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LABORATORY ECONOMICS

Competitive Market Analysis For Laboratory Management Decision Makers

SURVEY HIGHLIGHTS DOCTORS' CHALLENGES IN ORDERING AND INTERPRETING LAB TESTS

Primary care physicians have uncertainty for 14.7% of the clinical lab tests they order, and they experience uncertainty in interpreting the results 8.3% of the time, according to survey results published in *The Journal of the American Board of Family Medicine* (March-April 2014, Vol. 27, No. 2).

The survey of 1,768 doctors found the most problematic issues when ordering tests were: 1) uncertainty over patient cost (55%); 2) insurance policies that limit testing (48%); and 3) insurance policies mandating use of a specific lab (40%).

The most common tactic that surveyed physicians use to overcome uncertainty in ordering lab tests was "reviewing e-references," cited by 57%, while the least common tactic was "asking a lab professional," cited by only 6%.
Continued on page 11.

Primary Care Physician Challenges When Ordering Lab Tests

Patient costs	55%
Insurance policies limit testing	48%
Insurance policies mandate use of a specific lab	40%
Lack of comparative cost information	39%
Different test names	20%
Test not available except in a panel	20%
Different tests in test panels	18%

Source: *Primary Care Physicians' Challenges in Ordering Clinical Laboratory Tests and Interpreting Results*, JABFM, March-April 2014, pp. 268-274

NEW NCCI POLICY CUTS FISH TEST RATES BY 50%

Without warning or comment from the lab industry, CMS has issued guidance through its National Correct Coding Initiative (NCCI) Policy Manual, which effectively cuts Medicare reimbursement for FISH testing by 50%. The new NCCI policy states that if two or more probes are applied to a sample for CPT codes 88365, 88367 or 88368, only one unit of service can be billed because the two probes are part of the same "probe staining procedure." Thus CMS will reimburse $0 for the second, third or fourth FISH probe performed on a patient specimen. Previously, labs had billed one unit of service for each reportable FISH probe.
Continued on page 2.

Contents

NEW NCCI POLICY CUTS FISH TEST RATES BY 50% (*cont'd from p. 1*)

The new NCCI policy, which became effective January 1, 2014 and has gone largely unnoticed by the lab industry, seems to directly conflict with the existing AMA code descriptions for CPT 88365, 88367 and 88368.

The policy change will have a huge effect on those labs and pathologists that perform HER2 FISH testing for breast cancer and ALK FISH testing for lung cancer. These tests are used to determine which breast cancer patients will respond to $75,000-per-year Herceptin treatment and which lung cancer patients will respond to Xalkori treatment, which costs more than $100,000 per year.

For example, if a computer-assisted stain containing two FISH probes is applied to a specimen, labs are now supposed to bill for CPT 88367 (x1), according to the new NCCI policy.

Previously, labs performing a single stain containing two FISH probes had billed Medicare for each reportable probe (88367 x2).

In this example, the policy change lowers technical reimbursement to approximately $200 versus $400. Professional reimbursement is lowered to approximately $60 versus $120.

NeoGenomics Laboratories, which performs over 20,000 HER2 FISH tests per year, says the new NCCI policy doesn't make any sense at any level. In a Feb. 10 letter to Niles Rosen, MD, Medical Director at NCCI, NeoGenomics said the new reimbursement for HER2 testing falls below the cost to perform the test. Furthermore, NeoGenomics said new policy seems to contradict other existing NCCI policy that states that "one unit of service may be reported for CPT 88365, 88367 or 88368 for each reportable probe." [NCCI Manual, Section J, Paragraph 6]

NeoGenomics says it will lose approximately $3 million per year in revenue if the new NCCI policy is not changed.

It is not clear how the NCCI's new policy will affect the revaluation of CPT 88365, 88367 & 88368 that CMS is scheduled to conduct this year. These codes are under review as part of the agency's "potentially misvalued" code initiative.

Overall, Medicare Part B carriers paid $89 million in allowed technical and professional charges to labs and pathologists for the three FISH codes (88365, 88367 & 88368) in 2012, according to the latest available figures from CMS.

Medicare Part B Carrier Spending on FISH Testing in 2012

CPT Code (description)	*Claims Submitted*	*Allowed Charges*
88365 (FISH, each probe)	65,020	$5,055,801
88367 (FISH, each probe; computer-assisted)	239,574	$30,364,638
88368 (FISH, each probe; manual)	376,698	$53,476,640
Totals	681,292	$88,897,079

Source: CMS and CodeMap LLC

QUEST TO BUY SUMMIT HEALTH

Quest Diagnostics has agreed to purchase Summit Health (Novi, MI) for an undisclosed sum. The deal is expected to close by June 30.

Summit provides on-site health screening and flu shot programs through contracts with employers and health plans. Through these programs, contracted nurses go to offices to test workers' cholesterol, glucose values, blood pressure and BMI; they also complete a short health survey.

Summit has contracts with more than 100 employers and insurance companies, including Aetna, BCBS of Florida, BCBS of Michigan, Cigna, UnitedHealth, as well as Coca-Cola, Deere & Co., Ford, General Electric and Oracle.

Summit, which has 175 full-time employees, is based in the Detroit suburb and also has an office in Scottsdale, Arizona. The company generated revenue of $50 million in 2012 and $80 million in 2013 (60% growth).

LabCorp had been Summit's primary provider of lab testing services. However, in May 2012, Summit opened a 50,000-square-foot laboratory and office in Michigan and insourced most of its testing. Summit currently performs roughly 500,000 lab tests per year, primarily total cholesterol, HDL, TC/HDL ratio and glucose tests.

Summit CEO Richard Pennington has predicted growth of 25% to $100 million this year. One reason for Summit's fast growth has been the Patient Protection and Affordable Care Act, which gives employers incentives to implement health and wellness programs. For example, the federal law now allows employers to penalize individuals who are overweight in the form of an increased monthly health insurance premium (i.e. employees with a BMI above 30 pay an extra $100/month for healthcare), while employees who are at a normal BMI (below 30) get an extra $100/month in their paycheck.

Separately, Quest announced completion of its previously announced $570 million deal to acquire Solstas Lab Partners on March 10 (see *LE*, February 2014, pp. 4-5).

LABCORP COMPLETES PURCHASE OF MEDLAB IN TERRE HAUTE

In late February, LabCorp completed its acquisition of Terre Haute Medical Laboratory Inc. and Pathology Associates of Terre Haute from MedLab (Cincinnati, OH) for $10.5 million. The acquisition includes two labs and seven patient service centers in central Indiana. MedLab, which is based in Cincinnati, is going through a Chapter 11 bankruptcy restructuring and has $42 million in debt.

Correction: The February 2014 issue of *Laboratory Economics* incorrectly stated that Myriad Genetics has an in-house staff of nine lobbyists. In fact, Myriad employs one lobbyist and is represented by additional lobbyists through a contract with American Continental Group.

PATHOLOGY INSTITUTE HIGHLIGHTS

Nearly 160 pathologists and executives gathered in Orlando, February 28-March 1, for the Third Annual Pathology Institute conference put together by *Laboratory Economics* and G2 Intelligence. Key points of topic included the growing importance of pathologist compensation for clinical lab directorship, industry consolidation, the effect of more out-of-pocket responsibility for patients, CMS's revaluation of the CLFS, and "How will pathologists be paid in the ACO model?" Here are some highlights from some of the presentations:

Ron Champagne, MD, Managing Partner at **Peoria Tazewell Pathology Group** (Peoria, IL), emphasized the need for pathologists to be paid for the professional component of clinical lab testing. PTPG is an independent hospital-based pathology group with 13 pathologists that perform approximately 40,000 surgical and 20,000 cytologic cases per year. The group has nine hospital contracts in central Illinois; its largest is with UnityPoint Health-Methodist Medical Center (329 beds/15,500 inpatient admissions per year).

Champagne said that PTPG receives about 40% of its revenue from the PC of clinical lab testing. He noted that Illinois has an established history of paying for the PC of clinical lab testing. For example, in Smith v. Peoria Tazewell Pathology Group, Case No. 94-L-245 (Ill. Cir. 1997), the Illinois Circuit Court ruled: "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 hospitals at which the Pathologists practice….The Pathologists are entitled to bill patients for these services—regardless of whether the Pathologists personally perform the test or review the results."

Champagne said that hospital-based pathologists have not been immune to the effects of the in-office histology lab trend. In late 2011, a 10-doctor gastroenterology group in Peoria opened its own endoscopy center and histology lab and began billing globally for its 10,000 annual surgical cases. PTPG was at risk of losing its professional services contract with the group. A compromise was reached and PTPG negotiated a fixed fee (~$25 per 88305) for providing professional interpretations plus a stipend for lab directorship. The in-office lab, Illinois Gastroenterology Institute, is now in the process of being CAP accredited.

PTPG, which does not own a histology lab and bills PC only, anticipates a modest $75,000 loss in revenue this year because of reimbursement cuts. Champagne said the group has offset the projected lost revenue through health plan changes, switching billing companies, reducing pension plan administrative costs, and lower malpractice insurance.

Despite off and on discussions over the years, pathology groups in central Illinois have been reluctant to merge, according to Champagne. But he said health system mergers and reimbursement pressure may motivate groups to reconsider. "The younger partners know that only through growth can we hope for a future that even approximates the senior members' past," noted Champagne.

"Small and medium sized pathology groups are doomed and will ultimately become employees," predicted **Don Howard, MD, PhD**, Chairman and CEO at **CellNetix Pathology & Laboratories** (Seattle, WA). He said that only those groups with 20 or more pathologists will have the economies of scale needed to compete as hospitals consolidate, subspecialized pathology becomes more prevalent and reimbursement moves from fee-for-service to bundled payment.

Howard said the fear of hospital administration is paralyzing pathologists from acting. The default option for pathologists that refuse to change is becoming an employee at either a hospital, ACO, Quest, LabCorp, or a physician specialty group (GI, GU, derm, etc.), according to Howard.

Although nothing is imminent, Howard said he is hopeful that the two largest pathology groups in Washington (CellNetix and Incyte Pathology) will merge someday in the future.

CellNetix was formed by the merger of three pathology groups in western Washington in 2005. At the time of the merger CellNetix had about 25 pathologists. In 2007, CellNetix opened a 48,000-square-foot lab and office in Seattle. In September 2008, Northwest Pathology Services of North Seattle merged with CellNetix.

In addition, CellNetix acquired the pathology groups at Deaconess Hospital in Spokane and at Mat-Su Regional Medical Center in 2012. CellNetix is also in the process of acquiring Highline Pathology Associates, which is based at Highline Medical Center (full formal merger effective April 1st this year).

Today, CellNetix has 50 pathologists and 300 total employees that process 125,000 surgical cases and 150,000 Pap tests per year.

Pathologists at CellNetix own 100% of the professional corporation (CellNetix Pathology PLLC) and have majority ownership of the technical lab (CellNetix Labs LLC). Last year, the national reference lab PAML (Spokane, WA) bought a 22% stake in CellNetix Labs.

PAML and CellNetix recently invested a combined $3 million to form a 50/50 joint venture reference lab separately branded as Symbiodx. The new lab company will focus on molecular oncology, including Next Generation Sequencing, IHC, flow cytometry and cytogenetics. Symbiodx will initially focus on providing service to hospitals and cancer clinics within CHI (Catholic Health Initiative) and Providence Health and Services—the two owners of PAML. "We're pouring money into this because we think it's the future," said Howard. "While everyone is in chaos and standing like a deer in the headlights, we intend to be proactive, take risks and go for it."

Kenneth Ries, MD, Chief Executive at **Pee Dee Pathology Associates, PA** (Florence, SC), said his group began to explore a sale or partnership agreement in late 2011. The group had experienced several years of growth, but the handwriting was on the wall, according to Ries. The group's Pap testing volumes were beginning to slow down due to lengthened testing intervals and a large urology group client was opening an in-office histology lab. The threat of Medicare rate cuts and the increasing costs of EMR interfaces were also a concern.

So PDPA, which has eight pathologists, hired a consulting firm, ICG Capital Partners, and began meeting with potential suitors. Ries said PDPA met with dozens of private equity investors throughout 2012. PDPA also explored merging with other pathology groups in South Carolina, but the group cultures were too different and most groups lacked the motivation and leadership required to get a deal done, according to Ries.

Ultimately PDPA chose a unique deal with LabCorp. Under the arrangement, which was finalized in December 2012, PDPA sold its Pap testing, HPV and associated infectious disease testing business to LabCorp. PDPA's 35,000 Pap tests are now processed at LabCorp's cytopathology lab in Burlington, NC. Atypical test results requiring a pathologist review continue to be performed by PDPA's pathologists.

In addition, LabCorp made a minority investment in PDPA's histology lab business. And

PDPA is now LabCorp's exclusive AP technical lab and professional component provider in northeastern South Carolina.

Private equity investors have been scared away from the AP market because of rate cuts and continued competition from in-office labs, according to Ries. He sees two options left: 1) align with or be employed by a hospital, or 2) establish a relationship with a larger regional or national lab. "Pathologists can't expect to just hunker down and survive," said Ries.

Clay Cockerell, MD, President of **Cockerell Dermatopathology** (Dallas, TX), chose not to renew his employment contract with Quest Diagnostics last year and instead opened his own independent dermatopathology lab in Dallas. Cockerell had been Managing Director for Quest's Dermpath Diagnostics division in Dallas.

Under a business purchase agreement, Cockerell transferred nearly all of his clients and employees at Quest's Dermpath lab in Dallas to his new company. Cockerell purchased and renovated a 78,000-square-foot medical office building in Dallas. His new lab company uses about half the space and leases the rest to other medical-related tenants. Cockerell Dermatopathology began processing specimens on July 1, 2013. It currently has 50 employees, including four dermatopathologists, that are processing 200,000 cases per year for about 1,300 clients.

Among the former Quest/AmeriPath executives that have joined Cockerell Dermatopathology are Randy Wills, former Vice President, Laboratory Quality and Performance at AmeriPath; Rand McCarley, former Director of Marketing at AmeriPath; and Mark Faselle, former Director of Health Plans at AmeriPath.

AmeriPath originally acquired Cockerell's lab, formerly named Freeman-Cockerell Labs, in 1996. AmeriPath was then acquired by the private investment firm Welsh Carson and ultimately sold to Quest Diagnostics in 2007 for $2 billion.

Cockerell said that after nearly 20 years of working for AmeriPath/Welsh Carson/Quest, he got tired of the frequent management changes, bureaucracy and pressure to meet quarterly earnings expectations.

What is Dr. Cockerell's advice to any independent pathology group considering a sale to a national lab company such as Quest, LabCorp, Aurora Diagnostics, et al.? "First, get good advice from an expert in this field, both legal and financial. The market is much softer today and high multiples are a thing of the past so if you are doing it primarily for monetary reasons, that is not a good plan. Second, do serious soul searching as to whether becoming an employee is really right for you and the others in your group. You will be subject to the policies and procedures of the parent organization which has advantages and disadvantages. Sometimes the latter outweigh the former. Finally, don't let negative press and fear drive your decision."

Joe Song, Chief Executive at **Associated Pathology Medical Group** (Los Gatos, CA), noted, "Today there are more lab reps selling in doctors' offices than there are drug reps." He said the top reasons why physician groups change labs are: 1) lab mistakes; 2) turnaround time; 3) billing problems; and 4) sales rep likability. "Listening is more important than telling physician offices everything your lab does," according to Song.

APMG is an independent pathology group based in the heart of Silicon Valley. The group has eight pathologists, one pathologist assistant, four sales reps and 70 total employees. APMG operates its own technical lab that processed 150,000 slides, 50,000 Pap tests and 60,000

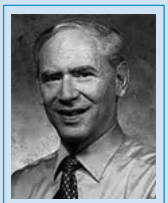
molecular tests in 2013. Annual volume growth has averaged approximately 12% over the past four years, according to Song.

Last year, APMG gained about 50 new clients (representing 110 doctors) and lost two accounts. Song is hopeful that the two lost clients will be regained this year. Most of APMG's new clients have come from the national labs and other out-of-state competitors, noted Song.

Diane Brandon, Vice President, Strategic Development & Payor Relations at **Bako Pathology Services** (Alpharetta, GA), noted that health plans have increased their focus on "leaker" data that identifies physicians that are referring specimens to non-participating labs. These reports are shared with contracted labs. In addition, some health plans, including Cigna, are now sending their local medical directors out to meet and cajole physicians that consistently refer to out-of-network labs.

Bako Pathology has some 300 insurance contracts, including Aetna, Cigna, Humana, United and 27 different BCBS plans, according to Brandon. The key to getting in-network contracts is convincing payers of the loyalty of your referral sources regardless of your contract status. "Unwavering support is needed while you work to secure contract coverage," explained Brandon.

Bako Pathology, which was formed in 2008, specializes in podiatric pathology and dermatopathology. The group's lab and five dermatopathologists are currently processing about 280,000 to 300,000 cases per year.



Bruce Friedman, MD, Active Emeritus Professor, Pathology, University of Michigan Medical School, warned that hospital cost-containment pressures combined with the high cost of EHR deployments is leading to wide adoption of enterprise-wide solutions. As a result, pathologists and lab professionals risk losing control and responsibility of selecting and managing their own lab information systems (LISs).

More and more hospital CIOs and central IT departments are favoring enterprise-wide solutions that come with embedded LIS modules. Enterprise-wide solutions are favored because of their "one price for all software" pitch which leads hospital executives to believe that the embedded LIS module will be a "free lunch."

As an example, Friedman cited Beaker, the LIS provided as part of the enterprise-wide Epic system, which is often perceived as "free." But while the Epic contract may cover the licensing cost of Beaker, it does not cover the installation fee. Friedman said that installation costs (e.g., $1 million) plus functionality deficits (e.g., no blood bank, weak on lab outreach and molecular) may result in Beaker costing as much as or more than a best-of-breed LIS.

Friedman urged pathologists to make the case to hospital executives for keeping their best-of-breed LIS versus installing a "good enough" LIS solely based on the hospital march toward an enterprise-wide solution.

According to Friedman, the key elements in this discussion are:

- "good enough" LIS may cost the same as a BoB LIS because of significant installation costs
- "good enough" LIS may have functionality gaps, which may result in the need for additional lab FTEs
- "good enough" LIS may impair lab services and alienate hospital clinicians who may already be happy with the enterprise-wide HER

Friedman directed the conference attendees to a free LIS Functionality Assessment Toolkit from

the Association for Pathology Informatics (API) that can be used to organize the case for keeping a BoB LIS (www.pathologyinformatics.org/lisstats).

Rina Wolf, Vice President of Commercialization Strategies, Consulting and Industry Affairs at **Xifin Inc.** (San Diego, CA), noted that no one really has any idea what to expect from Medicare's CLFS repricing project. The first group of codes selected and their proposed pricing is expected to be announced in the 2015 Medicare Physician Fee Schedule (usually published in July). The public will have 60 days to comment. Then CMS will announce the final adjusted reimbursement amounts in the 2015 Medicare Physician Fee Schedule Final Rule (usually released in November). "Think about the job they did on pricing 100 molecular tests. How will they handle 1,000 clinical lab test codes?" she asked.

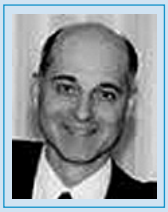
Currently, labs are stacking Tier 1 MDx test codes when billing for next-generation sequencing panels. However, specific reimbursement for Tier 2 nextgen tests is expected to be announced this summer and take effect in 2015, according to Wolf.

She noted that CMS has maintained its position that the CLFS only pays for clinical diagnostic lab tests and continues to place no value on multianalyte assays with algorithmic analyses (MAAAs).

So far only two Medicare contractors, Noridian (CA, NV, HI) and Palmetto (NC, SC, VA, WV), are using Palmetto's MolDx technical assessment and reimbursement program, although Palmetto wants to expand it nationally, noted Wolf. "The bar for coverage keeps inching higher and higher," she added.

Wolf also noted that commercial payers are still currently reimbursing IHC stains using CPT code 88342 and have not yet begun using the new Medicare codes G0461 and G0462.

Finally, she said that although CMS chose not to move forward linking anatomic pathology technical rates to the Outpatient Prospective Payment System (OPPS) for 2014, "I would not be surprised if they try to link to the OPPS for 2015."



David Scamurra, MD, President, **Eastern Great Lakes Pathology PC** (Amherst, NY), advised pathologists not to assume that their pathology group or lab will automatically be part of their hospital's ACO, or that their ACO won't also contract with an outside lab(s).

EGLP is an independent pathology group with 15 pathologists providing services to the 4-hospital Catholic Health System in Buffalo, New York. EGLP is also the pathology group in Catholic Medical Partners, an integrated delivery system with an ACO component and joint venture with 950 physicians and the hospital system.

Right now, EGLP is predominantly paid on a fee-for-service basis, but Scamurra expects compensation to shift toward ACO-shared-savings-type reimbursement over the next 3-5 years.

The million-dollar question is "How will pathologists be compensated under the ACO model?" Scamurra said the default method could be to pay pathologists a fixed percentage of the shared savings pool, assuming the ACO makes budget. However, he said this would imply that pathology services provide no real specialty impact on patient care and would likely result in a small percentage of shared savings allocated for pathologists. "Placing pathologists on fixed salaries in the ACO has the same effect of reducing our role to that of a commodity."

Alternatively, ACOs could link performance payments for pathologists to lab test utilization

rates. But Scamurra said this is a risky and simplistic option because most pathologists do not have adequate control over the LIS, hospital ordering program or physician compliance with stated test ordering guidelines to be confident they can achieve a raw test number decrease on a consistent basis. But more importantly this metric does not reflect the critical educational, management and analytic role that pathologists play in caring for the ACOs patients. These latter qualities need to be understood and properly valued by the ACO management because that is where pathology's impact on quality and cost lies, according to Scamurra.

Scamurra has been told by the ACO that profits cannot be shared for "outcomes consistently achieved or for basic competency of work." In his view, this reflects a lack of understanding of the pathologist's role in an integrated delivery model. "The dialogue has to start with understanding what the ACO needs and what pathology can deliver."

Shelly Gunn, MD, PhD, Chief Medical Officer at **MolecularHealth** (Woodlands, TX), noted that the U.S. spends more than $20 billion per year on cancer drugs, but that the majority of patients do not respond to treatment. So there is a clear opportunity for pathologists and labs to impact healthcare economics, according to Gunn.

In the age of personalized medicine, Gunn expects the pathologist's role to grow in prominence, particularly for nextgen sequencing. "As the custodians of the tissue, and thus the DNA, community pathologists can either just pass blocks to national reference labs, or retain ownership of the process," she noted.

Gunn said that community pathologists will continue to provide traditional slide-based biomarker services such as IHC (e.g., NSCLC, breast cancer subtyping) and FISH (e.g., HER2,EML4/ALK, heme specific translocations). In addition, she said there is the opportunity for pathologists to be involved with the preparation of clinical samples for nextgen sequencing by performing tumor circling and DNA extraction in-house.

Gunn said that pathologists also have the opportunity to get more involved with the interpretation of genetic tests results. She noted the new code G0452 (molecular pathology procedure; physician interpretation and report/ NLA=$19.34) and the existing code 80502 (Clinical pathology consultation; comprehensive, for a complex diagnostic problem/ NLA=$68.42).

MolecularHealth is an independent lab company focused on nextgen sequencing. The company operates a CLIA-certified lab in Houston that is in the process of rolling out a targeted gene panel of more than 500 known cancer genes under the brand name TreatmentMAP. MolecularHealth runs each patient's genetic test results through a software program that uses the FDA's adverse events database to analyze which drugs have been effective and which have been toxic in patients with a similar genetic makeup. TreatmentMAP test results are delivered back to the ordering oncologist with a ranked list of all the treatment options. The TreatmentMap testing service is expected to have a list price of approximately $5,000.

Greg Richard, Executive Vice President, Sales & Marketing, **StrataDx** (Lexington, MA), said the three most important factors determining client satisfaction with their pathology lab are: 1) reliable, consistent diagnosis; 2) turnaround time; and 3) access to pathologists. He said that Strata has invested in hiring subspecialized pathologists with brand name recognition. "Our marketing materials focus on our pathologists. They're the one aspect of your service that no one can replicate," according to Richard.

StrataDx has 13 sales reps and 19 pathologists, including seven dermatopathologists and four oral pathologists. StrataDx, which has annual revenue of approximately $30 million, was acquired by the private equity firm Linden Capital Partners in 2011.

Al Sirmon, CPA, Vice President, Pathology Services, **McKesson Business Performance Services**, warned that all payers may not be ready for the transition from ICD-9 to ICD-10 scheduled to take effect on October 1, 2014. "Who are your major payers and what are your average collections per month from each of them? What if any one of them has problems processing ICD-10?" asked Sirmon. He advised pathology groups and labs to set aside 20% of their cash collections per month for the next seven months to cover any payment delays associated with the transition to ICD-10. Furthermore, he urged groups and labs to secure a line of credit from their bank to help smooth any potential cash flow problems.

Comparison of Diagnosis Codes

ICD-9	*ICD-10*
3-5 characters	3-7 characters
Approx. 13,000 codes	Approx. 68,000 codes
First digit may be alpha (E or V) or numeric; digits 2-5 are numeric	First digit is alpha; digits 2 and 3 are numeric; digits 4-7 are alpha or numeric

Source: AMA

Laboratory Economics notes that the ICD-10 system will also require clinical labs to capture significantly more detailed diagnosis information from ordering physicians. As it is, labs already struggle with getting physicians to use correct ICD-9 diagnosis codes on lab orders. The transition to ICD-10 involves expanding the number of diagnosis codes by more than five-fold and is certain to increase the front-end billing costs of labs.

Meanwhile, Sirmon also noted an "accounts receivables creep" that's now taking place at most pathology groups. He estimated that days sales outstanding (DSOs = the average time it takes for collection on a claim) has increased by 3 to 4 days since the start of the year because of a slowdown in the payment process at most payers and increased denials. In addition, Sirmon noted that an increase in self-paying patients, as a result of higher deductibles, has put added strain on lab billing and collection. He noted that he average deductible for Bronze Health Plans is approximately $5,000 per year.

Barry Portugal, President, **Health Care Development Services, Inc.**, said that, as a result of the Accountable Care Act, hospital-based pathologists are increasingly being asked to expand their traditional Part A management responsibilities to include a greater emphasis on the development and management of lab test utilization programs. Pathologists will need to do a better job of recording their time spent on Part A services in order to support Part A compensation, as their role and compensation begins to transition away from CPT billing, according to Portugal.

He said that greater emphasis on lab test utilization management may drive a trend toward hospital employment for pathologists versus the traditional independent contractor model. Portugal noted cited data from the physician recruitment firm Merritt Hawkins, which showed that the recruitment of physicians into independent practice settings such as solo practice and partnerships has almost entirely abated. Sixty-four percent of Merritt Hawkins' search assignments in 2012/13 featured hospital employment of the physician, up from 11% in 2004.

SURVEY HIGHLIGHTS DOCTORS' CHALLENGES (*cont'd from page 1*)

The survey team was led by John Hickner, MD, of the University of Illinois at Chicago College of Medicine and researchers from the Centers for Disease Control and Prevention (CDC). The survey was conducted during 2011 and received responses from 1,768 family practice and internal medicine physicians. Surveyed physicians had an average 80.9 patient visits per week and reported ordering lab tests for an average of 31.4% of these patient encounters.

Primary Care Physician Challenges When Using Lab Tests

Results not received in a timely manner	34%
Previous results are not easily available	32%
Errors in results are suspected	25%
Results are inconsistent with patients' symptoms	24%
Lab-to-lab variation in normal range	22%
Lab-to-lab variation in report formats	21%
Lab report format is difficult to understand	18%
Not enough information in lab report	16%

Source: *Primary Care Physicians' Challenges in Ordering Clinical Laboratory Tests and Interpreting Results*, JABFM, March-April 2014, pp. 268-274

Surveyed physicians cited the following factors as important influences on their test ordering: national (63%) and local (46%) clinical practice guidelines, patients' costs (53%), patient factors related to insurance (40%), and malpractice concerns (39%).

The biggest issues concerning test results were: 1) results not received in a timely manner (34%); 2) previous results not easily available (32%); and 3) errors in results are suspected (25%).

Among the conclusions of the survey authors was that lab managers and pathologists should develop better communication channels with busy physicians to make consultative services more easily available.

LABCORP WINS BLUE CROSS CONTRACT IN PHILADELPHIA

Independence Blue Cross (IBC), which cover 2.2 million people in the Philadelphia region, has selected LabCorp as its exclusive national outpatient lab effective July 1, 2014. Quest Diagnostics is losing the contract. IBC said the contract switch will provide "significant savings."

IBC said that it will continue to contract with other labs, including Aculabs, Atlantic Diagnostic Labs, Genomic Health, Health Network Laboratories, Myriad Genetics, NeoGenomics, Thomas Jefferson University Hospital, University of Pennsylvania Hospital, et al.

In support of this contract, LabCorp has agreed to significantly expand its number of PSCs in the IBC service area. With the addition of newly built PSCs, LabCorp will have approximately 169 draw sites, including an estimated 50 new sites, in the IBC service area by July 1, 2014.

IBC's switch to LabCorp follows a similar change made by KeystoneFirst, which covers 302,000 Medicaid enrollees in the Philadelphia region. Effective December 1, 2012, KeystoneFirst switched from Quest to LabCorp. KeystoneFirst (formerly named Keystone Mercy Health Plan) is co-owned by IBC and BCBS of Michigan.

LAB STOCKS UP 24% YTD

Fourteen lab stocks increased an average of 24% year to date through March 19. In comparison, the S&P 500 Index is up 1% and the Nasdaq is up 4%. The top-performing lab stock so far this year is Foundation Medicine, up 72%, followed by Myriad Genetics, up 71%. LabCorp is up 8% and Quest Diagnostics is up by 4%.

Company (ticker)	Stock Price 3/19/14	Stock Price 12/31/13	2013 Price Change	Market Capitalization ($ millions)	P/E Ratio	Price/ Sales	Price/ Book
Bio-Reference (BRLI)	$26.82	$25.54	5%	$745	18.6	1.0	2.7
Cancer Genetics Inc. (CGIX)	17.67	13.78	28%	164	NA	28.1	21.6
CombiMatrix (CBMX)	3.53	2.30	53%	37	NA	6.0	3.6
Enzo Biochem (ENZ)	4.22	2.92	45%	180	NA	2.0	5.3
Foundation Medicine (FMI)	40.88	23.82	72%	1,131	NA	39.0	8.6
Genomic Health (GHDX)	29.49	29.27	1%	920	NA	3.5	6.3
LabCorp (LH)	98.25	91.37	8%	8,381	14.7	1.4	3.4
LipoScience (LPDX)	4.06	4.25	-4%	61	NA	1.2	1.2
Myriad Genetics (MYGN)	35.97	20.98	71%	2,625	15.5	3.8	3.9
NeoGenomics (NEO)	3.62	3.62	0%	175	71.4	2.6	8.1
Psychemedics (PMD)	17.94	14.69	22%	96	24.9	3.5	7.8
Quest Diagnostics (DGX)	55.81	53.54	4%	8,050	9.5	1.1	2.0
Response Genetics (RGDX)	1.48	1.16	28%	53	NA	2.7	9.3
Sonic Healthcare (SHL.AX)	17.41	16.58	5%	6,978	19.1	1.9	2.3
Unweighted Averages			24%		24.8	7.0	6.1

Source: Bloomberg and Zacks

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