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LABORATORY INDUSTRY REPORT®

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HIGHLIGHTS

Labs Breathe Sigh of Relief
CMS Rescinds New Signature Requirement

Clinical laboratories are breathing a sign of relief after the Centers for Medicare and Medicaid Services (CMS) said it would withdraw its controversial new policy requiring the signature of a physician or nonphysician practitioner on lab test requisitions.

CMS officials told lab groups about their decision Feb. 11. Enforcement of the new policy, which was finalized in the 2011 physician fee schedule final rule, was set to take effect April 1. CMS is expected to make a formal announcement about the policy soon.

Officials said in a call with lab groups that the agency had determined the policy is unworkable and the best thing to do is pull it back in its current form. The intention was to verify the adequacy of payments made for Part B laboratory services, but the policy does not achieve this and causes disruption and confusion, they said, noting that CMS wants to work with the laboratory community to re-evaluate the issues.

CMS's decision to withdraw the policy is a *Continued on page 2*

New York Gives Labs Amnesty Period To Unwind or Fix EHR Donation Agreements

The New York Department of Health (DOH) will give labs operating in the state until April 15, 2011, to unwind electronic health record (EHR) donation contracts or make other arrangements to ensure compliance with the state's ban on donations to referring physicians.

The DOH announced the amnesty period in mid-February in a frequently asked questions document distributed to laboratories. The FAQs follow a Sept. 27, 2010, letter stating that labs are prohibited from donating all or a portion of the cost of EHRs (even though federal law allows labs to donate or cost-share up to 85 percent of the cost of EHR software).

To minimize disruption of ongoing arrangements, DOH has set an amnesty period of 90 days (Jan. 15, 2011, to April 15, 2011) during which labs that have donated costs of EHRs to New York state clients may (1) take back the software and discontinue *Continued on page 8*

■ **LABS BREATHE SIGH OF RELIEF**, *from page 1*

victory for a broad range of provider groups that coalesced to oppose it, including the Clinical Laboratory Coalition, the American Medical Association, the American Hospital Association, and the American Health Care Association, among others.

CMS's decision likely was also influenced by bipartisan letters signed by 89 members of the House of Representatives and 34 senators. The letters were sent to CMS Administrator Donald Berwick on Feb. 10, the day before agency officials announced their decision to withdraw the policy.

The controversial physician signature requirement would have reversed long-standing policy, finalized in a 2001 rule developed by a negotiated rulemaking, that while a signature is one way to document who ordered a lab test, it is not the only permissible way as long as the order is documented in an alternate format, such as the beneficiary's medical record. This policy had been reiterated in CMS manual issuances as late as March 10, 2010, but in July 2010 the agency announced the new requirement in the proposed 2011 physician fee schedule and adopted it without modification in the final 2011 rule.

President's Budget Includes Money for Doctor Pay Fix

President Obama's fiscal year 2012 budget submission to Congress proposed to trim the deficit by $1.1 trillion over 10 years, with two-thirds of that coming from spending cuts. The budget blueprint, released Feb. 14, also proposed to pay for two years of reimbursements to Medicare physicians at current levels with $62 billion in specific health care savings. Without the change, Medicare payments to doctors would be cut by 30 percent.

While the budget blueprint proposed a permanent fix for Medicare's physician payment system, it provided payment offsets for only the first two years. Congress has grappled with the issue for years as Medicare's reimbursement system has resulted in annual reimbursement cuts. Rather than permanently fixing the system or adopting a new one, lawmakers have opted to implement a series of short-term plans that have canceled the cuts but left the underlying system in place.

The cost of the two-year fix is about $62 billion while the cost of a 10-year fix is about $370 billion, according to the Department of Health and Human Services. With the current focus in Congress on reducing federal spending, however, many observers doubt a two-year payment fix will be enacted this year. More likely, they say, is that Congress will pass another one-year extension, leaving action on a permanent fix until after the 2012 presidential election.

Obama would pay for the two-year payment freeze in physician payments through a variety of proposals, including implementing new Medicare program integrity initiatives, limiting states' ability to use provider taxes to pay the state share of Medicaid, eliminating graduate medical education payments for children's hospitals, and ensuring Medicare and Medicaid get the best prices for prescription drugs provided to beneficiaries.

The administration's proposal comes on the heels of action by Congress late in 2010 to implement a one-year payment fix, which followed several shorter fixes, some as brief as one month. Obama Dec. 15 signed legislation delaying a 25 percent cut in Medicare reimbursement for physicians for a year and making other changes in Medicare and federal health care programs.

The $19 billion Medicare and Medicaid Extenders Act of 2010 froze physicians' reimbursement for all of 2011, replacing a 25 percent cut that was scheduled to be implemented Jan. 1, 2011.

The administration's budget also seeks an increase in funding for biomedical research at the National Institutes of Health (NIH) and in basic science at other agencies.

The blueprint proposes boosting NIH funding 2.4 percent to more than $31.83 billion from $30.78 billion in 2010. Congress has not yet passed the budget for fiscal year 2011.

The 2012 budget proposal would cut funding for the Centers for Disease Control and Prevention from $6.47 billion in 2010 to $5.89 billion. Funding for the Food and Drug Administration (FDA) would increase from $2.6 billion to $2.74 billion. FDA officials have said they expect new revenue from changes to user fee policies to add another $1.62 billion for the year, bringing its total budget to $4.36 billion, a 33 percent increase over 2010 levels.

CPT 88305 Remains Top Pathology Procedure
CBC Ranks as Highest Lab Test by Volume

Surgical pathology, Level IV (CPT 88305) continues to rank as the highest-volume pathology procedure paid under Medicare Part B. CPT 88305 remains the first and only CPT code to top the $1 billion mark in allowed Medicare charges for a single year, according to the forthcoming updated *Medicare Reimbursement Manual for Laboratory and Pathology Services 2011* from Washington G-2 Reports.

The data comes from an analysis of the top 100 clinical laboratory and pathology procedures paid under Medicare Part B during calendar year 2009, according to the annual BESS file (Part B Extract and Summary System) for CPT codes in the 8000 series. Lab and pathology services are represented in the CPT code range 80047-89399.

CPT 88305 had about 18.3 million allowed services and $1.24 billion in allowed Medicare charges in 2009, well over three times more than any other single procedure on the top 100 list. The average allowed charge for 88305 was $67.46, a 2.8 percent increase over 2008.

For calendar year 2009, the top 100 laboratory and pathology services encompassed 329.6 million Medicare-allowed services. For these services, Medicare-allowed charges to both providers and suppliers totaled $5.68 billion, or an average allowed charge of $17.25 per procedure. This represents a $633 million increase in allowed charges in 2009 and a $1.32 rise in the average allowed charge, com-

Top 100 Medicare Part B Outpatient Laboratory and Pathology Procedures for 2009

Description	Allowed Services	Allowed Charges	Average Allowed Charges
Top 88 lab and 12 pathology tests	329.61M	$5.68B	$17.25
Top 88 lab tests	289.96M	$3.51B	$12.11
Top 12 pathology tests	39.65M	$2.17B	$54.80
% of pathology services/ charges Included in totals	12.03%	38.22%	

Source: CMS Part B Extract and Summary Systems (BESS) File

pared to the previous year when the allowed charges were $5.05 billion and the average allowed charge was $15.93.

Of the top 100 procedures examined in the CPT 8000 series, 88 were laboratory codes and the remaining 12 were pathology codes. Laboratory codes are generally paid via the Medicare Clinical Laboratory Fee Schedule, while pathology codes are payable under the Medicare Physician Fee Schedule.

Not surprisingly, the 88 laboratory codes included among the top 100 procedures accounted for a significant majority of Medicare-allowed services ($289.96 million or 88 percent). However, these tests constituted only 62 percent ($3.52 billion) of the total allowed charges, making for average allowed charge per procedure of $12.11. This represents an increase of 75 cents per laboratory procedure compared to the $11.36 per-test average allowed charged in 2008.

The 12 pathology codes included within the top 100 list accounted for about 40 million (12 percent) of allowed services. More importantly, these pathology services accounted for a robust 38.22 percent ($2.17 billion) of total allowed charges in 2009, for an average allowed charge of $54.80. This actually is a decline of $4.88 per procedure when compared to the average allowed charge in 2008 of $59.68. As a result, the average allowed charge for the 12 leading pathology procedures was about 4.5 times the average amount paid by Medicare for the top 88 laboratory tests.

Key Findings

In analyzing the 2009 BESS data used to identify the leading laboratory and pathology service reimbursed by the Medicare program, a number of interesting findings can be gleaned from the data. For example, a total of 64 procedures had 1 million or more allowed services, one more than the previous year. Of those, seven were pathology procedures:

- ❏ Level IV – Surgical pathology, gross and microscopic examination (CPT 88305)
- ❏ Immunohistochemistry, each antibody (CPT 88342)

- ❏ Flow cytometry (CPT 88185)
- ❏ Special stains, Group I for microorganisms (CPT 88312)
- ❏ Special stains, Group II, all others, except immunocytochemistry and immunoperoxidase stains (CPT 88313)
- ❏ Level III – Surgical pathology, gross and microscopic examination (CPT 88304)
- ❏ Cytopathology, cervical or vaginal, requiring interpretation by physician (CPT 88112)

Two pathology procedures continue to have the highest average allowed charges in 2009 among the top 100 list. The average allowed charge for Level V – Surgical pathology, gross and microscopic examination (88307) was $90.25, an increase from the 2008 average charge of $88.40 but still below the 2005 charge of $95.72. The average allowed charge for cytopathology, cervical or vaginal, requiring interpretation by physician (88112) was $69.62, down from $72.23 in 2008 and significantly below its 2005 average allowed charged of $80.97.

Consistent with previous years, the highest-volume laboratory procedure in 2009 was blood count, CBC, auto and auto differential WBC count (85025) with 31.9 million allowed services. This code generated $357.33 million in allowed charges, up 6 percent from 2008, and had an average allowed charge per test of $11.21, an increase of 4.4 percent over the previous year.

For high-volume laboratory tests having more than 1 million allowed Medicare services, there was a slight change in the half dozen procedures with the high average allowed charges, with natriuretic peptid and vitamin D, 25 hydroxy tests new to the list:

❏ Parathormone (83970)	$60.21
❏ Natriuretic peptid (83880)	$48.93
❏ Vitamin D, 25 hydroxy (82306)	$42.61
❏ Prostate-specific antigen (84153)	$26.79
❏ Thyroid stimulating hormone-TSH (84443)	$24.45
❏ Cyanocobalamin-Vitamin B-12 (82607)	$21.97

Blood count, CBC (85025) took over the top spot in 2009 as the high-volume laboratory test with the highest overall payment of $356.04 million, with TSH (84443) coming in second with $348.63 million. But when looking at highest average allowed charge for a test, parathormone (83970) comes in first at $60.21. The high-volume lab tests having the lowest average allowed charge per procedure were urea nitrogen, quan (84520) at $2.35 and bilirubin, direct (82248) at $2.26.

All of the seven highest-volume laboratory tests in the 2009 top 100 list showed an increase in average allowed charges over 2008: CBC (47 cents), TSH ($1.04), comprehensive metabolic panel (43 cents), lipid panel (67 cents), parathormone ($2.60), glycosylated hemoglobin test (60 cents), and vitamin D, 25 hydroxy ($1.73).

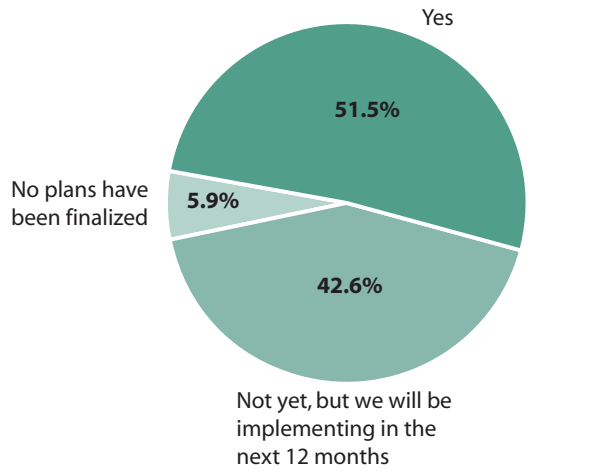
Hospitals Gearing Up for Changes From Health Reform

Outreach Labs Anticipate Additional Testing Volume

About a quarter of hospital and health system executives responding to a recent survey say they are in the process of developing plans for increased testing volume that is expected to come from the addition of formerly uninsured patients to the health care system, while a third believe their laboratories have sufficient capacity to handle additional testing.

About a third of respondents said they plan to perform an analysis of laboratory capacity within the next six to 12 months to evaluate testing equipment, space, and staffing needs to accommodate higher test volume. Another third say they have not scheduled planning to evaluate impacts of increased specimen volume. Many believe their hospital's laboratory currently has adequate technology and space to accommodate increases in test volume from formerly uninsured patients.

Has your institution implemented an EHR system that is interfaced to systems in physicians' offices?



Source: Washington G-2 Reports and Health Care Development Services

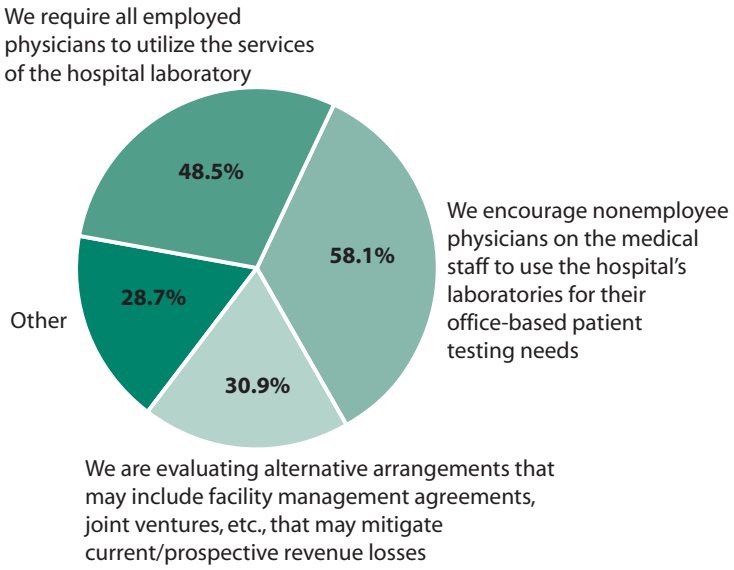
Washington G-2 Reports and Health Care Development Services Inc., a consulting company based in Highland Park, Ill., conducted a survey in summer-fall 2010 of hospital and health care system chief executive officers, chief operating and administrative officers, chief financial officers, and vice presidents with professional services responsibilities to learn how they believe health care reform regulations will impact laboratory and pathology services within their organizations. We received 125 validated responses from C-suite executives representing hospitals and health systems with more than 200 staffed beds.

When survey respondents were asked how they plan to combat anticipated fee schedule reductions in reimbursement, as well as from potential productivity adjustments, almost three out of four indicated they have already instituted actions to improve laboratory efficiency. About 30 percent of respondents also noted they are considering nonoperational strategies that include joint ventures and outsourcing. Almost half of respondents from large hospitals (more than 500 staffed beds) indicated they are considering such strategies while only 21 percent of respondents from smaller hospitals (200-299 staffed beds) are considering such approaches.

A little more than one-third of respondents believe that health care reform regulation-mandated wellness and preventive programs will contribute

somewhat to the increased test volume. Most respondents have not yet begun to consider the potential impact of these programs and commented that they are not yet clear whether wellness and preventive program testing will be performed in hospital and outpatient departments, in physician offices, or by independent and commercial laboratories.

Does your hospital have plans to limit pathology specimen migration to physician offices or to reverse the revenue loss when it occurs?



Source: Washington G-2 Reports and Health Care Development Services

EHR Implementation

Since laboratory and pathology information is the basis of more than 70 percent of patient-care decisions, we wanted to learn the extent of electronic health record (EHR) system implementation and interfaces with physician office systems. Responses indicated that 51 percent of the institutions represented in the survey had already implemented an EHR that is linked to physician offices. Most of the remaining respondents indicated their institutions planned to complete installation of an EHR within the next 12 months.

Migration of Pathology Services

The survey also focused on the migration of outpatient surgical pathology processing from hospital laboratory histology departments to physician office settings. Industry sources estimated that hospitals lose net revenue of about $50,000 to $75,000 per year for each urologist or gastroenterologist in practices that create in-office histology laboratories. We wanted to learn how C-suite executives are reacting to the loss of that hospital revenue.

Survey respondents indicated that almost half (48 percent) of hospitals require employed physicians to use hospital-based laboratory outreach programs. While independent practice physicians are encouraged to use the hospital's lab outreach program, no respondents indicated their hospital requires them to. Interestingly, about 30 percent of survey respondents indicated they are considering various alternative strategies to mitigate these revenue losses. Several respondents commented they plan to confirm hospital policies that state that only their hospital-based pathologists may provide diagnoses for all inpatient and outpatient medical records.

Full results of the survey are available at *www.hcdsinc.com*.

N.Y. GIVES LABS AMNESTY PERIOD, *from page 1*

prohibited services (i.e., unwind contracts), (2) arrange for the one-time sale of donated software and EHR components to the referral source at fair market value and discontinue payment for the prohibited services and connectivity, or (3) leave donated software of EHR components in place and continue to pay for connectivity for the nonlaboratory components of the EHR, and discontinue accepting specimens for testing from the referral source. A laboratory must maintain documentation of the chosen corrective action and make it available to the department upon request.

The DOH will not set fair market value (FMV) thresholds and says FMV should be determined by the lab, possibly in consultation with the EHR manufacturer. After April 15, 2011, labs found to be in violation of the NYS rules on electronic medical records systems as communicated in the Sept. 27 letter can be referred for civil or criminal penalties and administrative action against the laboratory owner.

The prohibition does apply to pathology groups holding a clinical laboratory permit. However, pathologists on staff at a general hospital or who contract with a general hospital to provide pathology services under the hospital's permit would be allowed to accept "computer services" from the hospital, including connectivity to a location off-site of the hospital.

Among other questions addressed by the Department of Health:

Q. What are the implications, including false claim risks, for laboratories enrolled in the NYS Medical Assistance Program (Medicaid) whose EHR donation programs are compliant under federal anti-kickback safe harbors but may not satisfy the NYS requirement?

A. A laboratory's operations in NYS must comply with NYS rules, even if that laboratory participates in federal or federally supported programs (i.e., Medicare and Medicaid, respectively). Any suspect arrangements, including concern for false claims, will be referred to the NYS Office of the Medicaid Inspector General (OMIG), which may conduct its own investigation and impose sanctions.

Q. May a laboratory pay a third-party vendor for charges involved in sending reports from a laboratory information system to the practice's EHR (i.e., a referral source)?

A. A laboratory may not pay an EHR vendor a "per click" charge for transmitting test orders or reports whenever the laboratory has already incurred the expense of establishing the interface that makes possible the electronic transmission of orders and reports from and to a referring practitioner.

Similarly, the laboratory may not pay "per physician" usage charges (as a separate cost or a cost component of a maintenance fee) as this is a cost that should be borne by the practice, which makes the decision on how many physicians have log-in privileges. A laboratory may, however, pay such charges to its own IT/LIS vendors who have no contractual relationship with either the EHR vendor or the referring provider even though the results of their work go to an EHR.

DOH says it will not contact physicians to inform them of the prohibition and verify their compliance, adding the labs may wish to share a copy of the Sept. 27 letter with their clients.

Quest Reports Drop in Revenues for 2010

Quest Diagnostics (Madison, N.J.) in late January reported revenues of $7.4 billion in 2010, a drop of 1.2 percent over revenues for the previous year. For the fourth quarter, revenues were $1.8 billion, 1.3 percent below the prior-year level.

Income from continuing operations was $167 million, or 97 cents per share, for the quarter ended Dec. 31, 2010, compared to $182 million, or 97 cents, for the fourth quarter of 2009. For full-year 2010, income from continuing operations was $723 million, or $4.06 per diluted share, compared to $730 million, or $3.88 per diluted share, for 2009.

Operating income for the quarter was $294 million, or 16.1 percent of revenues, compared to $330 million, or 17.9 percent of revenues. For the year, operating income was $1.3 billion, or 17.6 percent of revenues, compared to $1.4 billion, or 18.2 percent of revenues, for 2009.

GSK Sells Remaining Stake

British drugmaker GlaxoSmithKline said Feb. 1 that it would sell its remaining stake in Quest Diagnostics, representing 30.8 million shares. Quest will repurchase half of the shares (about 15.4 million), and the rest will be sold via a secondary offering at a price of $56.25 per share.

Based on a share price of $56.25, the offering will cost Quest more than $860 million and the use of much of the company's $1 billion in remaining share-repurchase authorization, according to equity research firm William Blair & Co. (WB-Chicago). The repurchase represents 9 percent of shares outstanding and will be financed with a combination of cash and debt.

As a result of this transaction, Quest is raising its 2011 guidance for diluted earnings per share (EPS) by 15 cents, to $4.25 to $4.45, which implies 5 percent to 10 percent growth. Based on that, William Blair has increased its EPS estimate by 18 cents, to $4.43.

Quest officials have said they will continue to pursue merger and acquisition transactions to fuel growth (particularly focused on acquiring additional esoteric testing capabilities in cancer, cardiovascular, and infectious disease testing). The company ended its most recent quarter with $450 million in cash and $750 million remaining on its revolver. William Blair expected Quest to generate more than $1 billon in free cash flow prior to this transaction and continues to model more than $1 billion in cash flow generation in 2012.

With the added debt, WB estimates the company will maintain a debt-to-EBITDA (earnings before interest, taxes, depreciation, and amortization) ratio of below 2.5 times earnings. Thus, Quest has significant capital and leverage to pursue acquisitions and future share buybacks. However, analysts at WB note that this share repurchase may limit Quest's ability to pursue large transactions to some degree—at least in 2011.

LabCorp Delivers Solid Results for Past Year

Laboratory Corporation of American (Burlington, N.C.) reported revenues of $1.295 million for the fourth quarter 2010, an increase of 11.2 percent over the fourth quarter of 2009. Testing volume, measured by requisitions, increased 3.6 percent, and revenue per requisition increased 7.3 percent.

Net earnings were $131.8 million compared to $142.7 million for the same period the previous year. Earnings per diluted share were $1.26 compared to $1.33 in 2009. Earnings per diluted share, excluding restructuring and other special charges recorded in the fourth quarter of 2010 and 2009 (adjusted EPS) were $1.34 and $1.16, respectively.

Operating income for the fourth quarter, ended Dec. 31, 2010, was $238.8 million compared to $215.8 million in the fourth quarter of 2009. Adjusted operating income was $252.4 million and $221.9 million, or 19.5 percent and 19.1 percent of sales, respectively.

Operating cash flow for the quarter was $259.2 million. The balance of cash at the end of the quarter was $230.7 million. As of Dec. 31, 2010, approximately $234.2 million of repurchase authorization remained under the company's approved share repurchase plan.

Full-Year Results

For the year, net earnings were $558.2 million, compared to $543.3 million in 2009. Earnings per diluted share were $5.29 compared to $4.98 in 2009. Adjusted EPS were $5.55, compared to $4.89 in 2009, an increase of 13.5 percent.

Operating income was $978.8 million compared to $935.9 million in 2009. Adjusted operating income was $1.02 billion, or 20.3 percent of sales, compared to $954.9 million, or 20.3 percent of sales, in 2009.

Revenues were $5 billion, an increase of 6.6 percent compared to 2009. Testing volume, measured by accessions, increased 0.1 percent, and revenue per accession increased 6.4 percent.

Outlook for 2011

Beginning in the first quarter of 2011, LabCorp intends to further modify its adjusted EPS to exclude intangible amortization associated with acquisitions. As the company continues to grow the business through acquisitions, it will begin using earnings excluding amortization as a measure of operational performance, growth, and shareholder returns. Company officials believe adjusting EPS for this amortization will provide investors with better insight into the operational performance of the business.

LabCorp expects revenue growth of about 9.5 percent to 11.5 percent in 2011 and adjusted EPS excluding amortization in the range of $6.12 to $6.32. While some analysts had expected slightly higher adjusted EPS, others characterize the guidance as in line with consensus expectations. Overall, it appears the underlying volumes seem to be improving.

Lab Index Off to Solid Start for Year, Up 5%

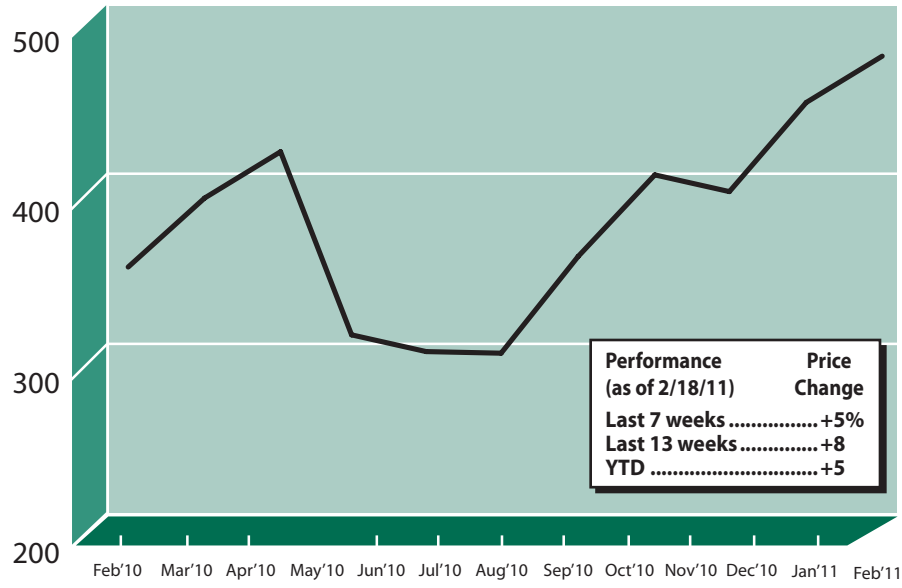
The G-2 Reports' Laboratory Stock Index is off to a good start in 2011, rising 5 percent as of Feb. 18, 2011. In comparison, both the Nasdaq composite and the S&P 500 are up about 7 percent for the year.

Ten of the 12 publicly traded lab companies posted gains during the period, while two showed declines. Shares of **Genoptix** (Carlsbad, Calif.) soared 31 percent to $24.98 on reports that Swiss pharmaceutical giant Novartis is buying the company for $470 million, about 2.4x estimated 2010 revenue of $196 million. Genoptix is expected to become part of Novartis's molecular diagnostics division.

Medtox (St. Paul, Minn.) shares climbed 17 percent to $15.29 after the company reported fourth-quarter and year-end results of the periods ended Dec. 31, 2010. Total revenues for the quarter increased 25.7 percent to $25 million and for the year increased 15.4 percent to $97.1 million. Gross profit for the quarter increased 50.5 percent to $10.4 million, and for the year increased 28.3 percent to $39.6 million. Operating income for the quarter was $1.2 million compared to a loss of $0.5 million the same quarter the previous year. For the year, operating incomes increased 138.2 percent to $4.7 million.

Shares of **Myriad Genetics** (Salt Lake City) dropped 17 percent to $19.07 after the company reported its profit fell 32 percent in the fiscal second quarter as its tax expenses increased. Myriad said in late January that its net income declined to $24.2 million, or 26 cents per share, from $35.4 million, or 36 cents per share, a year earlier. Revenue rose 8 percent to $100.4 million from $92.8 million.

G-2 Laboratory Stock Index



Source: The G-2 Laboratory Stock Index is tabulated weekly by Laboratory Industry Report *from the average percentage change of 12 laboratory testing service stocks.*

Percent Price Change, Seven weeks ended 2/18/2011

	Price	Percent Change
UP		
Bio-Reference	$22.41	+1%
Genomic Health	23.60	+10
LabCorp	89.01	+1
Medtox	15.29	+17
Quest	57.56	+7
Psychemedics	9.09	+11
Orchid Cellmark	2.09	+6
Genzyme Genetics	75.38	+6
Neogenomics	1.35	+4
Genoptix	24.98	+31
DOWN		
Enzo Biochem	4.59	-13
Myriad Genetics	19.07	-17

INDUSTRY buzz

Quest Reaches Tentative $241 Million Agreement With California

Quest Diagnostics (Madison, N.J.) has reached a "highly conditioned" understanding with the California Department of Health Care Services (CDHCS) under which it would pay $241 million to resolve matters relating to its Medi-Cal billing, the company says in its annual report filed with the Securities and Exchange Commission (SEC). The CDHCS contends that billing to Medi-Cal by Quest and several other laboratories violates state law. The state alleges that the labs charged Medi-Cal up to six times more for tests compared to other clients over the past 15 years. Quest officials say the company has been engaged in discussions in an attempt to resolve the matter. "During the fourth quarter of 2010, the company reached an understanding, which was highly conditioned, to settle these matters pursuant to which the company would pay $241 million. Conditions included, but were not limited to, reaching an agreement regarding the manner in which the company's future billings would be treated by the department." As of its SEC filing, the company has been unable to reach a final agreement and notes that no assurance can be given that an agreement will be reached.

References

Genoptix 760-268-6200

GlaxoSmithKline 888-825-5249

Health Care Development Services 847-498-1122

LabCorp 336-436-5274

Medtox 800-832-3244

Myriad Genetics 801-584-3600

New York Department of Health 518-474-7592

Quest 800-222-0446

William Blair & Co. 312-236-1600

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