross-walked 120 minutes from CPT code 88305 also resulted in a value of 3.60. ASCP firmly believes that CMS's methodological approach for valuing this service significantly undervalues the work involved.

The RUC's recommendation to value G0416 at 4.00 Work RVUs is based on agreement with the presented cross-walk methodology as well as the "compelling evidence" cited to justify the recommendation. We note that the Agency concurred with the evidence on which the RUC based its recommendation and that the work of HCPCS code G0416 may involve the examination of 20-60, or more, specimens. Thus, we believe the Agency's methodological approach to valuing this services *undervalues* this service and that it should accept the RUC's recommended work RVU recommendation of 4.0.

E. Cytopathology Fluids, Washings or Brushings and Cytopathology Smears, Screening, and Interpretation (CPT Codes 88104, 88106, 88108, 88112, 88160, 88161, and 88162)

In the CY 2017 Proposed Rule, CMS maintains its belief that tasks associated with the cytopathology family of codes (e.g., "Recycle xylene from stainer" and "Order, restock, and distribute specimen containers and/or slides with requisition forms) are indirect PE. CMS states that these services are not allocated to any individual service, despite the fact that the amount of clinical labor tasks involved are dependent on the amount of solvent allocated to each specimen, which varies with batch size and therefore by procedure. CMS proposes to maintain the CY 2016 refinements from the previous rulemaking cycle for CPT codes 88104-88162. Additionally, CMS proposes to refine the supply quantity of the non-sterile gloves (SB022), impermeable staff gowns (SB027), and eye shields (SM016) back to the RUC recommended value of 0.2 for CPT codes 88108 and 88112.

ASCP disagrees with the Agency's categorization of the solvent recycling system and its associated clinical labor tasks as indirect PE. CMS states that these services are not allocated to any particular individual service. We believe that the amount of related clinical labor tasks involved are dependent on the amount of solvent allocated to each specimen, which varies with batch size and therefore by procedure. Otherwise, ASCP agrees with the proposed refinements to the supply quantity for CPT codes 88108 and 88112.

II. Standardized Times for Clinical Labor Tasks Associated with Pathology Services

Beginning in the CY 2012 PFS Final Rule, CMS developed standard times for clinical labor tasks that have been used in finalizing direct PE inputs. In the CY 2016 PFS Proposed Rule, the Agency proposed to establish standard times for a list of 17 clinical labor tasks related to pathology services, and finalized

standard times for six of these tasks. In response, ASCP and many other stakeholders expressed concern over the feasibility of establishing a standard time for clinical labor tasks in pathology services due to differences in batch size or number of blocks across different pathology procedures.

Nonetheless, CMS has maintained its interest in standardizing clinical labor task times associated with pathology services, such as “Clean room/equipment following procedure” and “Dispose of remaining specimens,” which the Agency believes do not vary by batch size or block number. ASCP would argue that many pathology services tasks that could seemingly be standardized are, in fact, highly variable (e.g., dispose of remaining specimens, spent chemicals, and hazardous waste) based on batch size or block number. Further, by standardizing tasks associated with pathology services, some codes will inherently be undervalued while others are overvalued. As pathology practices can vary greatly based on their subspecialties, the lack of accurate clinical labor task times could pose significant economic challenges for some practices as they lack the mix of services provided by larger entities like hospitals.

ASCP appreciates that CMS is not proposing any additional standardized times for clinical labor tasks at this time. Further, we appreciate that the RUC Practice Expense Subcommittee plans to examine clinical laboratory tasks, both for pathology and other physician services, to determine where standardization may be possible. We look forward to working with the RUC on any proposals it considers to standardize clinical labor time.

III. Restore the Refinement Panel to Serve as the Relative Value Appeals Process

ASCP urges the Agency to restore the Refinement Panel to serve as the relative value appeals process. Having an objective, transparent, and consistently applied formal appeals process is paramount and the Refinement Panel has historically served reliably in this capacity. We, along with 88 other medical specialty societies and the AMA, strongly disagree with CMS’ intent to eliminate this vital process. Instead, we urge the Agency to open Refinement Panel review to all procedures and services under CMS review during the current rulemaking process.

Further, ASCP strongly disagrees with the Agency’s view that the Refinement Panel has not historically (prior to 2011) served as a formal appeals process; this position is unsubstantiated as the Refinement Panel has long been a text-book example of an appeals process. Without an independent mechanism for appeal, CMS officials are free to make valuation decisions without providing compelling rationale when rejecting relative value recommendations from the RUC and other stakeholders. The original Refinement Panel process, coupled with input from the RUC, would provide the best mechanism for utilizing physician and other health care professionals’ expertise to determine resource use in the provision of a service to Medicare beneficiaries.

IV. Diabetes Prevention Program Expansion

CMS proposes to expand the duration and scope of the Diabetes Prevention Program (DPP) model test, and refer to the new program as the Medicare Diabetes Prevention Program (MDPP). The Proposed Rule

provides a basic framework for the MDPP, and CMS notes that if finalized, it will engage in additional rulemaking within the next year to establish specific MDPP requirements. CMS proposes that the MDPP will be a 12-month program relying upon the Centers for Disease Control (CDC)-approved DPP curriculum.

According to the proposed rule, eligibility to participate in MDPP is available to Medicare beneficiaries who: (1) are enrolled in Medicare Part B; (2) have a body mass index of at least 25 or at least 23 if self-identified as Asian; and (3) within 12-months prior to attending the first core session have a **hemoglobin A1c test** with a value between 5.7 and 6.4 percent, or a fasting plasma glucose of 110-125 mg/dL, or a 2-hour post-glucose challenge of 140-199 mg/dL.

ASCP urges CMS to support use of the hemoglobin A1c test with result between 5.7 and 6.4 percent as one of the eligibility criteria for the Medicare DPP. That said, we should point out that CMS does not currently recognize HbA1c as a covered test to evaluate individuals for diabetes. Just as CMS covers tests that are necessary to diagnose other conditions, CMS should clarify its coverage policy for screening and evaluation using hemoglobin A1c tests in patients who have not yet been diagnosed with impaired glucose tolerance. This will make it clear that it is appropriate for physicians to screen their Medicare patients for pre-diabetes using hemoglobin A1c and, if appropriate, refer them to the DPP. While providing coverage is obviously necessary to facilitate success within the DPP, broader coverage of this important test would have important ancillary benefits.

V. The Impact of Inappropriate Physician Self-Referrals on Healthcare Delivery and Payment

ASCP appreciates the Agency's continued monitoring of financial arrangements in the health care industry, particularly in regards to per-unit of service compensation arrangements. The Society agrees that overutilization and abuse can occur under these types of arrangements and agrees with the re-proposal to limit such arrangements.

However, the Society would encourage CMS to respond to the White House's 2017 budget request and work with Congress to close the physician self-referral loophole. The Society maintains that the only way to fully ensure that physicians' financial interests are not driving clinical decision-making is to remove anatomic pathology and other such complex ancillary services from the in-office ancillary services (IOAS) exception. Absent Stark Law reform – a subject which has recently garnered increased interest with legislators – we are concerned that some referring clinicians may continue to make decisions that are influenced by the potential for financial gain; this would increase the unwarranted provision of anatomic pathology services, which threatens both patient safety and the long-term sustainability of the Medicare program.

Additionally, the Society urges CMS to consider removing anatomic pathology from the IOAS exception to encourage participation in alternative payment models (APMs). By removing anatomic pathology from the exception, providers would be further persuaded to enter into collaborative payment arrangements. ASCP urges Congress to pass legislation clarifying that truly integrated, multispecialty group practices participating in robust APMs, as outlined in MACRA, would not be impacted by narrowing the exception. The Society believes that such clarification would encourage additional physicians to take part in APMs.

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ASCP appreciates the opportunity to provide comment on this Proposed Rule. If we can be of any assistance on these or any other matter, please do not hesitate to contact me or Matthew Schulze, Director of ASCP's Center for Public Policy, at (202) 347-4450.

Sincerely

A handwritten signature in black ink that reads "David" followed by a stylized flourish.

David N.B. Lewin, MD, FASCP
President, ASCP