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LABORATORY ECONOMICS

Competitive Market Analysis For Laboratory Management Decision Makers

PEE DEE PATHOLOGY AND LABCORP FORM NOVEL PARTNERSHIP

Pee Dee Pathology Associates (PDPA-Florence, SC), an eight pathologist anatomic and clinical pathology laboratory practice, has struck a novel business arrangement with LabCorp. *Full details on page 11.*

PAML BUYS STAKE IN CELLNETIX

Pathology Associates Medical Laboratories (PAML-Spokane) has signed a letter of intent with CellNetix Pathology and Laboratories (Seattle) to purchase a minority equity stake in their laboratory business (CellNetix Labs LLC). As part of the deal, PAML and CellNetix will form a jointly owned molecular pathology esoteric testing division. By agreement, PAML and CellNetix will both have a seat on each other's boards. *Cont'd on page 8.*

20% LAB CO-PAY BACK ON THE TABLE

Private conversations with health policy advisors in Washington suggest that a 20% co-pay for Part B lab tests could be included as part of any new legislation aimed at deficit reduction. Policy advisors tell *Laboratory Economics* that a new 20% lab co-pay would be part of a broader restructuring of Medicare under a cost-saving being evaluated by the Congressional Budget Office (CBO) called Uniform Deductible, Catastrophic Cap and Uniform Coinsurance. This plan involves replacing the divergent Part A and Part B deductibles with a single, combined annual deductible of $550 and uniform 20% coinsurance for all services, including lab tests and home health services. Annual out-of-pocket spending for beneficiaries would be capped at $5,500. The CBO has estimated that the combination of changes would save the Medicare program $32 billion over 10 years (2012–2021). *Continued on page 3.*

QUEST CEO OUTLINES PLANS TO TURN AROUND AMERIPATH

Quest Diagnostics has struggled to effectively manage AmeriPath since making the $2 billion acquisition in 2007. Challenges include pathologist turnover, insourcing by GU, GI and derm groups, and now Medicare's unprecedented 52% cut to the technical component of CPT 88305. But Quest's new chief executive Steve Rusckowski says that Quest remains committed to anatomic pathology and AmeriPath. In an exclusive interview with *Laboratory Economics*, Rusckowski outlined the steps that Quest is taking to improve operations and fully integrate AmeriPath. *Continued on page 2.*

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QUEST CEO OUTLINES PLANS TO TURNAROUND AMERIPATH *(cont'd from p. 1)*

New Management

Steve Rusckowski

Rusckowski became chief executive of Quest on May 1, 2012. In October, Quest announced that Joan Miller, PhD, president of AmeriPath, had resigned. Quest expanded the management responsibilities of its chief medical officer, Jon Cohen, MD, to include cancer diagnostics and pathology services.

Integration of AmeriPath, DermPath and Quest

Rusckowski says that Quest is working to integrate its women's health and molecular oncology testing services with AmeriPath and DermPath to create a comprehensive cancer diagnostic solution. He says the majority of the integration will be completed during 2013 and may involve consolidation of some pathology practices and labs. "We'll have to make some tough choices," says Rusckowski.

Key to Maintaining Pathologist Loyalty

Rusckowski noted that the majority of physicians in the United States are now employees that work for big enterprises. "Doctors want to focus on the practice of medicine, not computers or billing issues," he says. "Our oncology strategy of combining capabilities will be inspiring to many pathologists," he adds.

Cost-Cutting Initiatives

Companywide, Quest has a goal of achieving $600 million in annualized cost savings by the end of 2014. For example, Rusckowski notes that Quest buys more than $2 billion per year of services and supplies from outside vendors. He says Quest will take advantage of its scale to cut its annual supply costs by $125-$150 million over the next two years. Additional savings are expected from a reduction in management layers, standardization of IT, and lab consolidation.

Medicare's 52% Cut to CPT 88305-TC

"It's a big and substantial cut that will have a significant impact on how care is provided....But it's too early to tell how it will all unfold," says Rusckowski. "Medicare is a benchmark and other payers will put this on their list of opportunities [for rate cuts]. There's no question there will be pressure."

Payment Under the ACO Model

There will be a gradual movement away from fee for service to a fixed payment per episode of patient care, according to Rusckowski. This time, unlike managed care capitation of the 1990s, he expects the capitated payment model to "stick." But it will be an evolutionary, not revolutionary, change.

Rusckowski notes that pathology and lab services represent only about 3% of the $2.4 trillion spent on healthcare annually in the United States. "The industry has the opportunity to make the case that lab testing is undervalued, but we need to have the clinical evidence to back it up."

Hospital Lab Outsourcing

Meanwhile, speaking at a recent investor conference in New York City, Quest's chief medical officer, Jon Cohen, MD, said more hospitals are seeking to outsource their laboratory. He said that hospitals can reduce their lab expense by 8% to 20% by outsourcing the lab to Quest. The savings come from lower equipment and supply costs and reduced payroll. "Our core business is running laboratories. And they know that, and we know that. So we think, again, it's an amazing opportunity for us." Outsourcing lab management, outright acquisitions of lab outreach businesses (e.g., University of Massachusetts) and joint ventures are all possible opportunities, according to Cohen.

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20% LAB CO-PAY BACK ON THE TABLE (*cont'd from p. 1*)

The threat of a lab co-pay has haunted clinical labs since 1988. The lab industry has argued that the administrative costs of collecting a 20% co-pay from beneficiaries would in many cases exceed the actual co-payment. For example, the American Clinical Lab Association (ACLA) has estimated that a lab co-pay would require labs to send more than 200 million new bills to seniors each year in an attempt to collect a median $6.20 co-pay from them.

However, this time around the fight to stop the lab co-pay will be tougher. One policy advisor to the Senate Finance Committee told *Laboratory Economics*, "They already collect co-pays from private payers and Medicare Advantage and they've admitted to Wall Street that they can handle a co-pay." The policy advisor noted a conference call in late 2011 where Quest Diagnostics' chief financial officer told analysts, "Look, we collect co-pays today, so we've got the infrastructure in place to do it. We know how to do it. And while it would add cost to us, it's something that we're certainly capable of accomplishing. And I believe for less than what you've just quoted [$3.50 per bill]."

However, ACLA president Alan Mertz says only 20% of Medicare Part B lab expenditures are paid to Quest Diagnostics and LabCorp. The majority of payments, 80%, go to smaller independent labs and hospital labs.

Mertz notes that any potential 20% co-pay would involve a 20% across-the-board reduction to the Part B clinical lab fee schedule. Labs would then need to collect that 20% from Medicare beneficiaries. He says that it would be difficult for labs to collect any payment from a large portion of Medicare recipients, including those in nursing homes, the disabled, and those with no supplemental coverage.

Furthermore, Mertz notes that clinical labs have already borne a disproportionate amount of cuts relative to the 1.6% they represent in the overall Medicare budget. The Medicare Part B clinical lab fee schedule is set to be cut by a total of 15% between 2010 and 2015. Adding another 20% reduction through a lab co-pay could put hundreds of small independent labs out of business.

Competitive Bidding for Lab Services

Competitive bidding for Part B lab services is also back on the table as a means to cut costs from the Medicare program. Its latest advocate is the Center for American Progress, an independent nonpartisan think tank with headquarters in Washington, D.C. The center has estimated that lab competitive bidding has the potential to save $4.2 billion over 10 years.

The center's proposal follows articles published in the August 1 issue of *The New England Journal of Medicine* which recommended expansion of competitive bidding to several Medicare services, including lab testing.

The last effort by Medicare to introduce a lab competitive bidding was axed in 2008 when Congress repealed the authority it had previously granted for a pilot program. Policy analysts say the saving grace for labs has been that competitive bidding does not generate high-cost saving estimates for the Medicare program.

Closing the Loophole to Stark In-Office Exemption

Finally, despite lobbying efforts by The College of American Pathologists, our anonymous policy advisor says it's an uphill battle for any legislation that would close the Stark in-office ancillary service exemption that allows urologists, gastroenterologists and dermatologists to operate in-office pathology labs. Any new legislation closing the loophole would need to include a grandfather clause for existing in-office pathology labs, according to our source.

CALIFORNIA MEDI-CAL LAB FEES UNDER PRESSURE

Quest Diagnostics, LabCorp and several independent labs paid the State of California a combined $300 million in 2011 to settle charges that they had violated the state's "lowest comparable charge" rule when billing the state's Medi-Cal for lab tests. As part of the settlement agreement, the accused labs were required to submit their Medi-Cal claims at no more than 85% of the Medi-Cal clinical lab fee schedule from May 1, 2011 through July 31, 2012.

The lawsuit was initiated by Hunter Labs (Campbell, CA) and its owner Chris Riedel, who received approximately $70 million for blowing the whistle (See *LE*, June 2011). There was hope that the lawsuit settlement would compel the national labs to raise their prices charged to private insurers, physician offices and GPOs up to the level of the Medi-Cal lab fee schedule.

But the reverse is happening. Medi-Cal lab test fees are being lowered toward private market rates.

In October 2011, CMS approved the state's plan to reduce Medi-Cal payments by 10% for providers, including clinical labs, retroactive to July 1, 2011. The cut was temporarily blocked when a federal judge in Los Angeles ruled that CMS had approved the rate reduction without adequately evaluating its effect on either providers or patients as required by law. But on December 13, the 9th Circuit Court of Appeals ruled that California can reduce Medi-Cal payments by 10%, overturning the lower court's decision.

In addition, in June 2012, Governor Jerry Brown signed Assembly Bill 1494 into law, which implemented a 10% fee reduction specific to clinical labs. This cut will be retroactive to July 1, 2012, pending approval from CMS.

The Medi-Cal clinical lab fee schedule had been set at approximately 80% of Medicare rates. The two 10% cuts will reduce Medi-Cal lab fees to about 60% of Medicare rates.

"These reductions absorb the 15% penalty to LabCorp and Quest, and leave them at parity with every other lab," notes Lale White, chief executive of the billing management firm Xifin Inc. (San Diego, CA).

It's almost as if the 15% penalty proved to the legislature that if LabCorp and Quest can afford the cut, then all California labs can, says Chris Riedel of Hunter Labs. He says the reductions are a "challenge to everyone except Quest and LabCorp."

When the smaller labs are making an average annual profit between 0% and 3%, they can't afford these cuts, says Riedel. He says the lawsuit settlement has led to "unintended consequences." He adds, "It didn't level the playing field; it just got everyone else's rates reduced."

Furthermore, AB 1494 directs California's Department of Health Care Services (DHCS) to develop a new rate methodology based on the lowest amounts other payers are paying for lab tests, including clinical and anatomic pathology tests (CPT codes 80047-89240). It requires labs to submit data reports specifying the lowest amounts other payers are paying, including other state Medicaid programs and private insurers, minus discounts and rebates, for every test performed by each California lab during 2011.

On July 1, 2013, the new Medi-Cal lab fee schedule will be implemented. "We're in a waiting period until July 1 for the plan that may or may not make complete sense," says Rick Nicholson,

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president of West Pacific Medical Labs (Newport Beach, CA). "Rates can't go much lower," according to Nicholson, who believes Medi-Cal fees are already very competitive. "The fees are so low I don't see how they can go much lower than they already are from a statewide implementation without labs doing some competitive bidding or HMO type arrangement."

Meanwhile, in written comments to the DHCS, the California Society of Pathologists warned, "It is imperative that the program not impose reimbursement levels that exclude providers, resulting in only large/national labs as the only providers in the program. Whatever short-term gains may be realized in lower reimbursements will create substantial risk that costs will rise when no meaningful competition exists."

Quest Diagnostics said that DHCS's proposal seeks a huge amount of data that would impose a crippling burden both on major labs like Quest Diagnostics and on DHCS itself. Quest said the proposal would require Quest to report some twenty data points on the 78 million tests it performed and billed at its California labs during 2011.

And LabCorp asked, "How can the Department justify going on a 'fishing expedition' for data when it has no idea how it might use that data in establishing new payment rates?"

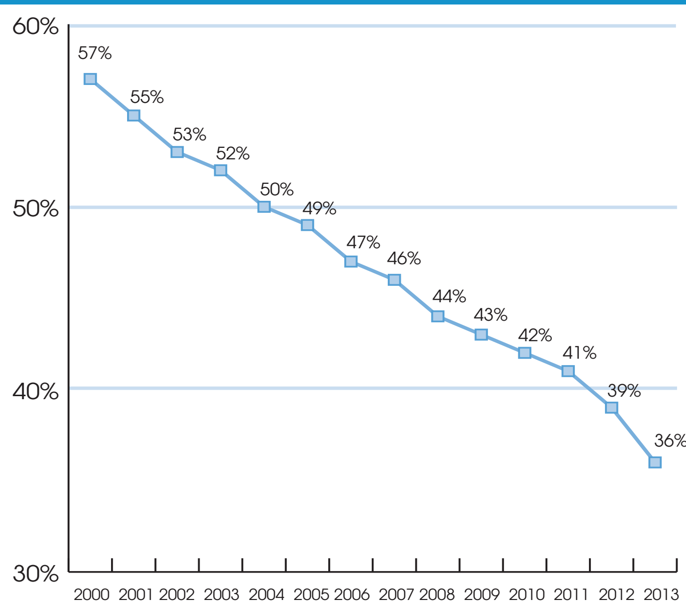
NUMBER OF INDEPENDENT DOCTORS SHRINKING

A report from the consulting firm Accenture finds a significant drop in physicians who practice independently, from 57% in 2000 to 39% in 2012. Furthermore, Accenture projects that only 36% of physicians will hold a practice ownership stake by the end of the 2013.

Accenture analyzed data from the American Medical Association and MGMA-ACMPE to determine trends in physician independence and practice ownership. Physicians were defined as independent if they owned at least part of a practice.

A related survey of 204 physicians found that 87% cited business expenses as a top concern influencing their decisions to seek employment. Sixty-one percent named managed care, and 53% identified requirements for electronic health record systems. In addition, 53% talked about problems managing staff, and 39% cited the number of patients needed to break even.

The shrinking number of independent doctors is limiting the customer market for independent clinical labs. For example, physician practices owned by a health system are often required to send their lab work to a central lab operated by the health system.



Source: "Clinical Transformation: New Business Models for a New Era in Healthcare," Accenture, Oct. 31, 2012

OUTPATIENT RATES FOR 88305-TC RAISED 3.5%

CMS has published its final rule governing payment policies and rates for the Medicare hospital outpatient payment system (OPPS) for 2013. The OPPS fee schedule covers Medicare payment to hospitals for technical services provided to outpatients. The national OPPS rate for the technical component of 88305 is being raised by 3.5% to $38.10 in 2013. OPPS reimbursement for immunohistochemistry (88342) is also being increased by 3.5% to $38.10. Rates for FISH testing for bladder cancer (88120 and 88121) are being raised by 174% to $157.05.

Medicare OPPS Payment Rates for Key Pathology Technical Services*

CPT/ HCPCS	Description	2013 APC	2012 APC	2013 Payment	2012 Payment	% Change
88104	Cytopath, smear	433	433	$23.43	$17.04	37.50%
88108	Cytopath, concentrate tech	433	433	$23.43	$17.04	37.50%
88112	Cytopath cell enhance tech	433	343	$23.43	$36.82	-36.37%
88120	FISH manual for bladder cancer	661	344	$157.05	$57.27	174.23%
88121	FISH computer for bladder cancer	661	344	$157.05	$57.27	174.23%
88172	Cytopath dx eval FNA 1st each site	433	433	$23.43	$17.04	37.50%
88173	Cytopath eval FNA report	343	343	$38.10	$36.82	3.48%
88184	Flowcytometry/tc, 1 marker	433	433	$23.43	$17.04	37.50%
88185	Flowcytometry/tc, add-on	342	433	$12.71	$17.04	-25.41%
88187	Flowcytometry/read, 2-8	433	342	$23.43	$11.21	109.01%
88188	Flowcytometry/read, 9-15	433	343	$23.43	$36.82	-36.37%
88189	Flowcytometry/read, 16 >	433	343	$23.43	$36.82	-36.37%
88300	Level I-surgical pathology	342	342	$12.71	$11.21	13.38%
88302	Level II-surgical pathology	433	433	$23.43	$17.04	37.50%
88304	Level III-surgical pathology	433	343	$23.43	$36.82	-36.37%
88305	Tissue exam by pathologist	343	343	$38.10	$36.82	3.48%
88307	Tissue exam by pathologist	344	344	$60.45	$57.27	5.55%
88309	Tissue exam by pathologist	661	344	$157.05	$57.27	174.23%
88311	Decalcification procedure	342	342	$12.71	$11.21	13.38%
88312	Special stains group 1	433	433	$23.43	$17.04	37.50%
88313	Special stains group 2	433	433	$23.43	$17.04	37.50%
88321	Microslide consultation	342	433	$12.71	$17.04	-25.41%
88331	Path consult during surgery	433	343	$23.43	$36.82	-36.37%
88332	Additional frozen section	342	342	$12.71	$11.21	13.38%
88342	Immunohistochemistry	343	343	$38.10	$36.82	3.48%
88346	Immunofluorescent study	343	343	$38.10	$36.82	3.48%
88360	Tumor immunohistochem/manual	343	343	$38.10	$36.82	3.48%
88361	Tumor immunohistochem/computer	343	344	$38.10	$57.27	-33.47%
88367	FISH-computer assisted	343	343	$38.10	$36.82	3.48%
88368	FISH-manual	344	344	$60.45	$57.27	5.55%

*National rates unadjusted for geographic wage differences
Source: *Laboratory Economics* from CMS

OPPS RATES AVERAGE 59% OF MPFS RATES

Medicare reimbursement rates for technical pathology services paid under the OPPS are an average of only 59% compared with the Medicare Physician Fee Schedule (MPFS), according to an analysis of 2013 rates by *Laboratory Economics*. One exception is CPT 88305-TC, which is now paid at a national OPPS rate of $38.10 versus a national MPFS rate of $33.70.

OPPS vs. MPFS for Key Pathology Technical Services in 2013*

CPT/ HCPCS	Description	OPPS Payment	MPFS Payment**	Variance	OPPS/ MPFS
88104	Cytopath, smear	$23.43	$47.65	($24.22)	49%
88108	Cytopath, concentrate tech	$23.43	$78.97	($55.54)	30%
88112	Cytopath cell enhance tech	$23.43	$51.40	($27.97)	46%
88120	FISH manual for urine sample	$157.05	$565.36	($408.31)	28%
88121	FISH computer for urine sample	$157.05	$510.22	($353.17)	31%
88172	Cytopath dx eval FNA 1st each site	$23.43	$19.40	$4.03	121%
88173	Cytopath eval FNA report	$38.10	$79.99	($41.89)	48%
88184	Flowcytometry/tc, 1 marker	$23.43	$88.84	($65.41)	26%
88185	Flowcytometry/tc, add-on	$12.71	$54.12	($41.41)	23%
88187	Flowcytometry/read, 2-8	$23.43	Prof. Only	NA	NA
88188	Flowcytometry/read, 9-15	$23.43	Prof. Only	NA	NA
88189	Flowcytometry/read, 16 >	$23.43	Prof. Only	NA	NA
88300	Level I-surgical pathology	$12.71	$10.21	$2.50	124%
88302	Level II-surgical pathology	$23.43	$24.17	($0.74)	97%
88304	Level III-surgical pathology	$23.43	$33.36	($9.93)	70%
88305	Tissue exam by pathologist	$38.10	$33.70	$4.40	113%
88307	Tissue exam by pathologist	$60.45	$215.46	($155.01)	28%
88309	Tissue exam by pathologist	$157.05	$304.64	($147.59)	52%
88311	Decalcification procedure	$12.71	$8.17	$4.54	156%
88312	Special stains group 1	$23.43	$71.48	($48.05)	33%
88313	Special stains group 2	$23.43	$55.82	($32.39)	42%
88321	Microslide consultation	$12.71	Prof. Only	NA	NA
88331	Path consult during surgery	$23.43	$38.46	($15.03)	61%
88332	Additional frozen section	$12.71	$13.27	($0.56)	96%
88342	Immunohistochemistry	$38.10	$73.52	($35.42)	52%
88346	Immunofluorescent study	$38.10	$67.39	($29.29)	57%
88360	Tumor immunohistochem/manual	$38.10	$74.88	($36.78)	51%
88361	Tumor immunohistochem/computer	$38.10	$99.39	($61.29)	38%
88367	FISH-computer assisted	$38.10	$198.78	($160.68)	19%
88368	FISH-manual	$60.45	$170.53	($110.08)	35%
AVERAGE					**59%**

*National rates unadjusted for geographic wage differences
**MPFS assumes conversion factor remains at 34.0376
Source: *Laboratory Economics* from CMS

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PAML BUYS STAKE IN CELLNETIX (*cont'd from page 1*)

CellNetix is a pathologist-owned company that includes two business entities:

- **CellNetix Pathology PLLC** is the professional corporation formed by the merger of three pathology groups in Washington—Black Hills Pathology (Olympia), Associated Pathology (Everett) and Washington Pathology Consultants (Seattle)—in October 2005. Last month, a fourth group—Pathology Services PS (Spokane), with four pathologists—merged into CellNetix. Altogther, CellNetix Pathology now includes 50 pathologists that provide professional services to CellNetix Labs as well as 20 hospitals.
- **CellNetix Labs LLC** manages a 49,000-square-foot lab in Seattle that provides technical services to CellNetix Pathology. Owners include pathologists and top executives, and PAML will soon own a minority stake.

CellNetix at a Glance

Chairman and CEO	Don Howard, MD, PhD
# Pathologists	50
Total employees	300
Hospital clients	20
Surgical biopsies	~130,000/year
Pap tests	~120,000/year

Source: CellNetix

PAML, which has more than 1,300 employees, is a full-service reference lab based in Spokane. It operates PacLab Network Laboratories, which provides lab services throughout Seattle and western Washington, and is a partner in hospital-based lab joint ventures in Idaho, Washington, Oregon, Utah, California, Colorado and Kentucky. PAML is owned by Providence Health & Services and Catholic Health Initiatives.

RDX HOLDS OFF ON DEAL-MAKING FOR NOW

Regional Diagnostic Laboratories (Brentwood, TN) has backed away from two deals to buy clinical labs and it may be another 12 to 18 months before it buys its first lab. RDX was formed earlier this year with an equity commitment of up to $250 million from the investment firm Warburg Pincus. RDX had planned to acquire and manage hospital-based outreach labs. Its first acquisition had been expected to close by the end of last August (see *LE*, May 2012), but RDX has chosen to hold off deal-making for now.

"We can deal with a 5% cut to Medicare's clinical lab fee schedule, but there's too much uncertainty in the near term regarding Accountable Care Organizations along with several other dislocating events," says RDX's chief executive Brian Carr.

"If ACO contracts are going to become a material method of healthcare delivery, then it is critical that labs gain some understanding of how they will be paid, both the method and the amount….But we can't find anyone that truly understands how labs will get paid in the ACO model," says Carr.

In addition, Carr says that health systems are aggressively buying physician practices, a trend Carr has lived through before but this time may be different, he says. "In some markets 70% of physician offices can't pick their own labs," he notes. "We are seeing a lot of regional labs lose large, longstanding physician group customers to health system acquisitions."

Carr says RDX walked away from one potential lab outreach deal because its health system owner was not an active buyer of physician group practices, while competing health systems in the market were aggressively acquiring physician practices.

RDX believes the reimbursement uncertainty and spike in market dislocation caused by ACOs should sort itself out by 2014. "The lab business is not going away and Warburg is still committed to the diagnostic space," according to Carr. He says that RDX will be patient but will continue to actively look for quality investment opportunities that may now include anatomic pathology and molecular diagnostic labs.

GAME PLANNING FOR THE NEW REIMBURSEMENT REALITY

As every pathologist should know by now, Medicare Part B reimbursement for the technical component of CPT 88305 is being cut 52% effective January 1, 2013. On November 27, *Laboratory Economics* sponsored a teleconference: Game Planning for the New Reimbursement Reality: Limiting the Damage from Medicare's 88305-TC Cut. The teleconference featured three expert speakers: Mick Raich, president of Vachette Pathology; James Richard, DO, medical director for CAP-Lab; and Donna Beasley, specialty vice president at McKesson. Here are some highlights:

Are the commercial health plans going to follow suit with Medicare?
Mick Raich: Yes. Most labs have contracts built on a percentage of Medicare and they're going to follow suit. So if you have a BlueCross/BlueShield contract, for example, paying at 110% of Medicare, then you'll see a 50% pay cut for technical reimbursement of 88305. There are going to be labs that call us next June and say, "Wow, we took this pay cut. We didn't even know it was coming" or "We didn't think it would actually take place."

Pathology groups should also make sure that commercial payers don't just stick them with an 88305-TC cut, while not increasing rates for other AP codes. The Medicare rate for global 88342 is going up 10% in 2013, 88307 is going up 27% and special stains are going up 3-5%. What we find is that payers can be very "selective" when adjusting their rates.

How should small independent pathology labs approach commercial health plans?
Dr. James Richard: You need to find out who the medical directors are for your commercial plans and develop a dialogue with them. And you need to utilize your state medical society—most of them have an insurance or reimbursement liaison that can help you initiate contact with a commercial plan medical director or their administrative assistant.

This is not an overnight process. I have spent years cultivating certain relationships with individuals in an effort to try to make an impact. With some people you can, while others have a very long drawn-out process. You just have to be on top of it every day.

You need to move payers away from the fee-for-service mindset toward a payment-for-value mindset by establishing quality and performance measures such as double signatures on all malignancies and showing that you've got all your protocols done for a resection that follows CAP ASCO guidelines. Ultimately, you want to get quality and performance measures built into your contracts.

Donna Beasley: If you're using a billing company, then they should have experts that have relationships with payers and can represent your lab on your behalf.

There are some commercial plans that pay independent pathology labs at 60% of Medicare rates or below. If these payers make proportionate cuts in 2013, then they'll be paying only about $17 for each 88305-TC. At what point should a pathology lab walk away from a contract?
Donna Beasley: Knowing your costs is absolutely essential and most labs struggle with this. You need to be sure that you can monitor your true collections by payer and by test and then compare that with your costs to be sure that you're actually profitable. Those payers and tests that are not profitable need to be evaluated. But the key is accurately measuring collected revenue and costs.

What about commercial payer contracts not tied to the Medicare Physician Fee Schedule? How likely is it that those payers will seek to renegotiate their rates for 88305?
Mick Raich: It's very likely. The payers have people that spend their days looking at the rates and what they pay you, and if you're outside the curve, I guarantee you're going to get the phone call. I was talking to one of my clients yesterday, and they have a very nice contract, and they said the payer called

and wants to renegotiate the contract. It's not something we want to do, but it's something the payer wants because they think they're paying above the market.

What cost-cutting steps are available to help offset the reimbursement reduction?
Dr. James Richard: As far as non-physician cost cutting, you need to look at your team and ask "Who is essential and who is not?" And just as importantly, "What level of productivity are you getting out of your staff?" In terms of productivity for histotechnologists, an experienced histotech ought to be able to handle 80 blocks per day. If you look for 80 blocks per tech and you've got three techs, then your lab ought to be able to process 240 blocks a day, including all related special stains and immunoperoxidase. You should be using that kind of a metric to determine if you are right-sized with regard to your workload.

How will the large national pathology labs respond to the rate cut?
Mick Raich: This is going to affect their revenue streams going forward. Their business models will have to change. If you're given a 33% cut to the majority of your business, then you're going to have to cut costs by 33% or you're going to have to cut your margin. It wouldn't surprise me if in the next two to five years the national labs say, "You know what, we just don't make as much money on this as we used to, so we're going to roll this off and we're going to focus on the clinical lab side."

What is the outlook for independent pathology labs?
Donna Beasley: I think many of the smaller independent pathology labs won't survive these payment cuts. The number of new pathology labs being opened, which grew rapidly over the last several years, will slow down. Hospital histology labs may be the ones that end up capturing some of these additional volumes from these sources that end up closing. The large commercial labs might also pick up some volume.

How will in-office pathology labs at urology, gastroenterology and derm respond to the cut to 88305-TC?
Dr. James Richard: Make no mistake, these arrangements are strictly economically driven and will continue as long as the urologist, GI, or derm is making money that they don't have to work for. I mean, if someone walked up to you and said you don't have to do anything and I'll only pay you $10,000 a year. Are you going to walk away from that? Probably not.

But eventually this sort of situation is probably going to get squeezed out by regulation because of all the reports on self-referral over utilization. So in-office labs may have a limited shelf life.

But these doctors don't care about what might happen three to five years from now. They only care about the next six months.

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AURORA DX RECORDS $115 MILLION WRITE-OFF

Aurora Diagnostics (Palm Beach Gardens, FL) has reported a net loss of $111.4 million for the three months ended September 30, 2012, according to the company's third-quarter financial report filed with the Securities & Exchange Commission on November 13. Aurora's third-quarter results included a $114.6 million non-cash charge related to goodwill and intangible asset write-downs for eight acquired pathology practices.

The write-downs were made primarily because of the loss of hospital contracts or customer relationships. Aurora is also recognizing lower revenue due to changes to client bill arrangements or the switch

from global billing to either technical component (TC) or professional component (PC) only services. These factors, combined with higher operating costs, including higher pathologist compensation, have resulted in slower projected revenue and profit growth at eight pathology practices owned by Aurora.

Furthermore, Aurora says that it may need to record more charges in the fourth quarter due to Medicare's recently announced 52% rate cut to the technical component of CPT 88305. Aurora estimates that changes to the 2013 Medicare Physician Fee Schedule, assuming no change in the conversion factor, will reduce its Medicare revenue by $21 million per year.

Aurora's average collected revenue per patient accession was $127 in the third quarter. The company expects its average revenue per accession to decline to approximately $117 in 2013.

To help offset reduced Medicare revenue, Aurora recently implemented staff reductions and is taking other cost-cutting actions in the areas of compensation, benefits and vendor supplies. The company has also sold a clinical lab that served Florida nursing homes. The clinical lab had been operating at a loss of about $400,000 per month.

Aurora Diagnostics

Financials ($ 000)	***3Q12***	***3Q11***	***% Chg***
Revenue	$69,384	$70,717	-1.9%
EBITDA*	-97,675	-16,461	NA
Net income	-111,362	-28,996	NA
Total debt (LT debt+contingent notes)	356,477	369,926	-3.6
Long-term debt	319,817	323,206	-1.0
Contingent note liability	36,660	46,720	-21.5
Cash & securities	5,721	5,445	5.1
Shareholders' equity	64,727	181,744	-64.4
Accessions	543,400	534,300	1.7
Revenue per accession	$127	$133	-4.5

*EBITDA=earnings before interest taxes depreciation and amortization
Source: Aurora Diagnostics 10Q Report

Aurora owns 21 pathology practices and employs more than 100 pathologists. Its largest practices include Greensboro Pathology Associates (Greensboro, NC), Cunningham Pathology (Birmingham, AL) and LMC Pathology Services (Las Vegas, NV). Aurora is owned by the private equity firms Summit Partners and KRG Capital Partners.

PEE DEE PATHOLOGY AND LABCORP (*cont'd from page 1*)

Under the deal, which closed on December 17, PDPA has sold its Pap testing and associated infectious disease testing business to LabCorp for an undisclosed purchase price. PDPA processes about 35,000 Pap tests per year, which will now be sent to LabCorp's cytopathology lab in Burlington, NC. LabCorp will perform and bill for all Pap test screening and DNA-based HPV testing on these specimens as well as STD testing for GC/chlamydia, herpes, etc. Atypical test results requiring pathologist review will be handled by PDPA's pathologists.

LabCorp has also made a minority investment in PDPA's anatomic pathology business. And PDPA is now LabCorp's exclusive anatomic pathology technical lab and professional component provider in northeastern South Carolina.

Kenneth Ries, MD, pathologist partner at PDPA, says the partnership with LabCorp should help PDPA grow its anatomic pathology lab volumes. "Increasing market share and economies of scale is the best strategy for dealing with reimbursement pressure," says Ries.

LabCorp has a stated goal of increasing its women's health testing business and is expected to seek similar arrangements with independent pathology labs throughout the country, notes *Laboratory Economics*.

LAB STOCKS UP 29% YEAR TO DATE

Ten lab stocks have risen by an unweighted average of 29% so far this year. The combined market capitalization for the group is unchanged at $22 billion. In comparison, the S&P 500 Index is up 15% year to date through December 17. Shares of NeoGenomics have performed best (up 106%). In terms of valuation, Quest Diagnostics is currently trading at 1.2x its annual revenue with a price-to-earnings ratio of 12.8x. LabCorp trades at 1.5x its annual revenue and 13.9x trailing earnings.

Company (ticker)	Stock Price 11/7/12	Stock Price 12/30/11	2012 Price Change	Market Capitalization ($ millions)	P/E Ratio	Price/ Sales
Bio-Reference (BRLI)	$29.47	$16.27	81%	$816	19.6	1.2
CombiMatrix (CBMX)*	6.28	20.00	-69%	7	NA	1.3
Enzo Biochem (ENZ)	2.64	2.24	18%	104	NA	1.0
Genomic Health (GHDX)	27.71	25.39	9%	852	102.6	3.7
LabCorp (LH)	87.17	85.97	1%	8,246	13.9	1.5
Medtox Scientific (MTOX)**	27.00	14.05	92%	242	16.6	2.1
Myriad Genetics (MYGN)	27.11	20.94	29%	2,207	19.8	4.4
NeoGenomics (NEO)	2.88	1.40	106%	130	NA	2.2
Psychemedics (PMD)	11.00	9.10	21%	58	18.3	2.3
Quest Diagnostics (DGX)	59.46	58.06	2%	9,452	12.8	1.2
Unweighted Averages			29%	$22,114	29.1	2.1

*Medtox was acquired by LabCorp on July 31 for $27 per share
Source: Bloomberg

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