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LABORATORY ECONOMICS

Competitive Market Analysis For Laboratory Management Decision Makers

LABS STRUGGLING TO MAKE EMR CONNECTIONS

More and more physician offices want to receive test results into their electronic medical records (EMRs)—and they expect labs to pick up the tab for these difficult and costly connections. Twenty-eight percent of independent labs and hospital outreach programs with Web-connectivity systems say they have established "many" EMR interfaces—up from 17% two year ago, according to *LE's* latest *Web-Connectivity and EMR Survey* completed by 210 labs in early January.

Physician adoption of EMRs is accelerating because of new federal incentives that kick in this year. Lab-to-EMR connections for test ordering and results reporting should ultimately cut costs and increase quality of care. However, the transition period over the next five years will place an enormous financial and IT staffing strain on all labs competing for physician-office clients. For a complete summary of survey results, *see pages 5-7*.

Are You Interfacing Your Web System Into Physician Client EMRs?

	Jan. 2011	*Dec. 2008*	*Dec. 2007*
Yes, many EMR interfaces established	28%	17%	10%
A handful of EMR interfaces established	42%	41%	36%
No, but we plan to start soon	21%	22%	35%
No immediate plans	9%	20%	19%

Source: *LE's Web-Connectivity & EMR Survey*, January 2011; n=210

PHYSICIAN SIGNATURE RULE WILL BE BURDENSOME

The Centers for Medicare and Medicaid Services (CMS) has delayed by three months its new rule requiring the signature of the ordering physician on all paper requisitions for Part B lab tests. Nonetheless, more than 60% of labs say the rule will be "very burdensome," according to *LE's* latest *Web-Connectivity and EMR Survey*. Another 24% said the rule will be "somewhat burdensome" and only 14% expect "little or no impact." *Continued on page 12.*

How burdensome will Medicare's new physician signature requirement for paper requisitions be?

Very burdensome	62%
Somewhat burdensome	24%
Little or no impact	14%

Source: *LE's Web-Connectivity & EMR Survey*, January 2011; n=210

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REVISED CONVERSION FACTOR LOWERS PATHOLOGY RATE GAINS

The Centers for Medicare and Medicaid Services (CMS) has released a revised conversion factor to be used to translate the relative value units (RVUs) of the Part B Physician Fee Schedule into reimbursement rates.

CMS announced on December 29, 2010, that the conversion factor for 2011 is $33.9764 versus $36.8729 in 2010. The change means that pathologists will still see increased Medicare reimbursement rates for most pathology codes, but the increase will not be as high as Laboratory Economics first calculated in November (see *LE*, November 2010, page 4).

"While the physician fee schedule update will be zero percent, other changes to the RVUs (e.g., misvalued code initiative and rescaling of the RVUs to match the revised Medicare Economic Index weights) are budget-neutral. To make them so, CMS must adjust the conversion factor," according to the agency's confusing December 29 announcement.

The bottom line for pathologists is an average 4.3% increase in Medicare reimbursement for the most common pathology procedures (see table below).

Global reimbursement for CPT 88305 (tissue exam by pathologist)—the most frequently billed anatomic pathology procedure—has been raised by 2.6% to a global rate of $106.35 for 2011. The technical component was increased by 5.5% to $70; the professional component was decreased by 2.4% to $36.35.

Global Medicare Reimbursement* for Key Pathology Codes, 2011 vs. 2010

CPT Code (Description)	2011	2010	% Chg
88108 (cytopath, concentrate tech)	$75.43	$72.27	4.4%
88112 (cytopath, cell enhance tech)	103.29	101.77	1.5%
88173 (cytopath eval FNA)	138.28	133.48	3.6%
88184 (flow cytometry, 1 marker)	84.26	78.91	6.8%
88185 (flow cytometry, add-on)	50.62	47.20	7.3%
88189 (flow cytometry)	103.29	106.19	-2.7%
88300 (surgical pathology)	26.84	23.97	12.0%
88302 (tissue exam by pathologist)	53.68	49.04	9.5%
88304 (tissue exam by pathologist)	62.86	61.95	1.5%
88305 (tissue exam by pathologist)	106.35	103.61	2.6%
88307 (tissue exam by pathologist)	226.96	212.76	6.7%
88309 (tissue exam by pathologist)	344.18	323.01	6.6%
88312 (special stains)	107.03	99.93	7.1%
88313 (special stains)	78.15	73.01	7.0%
88321 (microslide consultation)	90.72	90.71	0.0%
88323 (microslide consultation)	143.04	142.70	0.2%
88331 (pathology consult during surgery)	91.74	89.60	2.4%
88342 (immunochemistry)	104.31	100.29	4.0%
88346 (immunofluorescent study)	102.27	99.56	2.7%
88361 (digital pathology)	152.21	147.12	3.5%
Overall Unweighted Average			4.3%

*Unadjusted for geographic practice cost differences
Source: *Laboratory Economics* from CMS Physician Fee Schedule

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Separately, *LE* notes that Medicare reimbursement for UroVysion bladder cancer testing is still being cut by roughly 50% in 2011 through the introduction of two new codes: CPT 88121 and 88120 (see *LE*, December 2010, pages 1, 4).

QUEST DIAGNOSTICS SUSPENDS BILLING MEDI-CAL

Following a recent audit of Quest Diagnostics' billing to Medi-Cal, the California Department of Health Care Services (DHCS) is contending that Quest's billing practices are not consistent with California regulations (Title 22, section 51501) stating that "no provider shall charge for any service or any article more than would have been charged for the same service or article to other purchasers of comparable services or articles…"

In its third-quarter 10Q financial report, Quest said that while it believes it is in compliance in all material respects with California's lab test billing requirements, the company has entered into an interim agreement under which it has agreed to temporarily suspend billing Medi-Cal for a period of up to six months, during which it continues to provide services, pending resolution of the California Attorney General's Medi-Cal Fraud Lawsuit.

Quest says that an unfavorable outcome of the California Lawsuit could result in reduced reimbursement from the Medi-Cal program. Quest's annual revenue from the Medi-Cal program in 2009 was approximately $66 million.

The California Lawsuit—California ex rel. Hunter Laboratories, LLC vs. Quest Diagnostics, et al.—was prompted by a whistleblower claim made by Chris Riedel, chief executive of Hunter Labs (Campbell, CA). Riedel filed a private false-claims action under seal in November 2005. The California Attorney General's office then began its investigation and joined the case in November 2008; the lawsuit became public on March 20 (see *LE*, April 2009, pp. 1, 5-7). The lawsuit claims that seven labs, including Quest Diagnostics and LabCorp, overcharged Medi-Cal for lab tests and violated the California False Claims Act.

This lawsuit has been in the discovery phase for more than one year. A trial date has been set for Quest at Sacramento Superior Court this spring and for LabCorp in the fall. Quest says that it is in discussions with the plaintiffs which could lead to an agreement to resolve some or all of the matters. However, Quest says that if it cannot resolve the lawsuit through these discussions, it will continue to vigorously defend itself.

Laboratory Economics notes that an enormous amount is at stake. The California AG contends that the Medi-Cal program has been overcharged by about half a billion dollars over the past 15 years.

In a January 7 research note, Bill Bonello, stock analyst at RBC Capital Markets, said that Quest could be poised to pay a significant sum ($100 million plus) settlement to the State of California. Bonello noted that such a settlement could be a precedent for similar settlements with other states.

Separately, in its third-quarter 10Q financial statement, LabCorp reported that after an audit, the DHCS is contending that it too overcharged the Medi-Cal program. DHCS proposed an agreement related to LabCorp's billing to the Medi-Cal program, including a requirement that the company charge Medi-Cal the "lowest price" it charges others for lab tests. LabCorp says it disagrees with DHCS' interpretation of its regulations and believes that it has properly charged Medi-Cal. LabCorp says that it continues to cooperate with DHCS with respect to the audit.

In addition, LabCorp reported that it has received three other subpoenas related to its Medicaid billing, including a subpoena from Florida in June 2010, Michigan in October 2009 and Virginia in February 2009.

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SONIC BUYS PHYSICIANS AUTOMATED LAB IN CALIFORNIA

Sonic Healthcare USA (Austin, TX) acquired Physicians Automated Laboratory (PAL-Bakersfield, CA) on December 31, 2010. Terms of the deal were not disclosed.

PAL is a full-service clinical and anatomic pathology lab covering central California. The company has 210 employees and processes about 2,000 patient specimens per day. Annual revenue is approximately $20 million.

Sonic Healthcare USA president David Schultz plans to leave PAL intact. No layoffs or other significant changes to PAL are planned.

PAL's primary owners, chief executive Bruce Smith, 65, and laboratory director William Schmalhorst, MD, 80, will stay with the company.

Sonic's Australian parent company now generates roughly 25% of its overall revenue from the U.S. lab market. After adjustments for acquisitions and exchange rates, Sonic reports that its revenue in the United States grew by 6.3% to AUS$778 million (~US$750 million) in the fiscal year ended June 30, 2010.

Over the past five years, Sonic has acquired 15 labs in the United States for an estimated US$1+ billion. Schultz says Sonic plans to pursue additional acquisitions in California as well as other regions in the United States.

U.S. Lab Acquisition Summary for Sonic ($ millions)

Date	Laboratory (location)	Purchase Price	Acquired Revenue	Price/ Revenue
Dec-10	Physicians Automated Lab (California)	NA	$20	NA
Nov-09	East Side Clinical Lab (Rhode Island)	NA	30	NA
Aug-09	Piedmont Medical Labs (Virginia)	NA	11	NA
Jun-09	Axiom Labs (Florida)	NA	5	NA
Sep-08	Clinical Labs of Hawaii (Hawaii)	121	110	1.1
Jan-08	American Clinical Services (New Jersey)	NA	13	NA
Nov-07	Consolidated Lab Services (Nevada)	NA	2.5	NA
Oct-07	Woodbury Clinical Lab (Tennessee)	NA	4	NA
Jul-07	Sunrise Medical Labs (New York)	168	75	2.2
Apr-07	Mullins Laboratory (Georgia)	NA	15	NA
Jan-07	American Esoteric Labs (Tennessee)	180	100	1.8
Dec-06	Lookadoo Skyline Labs (Florida)	NA	NA	NA
Sep-06	Cognoscenti Health Institute (Florida)	NA	7	NA
Mar-06	Muskogee Clinical Lab (Oklahoma)	NA	NA	NA
Oct-05	Clinical Pathology Labs (Texas)	$380	190	2.0
Totals		$1+ billion	$600	~1.5-2.0

Source: Sonic Healthcare

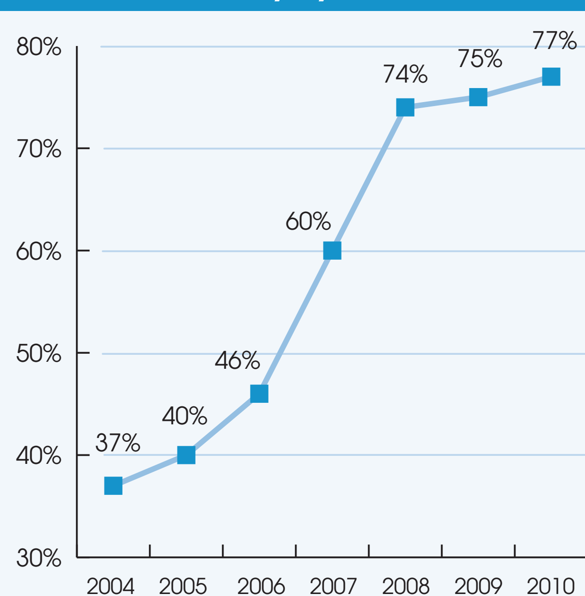
WEB-CONNECTIVITY & EMR SURVEY RESULTS

Over the past seven years, most labs have put a Web-connectivity system in place to send test results to their physician clients. Seventy-seven percent of labs now have a Web-connectivity system versus 37% in 2004, according to *LE's* latest Web-Connectivity and EMR Survey.

Among those labs that have established a Web-based connection with their physician clients, 15% say they are using Atlas LabWorks. Nine percent of surveyed labs use Cerner, while 7% each use LifePoint/LabTest and Meditech. Another 7% reported using an internally-developed system.

Only 8% of surveyed labs said they had established direct LIS-to-EMR connections to their physician clients (without the use of a Web system vendor). This percentage is up slightly from 5% in our similar survey two years ago.

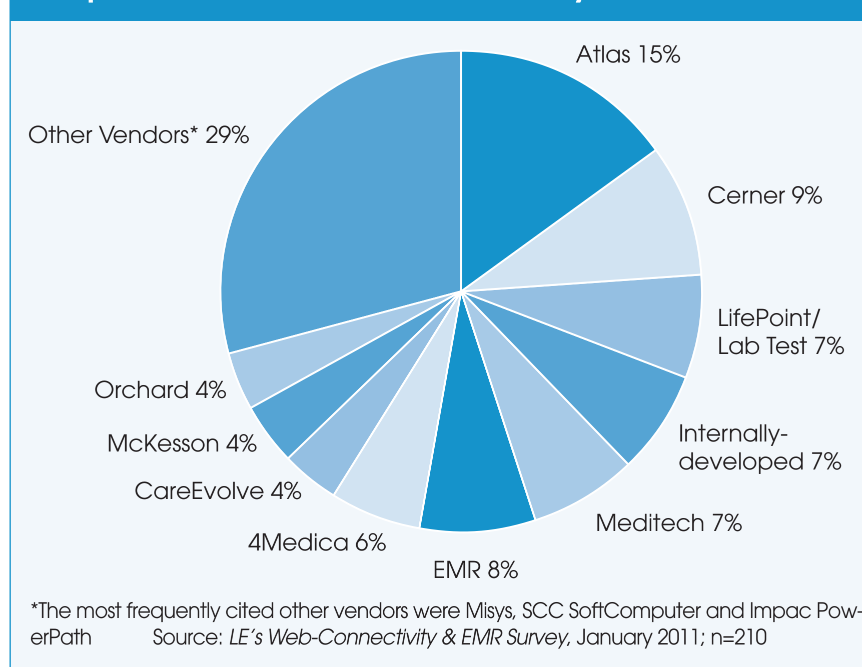
Percent of Labs with a Web-Connectivity System*



*Includes labs with results reporting and/or order entry systems
Source: *LE's Web-Connectivity & EMR Survey*, January 2011; n=210

Instead, it looks like most labs are using Web vendors as a gateway between the EMR and LIS, so that orders can be cleaned up and checked for proper ICD-9 codes before being transmitted to the lab. Web vendors are also providing expert IT support staff to help labs establish interfaces with EMRs.

Market Share among Survey Respondents with Web-Connectivity



*The most frequently cited other vendors were Misys, SCC SoftComputer and Impac PowerPath Source: *LE's Web-Connectivity & EMR Survey*, January 2011; n=210

SURVEY DEMOGRAPHICS: *LE's Web-Connectivity & EMR Survey* was e-mailed to approximately 5,000 lab directors and managers across the country in early January 2011. A total of 210 surveys were judged usable, yielding a response rate of 4%. Among the 210 respondents, 93 were from hospital/health system labs, 72 from independent labs, 17 from pathology groups, 11 from physician office labs, 10 from academic medical centers, and 7 from other labs (e.g., lab networks, clinics, HMO labs, etc.).

The most frequently cited benefit surveyed labs said they received from Web connectivity was "Cleaner lab test orders" at 56%. Next was "Better client retention/need it to compete with Quest and LabCorp" (51%). Fifty-percent cited "Fewer phone calls from physician offices seeking test results," followed by 37% for "Better tracking of specimens." Thirty-six percent said it "Will help comply with Medicare's new physician signature rule."

Benefits from Web Connectivity?

	Jan. 2011	*2008*	*2007*	*2006*
Cleaner lab test orders	56%	62%	53%	42%
Better client retention/need it to compete with Quest and LabCorp	51%	46%	44%	37%
Fewer phone calls from physician offices seeking test results	50%	58%	46%	50%
Better tracking of specimens	37%	28%	22%	28%
Will help comply with Medicare's new physician signature rule	36%	NA	NA	NA
Other	8%	6%	10%	7%

Note: Survey respondents were allowed to pick more than one answer
Source: *LE's Web-Connectivity & EMR Survey*, January 2011; n=210

It's no surprise that surveyed labs cited "Cleaner lab test orders" as the biggest benefit they have received from Web connectivity. Test order entry through Web systems eliminates legibility problems associated with hand-written orders and helps reduce the number of orders that labs receive with missing information necessary for billing. But getting physician offices to switch from paper-based methods of ordering lab tests has always been difficult. Of all the labs surveyed that have a Web-based order entry system in place, only 30% said "Nearly all physician offices we hook up use it regularly."

How have physician clients responded to order entry on your Web-connectivity system?

	Jan. 2011	*2008*	*2007*	*2006*
Nearly all physician offices use it regularly	30%	38%	37%	31%
Some physician offices use it and some don't	54%	53%	52%	54%
Physician offices have been reluctant to input their own lab test orders	16%	9%	11%	15%

Source: *LE's Web-Connectivity & EMR Survey*, January 2011; n=210

An exception under the Stark self-referral law allows labs to subsidize 85% of the cost of EMRs to physicians. The recipient is required to pay its 15% share prior to receiving the EMR. In donating EMR technology, the lab cannot take into account the volume or value of referrals from the physician-office recipient. Big deep-pocket labs are taking full advantage of this controversial Stark-rule exception. But our survey shows that most labs don't have the means to "donate" EMRs to their physician-office clients. Seventy-eight percent of surveyed labs said they do not give EMR systems to their clients.

Does your lab "donate" EMR systems to physician-office clients?

Yes, to most clients 9%
Yes, but only to biggest clients 13%
No, we do not 78%

Source: *LE's Web-Connectivity & EMR Survey*, January 2011; n=210

SURVEY PARTICIPANT COMMENTS

Surveyed pathologists and lab executives were asked to comment on Web-connectivity and EMRs. Although this technology has been around for more than 10 years, its biggest impact on labs will occur during the next five years. The consensus: Establishing lab-to-EMR interfaces is expensive, but it's a mandatory cost of doing business.

The Downside

"Practically all of our clients want Web results and ability to pull our results into their EMR. But for order entry, they still prefer to use paper reqs at this time."

—pathologist from Florida

"I have concerns that the dwell-time for physician offices to realize the benefits of an EMR will be counter-productive to hospital labs being able to sustain access to deep pockets necessary to fund the interfaces and IT support."

—hospital lab manager from Tennessee

"So far we have experienced a lot of problems with orders coming to the lab properly and completely. It is a work in progress. It actually slows us down when processing orders and incoming specimens."

—hospital lab manager from Michigan

"Different OPM systems/EMRs require unique solutions making it very expensive to connect with a wide variety of clients in an efficient manner. Generally, only early-adopter physicians have embraced the technology and incorporated it into their office protocols. The vast majority remain on the sidelines."

—lab consultant from Texas

"A bit early for EMR connectivity in our market since many offices don't have EMRs. However, many offices anticipate installing within the next 18-24 months."

—lab executive from Indiana

The Upside

"Best thing since sliced bread. If a lab is not doing this, they are way behind the curve. We have had this system for three years. Cuts down on order discrepancies, saves lab time in clarification of orders, almost eliminates paper, cuts down on phone calls and allows supply orders to come in a timely manner."

—pathologist from Georgia

"Labs cannot plan a future without it. More and more clients are demanding it. It comes with expense, but convenience is the driving factor."

—lab director from Pennsylvania

"Electronic or Web-based orders are the only solution I see for compliance with the CMS signature requirement ruling. Labs will be forced to reject paper orders without signatures or take them knowing they won't get paid."

—hospital lab manager from Texas

"It's essential to improve our healthcare system and to compete with the large labs. Most importantly, it improves safety and patient care."

—pathologist from Delaware

"EMR donation is a competitive advantage for those labs that can afford it."

—lab executive from Tennessee

"Web-based connectivity and EMR systems will be the future, but it will require several years before the 'tipping point' is reached."

—lab executive from Indiana

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ELECTRONIC MEDICAL RECORD Q&A WITH PAT WOLFRAM

For further insight into lab-to-EMR integration, *Laboratory Economics* spoke with expert Pat Wolfram, vice president of marketing and customer services for Ignis Systems Corp. (Portland, OR), a company that provides EMR integration services. Here's a summary of our Q&A:

An estimated 10% of office-based physicians currently use a fully functional EMR, according to the CDC's latest National Ambulatory Care Survey (see graph on next page). Why don't more physicians fully utilize EMRs?

Two reasons:

1) It's a workflow challenge. Most practices have optimized their paper chart workflows. The transition to an EMR based workflow is very disruptive to a physician office during the initial year of implementation. The real efficiencies come in the second and third years after implementation, where workflows are tuned and patient charts contain more clinical data.

2) The out-of-pocket costs are not insignificant. EMR vendors using the subscription model typically charge between $500 and $800 per month per doctor. Plus there are start-up costs of $4,000 to $5,000 per doctor.

Under the license model used by other EMR vendors, the start-up costs average roughly $20,000 per doctor. In addition, there are annual fees that average between $2,000 and $4,000 per doctor per year.

What are the federal incentives to physicians that adopt EMRs?

Physicians that install an EMR and meet the "meaningful use" criteria are eligible to receive an $18,000 Medicare incentive per doctor in 2011. Each doctor can receive a total of $44,000 between 2011 and 2015. If a physician waits until 2013 to get started with an EMR, the four-year incentive drops to $39,000. It drops to $24,000 if they wait until 2014.

What are the meaningful use criteria for 2011?

To qualify for incentive payments in 2011, physicians must prove they've used an EMR in a meaningful manner during a 90-day consecutive period. There are 15 "core" meaningful use measures (MUMs), and 10 additional "menu" MUMs from which they must use five. Core MUMs include the entry of basic data: patients' vital signs and demographics, active medications and allergies, and smoking status. Other core MUMs include the ability to electronically prescribe drugs. The initial meaningful use requirements also include providing patients with electronic versions of their health information. Among the 10 menu MUMs is the ability to incorporate structured lab test results into the EMR.

What are you seeing in the physician-office market today?

The number of physician offices requesting lab-to-EMR interfaces has more than doubled compared with a year ago. And the number of new EMR systems entering the market is higher than ever before. The challenge for labs is that each EMR has its own quirks when it comes to interfacing with lab systems.

What's your advice to labs?

I'd suggest several things:

First, look internally at your LIS, your interface team, and/or your middle-ware vendor to

determine if you're geared up to handle twice the volume of EMR interfaces with dozens of new EMRs. Are you ready to send lab results to those new EMRs in their HL7 dialect, with their required content, and with the right result codes (LOINC or otherwise)? Are you ready to receive electronic orders from them?

Second, get involved with the EMR selection process for the practices in your region. Help them understand how to insist upon specific lab interface criteria, not just a check-in-the box requirement. Host a town-hall and inform local practices of the importance of lab interfaces in their EMR selection criteria and that you're available to help with that selection.

Lastly, reach out to your state agencies that manage the federally funded Regional Extension Centers (RECs) and Health Information Exchange (HIE) initiatives. Although these programs vary by state, they both have goals to assist with EMR-to-lab connectivity.

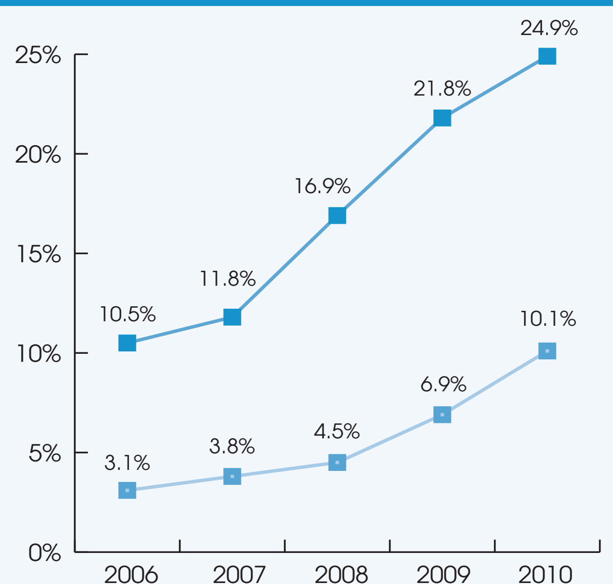
CDC SURVEY SHOWS RISING EMR ADOPTION

While overall use of EMRs has increased, office-based physicians are using them in limited ways, according to preliminary results from the Centers for Disease Control and Prevention's National Ambulatory Care Survey.

The CDC survey, which surveyed more than 10,000 physicians between April and July 2010, showed that nearly 25% of physicians used EMRs that met criteria for a "basic" system, up from 21.8% in 2009. However, only 10.1% said their systems met the criteria of a "fully functional" system, compared with 6.9% in 2009.

A basic EMR system was defined as having the ability to view patient demographic information, patient problem lists, clinical notes, and lab test and imaging results.

Systems defined as fully-functional include all functionalities of basic systems plus the following: the ability to store and track patient's medical history, make electronic orders for prescriptions, lab and radiology tests, and provide warnings of drug interactions or contradictions.



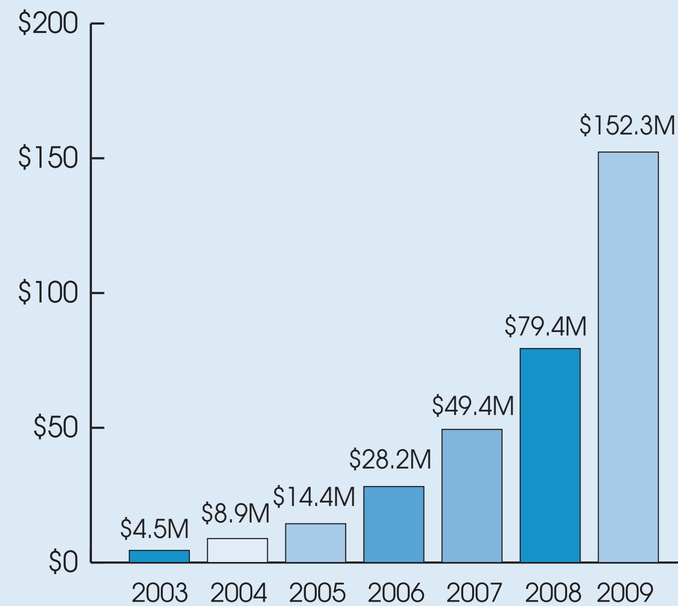
AMERICAN PATHOLOGY PARTNERS BUYS FLORIDA PATH LAB

American Pathology Partners (Brentwood, TN) has acquired the technical lab operations of Palm Beach Pathology (West Palm Beach, FL). Palm Beach Pathology, which has 13 pathologists, will remain an independent pathology group with a long-term contract to provide professional services to APP. This is APP's third acquisition of a pathology group's technical operations. APP bought Unipath (Denver, CO) in December 2008 and Eastern Carolina Pathology (Wilson, NC) in March 2009.

AMERITOX TO PAY $16 MILLION TO RESOLVE KICKBACK CLAIMS

Ameritox Ltd. (Baltimore, MD) has agreed to pay $16.3 million to settle allegations that it paid kickbacks to physicians in order to induce them to refer Medicare business, according to the U.S. Attorney's Office in Tampa, Florida. Ameritox operates a laboratory in Midland, Texas, that specializes in drug-of-abuse testing, including pain management testing for prescription drug users.

The settlement resolves allegations that Ameritox made cash payments to its physician clients from January 2003 through December 2006 to induce the referral of drug testing services. It also resolves claims arising from the offer by Ameritox of free collector personnel to its physician clients from January 2003 through June 2010, in order to induce the referral of Medicare business.



Of the total settlement, the federal government will receive $15.5 million with the balance of $814,000 to be split among various states.

The case was originally brought to light by a lawsuit filed in 2007 by Debra Maul, a former senior sales rep at Ameritox. Maul tried to address the improper billing practices with Ameritox's management, according to the lawsuit, case no. 8:07-cv-953-T-26EAJ (Middle District of Florida). But she was "constructively terminated" (i.e., forced to quit) in May 2006.

Maul, who filed the suit under the "whistleblower" provisions of the False Claims Act, will receive $3.4 million out of the federal share of the settlement.

Drugs-of-Abuse Testing Continues to Boom

As *Laboratory Economics* noted in our September 2010 issue, urine screens for drugs of abuse have been a booming business for the past several years. Medicare Part B spending on CPT 80101 (drug screen) nearly doubled to $152.3 million in 2009, according to figures supplied by the lab reimbursement consulting firm CodeMap LLC (Barrington, IL). Between 2003 and 2009, Medicare Part B payments for CPT 80101 grew at an annual rate of 80%. The big driver has been increased pain medication testing to monitor appropriate patient use of chronic pain drugs (e.g., codeine, hydrocodone, methadone, oxycodone, oxymorphone, et al.).

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CLARIENT AT TOP FOR STOCK RETURN IN 2010

Shares of Clarient Inc. jumped 89% to $5 per share in 2010, leading all publicly-traded lab stocks. Clarient's stock gain was fueled by GE Healthcare's acquisition of Clarient for $585 million, which was completed in December 2010.

Medtox Scientific had the second-highest stock price gain last year, up 69% to $13.10 per share. A small rebound in the economy helped Medtox's drugs-of-abuse testing business, and rapid growth in the company's new clinical lab testing business helped push its stock price higher.

Looking at the two largest publicly-traded lab companies:

Shares of LabCorp increased by 17% to $87.92 per share.

Quest Diagnostics had a total return of -10% (after adjusting for the company's quarterly dividend of 10 cents per share).

The S&P 500 Index had a total return of 15% (including dividends) in 2010.

5-Year Annual Returns
NeoGenomics has the highest 5-year annual return. Its shares increased by an average 47% per year between 2005 and 2010.

10-Year Annual Returns
Bio-Reference Labs has the highest 10-year annual return. Between 2000 and 2010, shares of Bio-Reference have increased by an average of 37% per year.

Over the past 10 years, LabCorp has risen by an average of 7% per year.

Quest's 10-year total return shows an average rise of 5% per year.

Lab Company Stock Performance

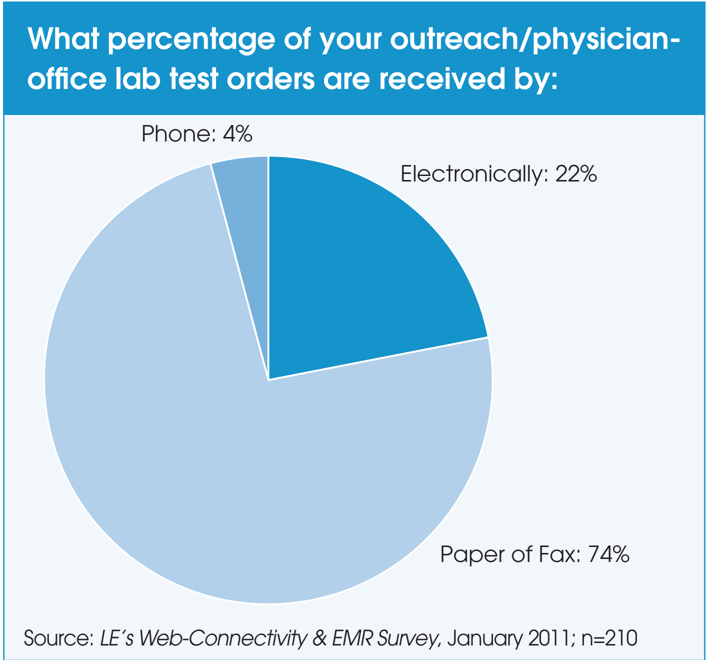
Company (ticker)	Stock Price 12/29/00	Stock Price 12/30/05	Stock Price 12/31/09	Stock Price 12/31/10	2010 Price Gain	5-Year Annual Return	10-Year Annual Return
Bio-Reference (BRLI)	$0.94	$9.40	$19.56	$22.18	13%	19%	37%
Celera (CRA)	36.13	10.96	6.90	6.30	-9%	-10%	-16%
Clarient (CLRT)	NA	1.30	2.65	5.00	89%	31%	NA
Enzo Biochem (ENZ)	21.49	12.42	5.38	5.28	-2%	-16%	-13%
Genomic Health (GHDX)	NA	9.11	19.56	21.39	9%	19%	NA
Genoptix (GXDX)	NA	NA	35.53	19.02	-46%	NA	NA
LabCorp (LH)	44.00	53.85	74.84	87.92	17%	10%	7%
Medtox Scientific (MTOX)	3.48	7.58	7.75	13.10	69%	12%	14%
Myriad Genetics (MYGN)	37.52	9.43	26.09	22.84	-12%	19%	-5%
NeoGenomics (NGNM)	NA	0.19	1.50	1.30	-13%	47%	NA
Psychemedics (PMD)	12.60	9.62	7.35	8.20	18%	-3%	-4%
Quest Diagnostics (DGX)	33.64	49.47	60.38	53.97	-10%	2%	5%
S&P 500 Index	1,320.28	1,248.29	1,115.10	1,257.64	15%	2%	2%

Note: All annual total returns include adjustments for stock splits and dividends
Source: Laboratory Economics from Morningstar Inc.

PHYSICIAN SIGNATURE RULE WILL BE BURDENSOME *(cont'd from page 1)*

CMS argues that the new requirement, now effective April 1, will eliminate uncertainty about whether documentation was required and will not increase the burden on physicians because "it is our understanding that physicians are already annotating the medical record or signing the paperwork provided to the laboratory."

The burden will be placed on labs. Most paper requisitions are filled out by a nurse or office staff and never signed. Now once the requisition has been completed the office staff will have to return it to the physician to sign. Labs have no way of enforcing the requirement and are the only provider at financial risk if the requisitions are not signed. Labs will be required to obtain missing signatures before filing claims for paper orders.



Source: *LE's Web-Connectivity & EMR Survey*, January 2011; n=210

Currently, the vast majority (74%) of lab test orders are received by labs on paper requisitions or by fax, according to *LE's Web-Connectivity and EMR Survey*. Consequently, the physician signature requirement will be a challenge for nearly every lab, especially those serving home health agencies, nursing homes and other health facilities that order lab tests but do not have a physician on site.

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