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LABORATORY INDUSTRY REPORT®

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HIGHLIGHTS

What's the Big Deal About Palmetto's MolDx Program?

Palmetto GBA's recent announcement that it will implement its own coverage and payment program for molecular diagnostic tests has generated a great deal of discussion in the lab industry.

While some say the new policy will help level the playing field and allow labs to better assess what tests will be covered and how much they will be paid, others argue that the Molecular Diagnostics Services Program (MolDx) gives too much power to one Medicare contractor and essentially takes away labs' ability to appeal a payment denial.

Whether you support or oppose Palmetto's efforts to establish coverage and payment policies, one thing is certain: the new program is getting a lot of attention and other contractors and private payers are sure to watch what happens as they grapple with the issue of how to reimbursement molecular diagnostic tests.

For more on the Palmetto MolDx program, see *Inside the Lab Industry* beginning on page 5.

Senate Inquiry Takes Issue of Lab Discounts to National Level

A new Senate inquiry into clinical laboratory discounting practices could potentially lead to fines or settlements, and may eventually result in legislation governing what labs can charge, say industry experts.

"This inquiry shows interest by an important committee at the federal level," Patric Hooper, a partner at the health care law firm Hooper, Lundy & Bookman, tells *Laboratory Industry Report*. "It could result in legislation or some type of federal enforcement mandate."

In the wake of high-profile settlements with the state of California by the two major national labs, the chairman and the ranking minority member of the Senate Finance Committee have asked Quest Diagnostics, LabCorp, and three major health insurance companies for information about their discount and billing practices for clinical laboratory services.

In a Nov. 8 letter, chairman Max Baucus (D-Mont.) and ranking Republican Charles Grassley (Iowa) said they are investigating a

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■ **Senate Inquiry Into Lab Discounts**, *from page 1*
practice known as "pull-through." It involves the alleged offering by a clinical lab testing company that contracts with an insurer for discounted or below-cost pricing in exchange for the insurer directing its in-network physicians to refer, or arrange for the referral of, other lab testing business, including testing for Medicare beneficiaries, to that clinical lab company.

"Congress passed the anti-kickback law to protect patients and federal health programs from potential influence of financial arrangements on health care decisions," the senators noted. "The Inspector General for the Department of Health and Human Services (OIG) has issued advisory opinions about the pull-through practice, noting that discount arrangements such as those at issue here are 'particularly suspect'."

Wide Range of Documents Requested

Grassley and Baucus asked Cigna, LabCorp, Aetna, UnitedHealth Group, and Quest Diagnostics to submit by Dec. 1 copies of lab services agreements, correspondence related to negotiation of the contracts, presentations to the board about contracts, presentations to clinical laboratory testing providers, and other documents related to pull-through practices, including those provided in response to subpoenas from attorneys general.

On the list of requested documents from Quest and LabCorp are pricing schedules for the 10 most commonly ordered lab tests, presenting the price per test charged to each of their five largest managed care clients and the price paid by Medicare.

The request from the Senate Finance leaders is significant because, until now, most challenges to lab pricing practices have come at the state, not the federal, level. Both Quest and LabCorp in 2011 agreed to settlements over allegations that they engaged in illegal price discounting by not offering the state's Medicaid program, known as Medi-Cal, the lowest price offered to other payers.

Both Quest, which settled for $241 million, and LabCorp, which settled for $49.5 million, denied any wrongdoing. The settlements have spawned investigations in Florida, Georgia, Minnesota, Massachusetts, Nevada, and Virginia.

In a Nov. 17 conference call with Deutsche Bank and investors, David Nichols, president of Nichols Management Group, said the Grassley-Baucus letter is a very significant industry development and could potentially lead to fines or settlements although the investigation process could drag out over several years.

According to a Deutsche Bank industry alert issued after the conference call, "the Senate investigation will likely find political justification for cuts –i.e., the output of this work could serve as political cover for Medicare cuts."

Inconsistency on Lab Discounts

At G2 Intelligence's annual Lab Institute, held in October, Hooper predicted that the issue of discounting could be lifted to the national level.

Hooper reviewed over 30 years of case law and policy positions that showed the government has been inconsistent with its interpretation of terms such as "substantially in excess" and "usual charge" for lab test pricing to the Medicare and Medicaid programs.

The OIG jumped into this minefield in 2003 when it proposed a rule to define overcharges to these programs, but after the proposal languished for four years, the OIG threw in the towel, abandoning its effort to establish a "bright-line" standard to determine when the statutory ban on discriminatory pricing is violated and when sanctions, including exclusion from Medicare and Medicaid, would be imposed. Under that rule, the OIG would have had discretion to exclude any provider that charged the programs "substantially in excess" (or more than 120 percent) of its usual charge for the same service or item (though physician services, including anatomic pathology, would have been exempt).

In withdrawing the rule in June 2007, the OIG concluded it did not have sufficient information to set a single, fixed benchmark that could apply across health care sectors. Still, the agency said it would address overcharging on a case-by-case basis. The OIG has kept its eye on comparative lab test pricing in its annual work plan over the last few years. The plan for fiscal year 2012 is no exception. It includes a review of Medicare lab test payment rates versus those of other government and private payers.

Medicare to Cover Screening for Cardiovascular Disease, Sexually Transmitted Infections

The Centers for Medicare and Medicaid Services (CMS) Nov. 8 announced new Medicare coverage for behavioral counseling and screening to prevent heart disease and sexually transmitted infections (STIs).

"Evidence is adequate to conclude that intensive behavioral therapy for cardiovascular disease (CVD) is reasonable and necessary for the prevention or early detection of illness or disability," CMS said in a final coverage decision memorandum.

In a separate memo, the agency said Medicare will cover high-intensity behavioral counseling and screening for chlamydia, gonorrhea, syphilis, and hepatitis B.

CMS proposed the two coverage decisions in August. CVD counseling was initially proposed for every two years, but in the final decision, CMS said it will cover annual face-to-face visits. The counseling must be done by primary care practitioners, such as a beneficiary's family practice physician, internal medicine physician, or nurse practitioner.

"During these visits, providers may screen for hypertension and promote healthy diet as part of an overall initiative to reduce the burden of cardiovascular disease in the United States," CMS said.

STI Coverage Decision

In the decision on STIs, CMS said it will cover screening for chlamydia, gonorrhea, syphilis, and hepatitis B, with the appropriate laboratory tests, when ordered by a primary care physician or practitioner. In general, coverage is aimed at pregnant women, it said. Chlamydia and gonorrhea screening is also for women at increased risk for STIs. Syphilis screening will be for men and women at increased risk for STIs. About 8 million people are covered by Medicare because of a disability, rather than age.

Also covered will be two annual 20-to-30 minute, face-to-face counseling sessions. CMS originally proposed covering up to two 30-minute, face-to-face counseling sessions annually. The counseling is intended to promote sexual risk reduction or risk avoidance. It will include education, skills training, and guidance on how to change sexual behavior.

Molecular Testing Appears to Be Gaining Traction, Finds Survey

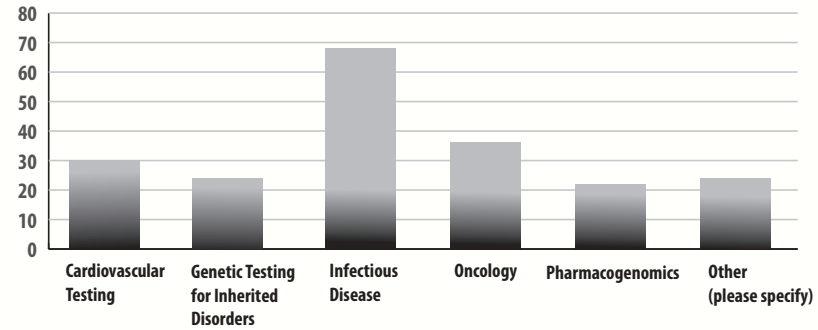
More than 40 percent of clinical laboratories responding to a diagnostic testing survey conducted by G2 Intelligence say they are currently offering molecular diagnostic testing (MDx) while another quarter are evaluating whether to begin offering the testing.

Of the 51 labs responding to an e-mail survey conducted in October, 42 percent said they offer MDx and plan to expand their molecular offerings, 32 percent said they cannot financially justify offering MDx, and 24 percent said they are considering adding some molecular tests to their menu.

When asked what type of tests they are most likely to add in the near future, 68 percent said infectious disease testing, followed by oncology (36 percent), cardiovascular testing (30 percent), and genetic testing for inherited disorders (24 percent).

Almost all respondents said that changes to the test menu are driven by physician demand, revenue potential, and the desire to reduce send-out costs. Most respondents also said they collaborate with physicians before making changes and that electronic order systems aid in proper test selection.

When your laboratory next adds new tests, they will likely be in the area of . . .



Source: G2 Intelligence

When asked about advances in point-of-care testing, 52 percent of respondents said it would help them by reducing turnaround times, while 38 percent said it would hurt them by reducing test volumes.

The most significant challenge facing clinical labs responding to the survey is declining reimbursement or reimbursement uncertainties, followed by personnel shortages, competition from national labs, regulatory uncertainties for lab-developed tests, competition from local labs, and consolidation of laboratories. Also mentioned was the challenge of reinventing the lab for the era of accountable care organizations.

Of the 51 labs responding to the survey, 32 (63 percent) were hospital/health systems labs, 9 (18 percent) were physician office labs, one was a private pathology practice, three were independent labs, and six fell into the "other" category (academic medical center, dialysis lab).

Palmetto MolDx Program Changes the Game For Reimbursement of Molecular Diagnostic Tests

A recent announcement by Palmetto GBA, one of the largest Medicare administrative contractors in the country, that it will implement a new program to determine coverage and payment for molecular diagnostic tests is raising widespread concerns in the lab industry.

The Molecular Diagnostics Services Program (MolDx), which is set to launch in March 2012, will establish a policy for determining whether MDx tests submitted for payment are "reasonable and necessary" and how much labs will be paid for the tests.

Currently, most molecular diagnostic tests are paid through "code stacking." This involves using a series of current procedural terminology (CPT) codes to describe a test that does not have a designated code. Payers contend this makes it difficult to know precisely what is being tested and what they are paying for.

Palmetto signaled its intent to address the issue in October when it issued two draft local coverage decisions (LCDs), to take effect in February 2012, that restrict payment on genomic tests not previously reviewed and specifically approved by Palmetto policy staff.

Under the new program, laboratory service providers will register their molecular diagnostic tests with Palmetto and submit test information and supporting evidence for a coverage and reimbursement determination. Subject matter experts in academia and industry will provide technical assessments.

Labs Must Get Z-Codes

Each test will be assigned a unique McKesson Z-Code™ that is maintained in an automated registry that can accommodate changes on the fly, McKesson says. Palmetto will use the system to identify the billed test, determine if evidence supports it as reasonable and necessary, and apply appropriate reimbursement. Palmetto will set a specific value for each test using enhanced gap-filled, value-based, and market-based methodologies. Once a Z-Code is assigned using McKesson's proprietary software, the provider will not have to submit documentation with every claim for the test.

The onus is on the lab to make the best case using any and all evidence to support clinical utility, notes Palmetto. Labs and manufacturers that get a determination of noncoverage may ask for a new technical assessment six months after the noncoverage notice was issued.

All hospital, private, and reference laboratories that perform molecular diagnostic testing and bill Medicare in A/B MAC Jurisdiction 1 (J1) will be affected by the new program. This includes California, Nevada, Hawaii, and the Pacific Territories of Guam, American Samoa, and the Northern Marianas. Labs that bill J1 services performed by a lab not in J1 will have to register their molecular tests.

Lab providers were able to begin requesting Z-Codes via a downloaded template as of Nov. 14. In January 2012, they can go online to access their existing

Z-Code assignments and register new tests in an interactive data repository (McKesson Diagnostic Exchange™). Starting March 1, 2012, claims without a Z-Code will be rejected. Claims will not be considered for adjudication unless the test has been submitted to the registry for review and a Z-Code has been assigned. Providers will use existing CPT codes in the formal claim lines and the Z-Codes in the "comment" box of the claim form.

Lab Concerns

Labs are very concerned about the MolDx program, says Alan Mertz, president of the American Clinical Laboratory Association. "We have a lot of problems with it," Mertz tells *Laboratory Industry Report*. "We're concerned about the use of a private entity like McKesson, we're concerned about the review panel, and we're concerned about how fast this is being implemented."

Mertz also notes that it's unclear how use of Z-Codes will intersect with the new molecular diagnostic codes developed by the American Medical Association (AMA). The Centers for Medicare and Medicaid Services (CMS) has indicated that it will establish pricing for those codes sometime in the next year, either through the clinical laboratory fee schedule or the physician fee schedule.

Rina Wolf, vice president of commercialization strategies for XIFIN, a San Diego company that offers revenue cycle management software and solutions, tells *LIR* that the most immediate concern is the role of McKesson, a private vendor, in licensing codes. "We don't really have a choice in whether we want to participate in the Z-Code process. This pretty much gives McKesson carte blanche to do whatever they want with this proprietary information."

McKesson stated in the past that it plans to develop a test registry that could be utilized by other third-party payers and have already been approaching laboratories with requests for them to voluntarily participate in this registry, she says. "Clearly the Palmetto program is not voluntary, and they are asking for a lot of specificity about proprietary information that [labs] may not want them to have access to. If their intent is truly to assign an identifying code, they don't need all the information they're requesting."

There is also a potential conflict of interest since McKesson owns US Oncology, which is a potential competitor for many clinical labs, adds Wolf.

The MolDx program, coupled with the two local coverage policies that target elimination of stacking codes, array codes, cytogenetic codes, serology codes, and anatomic pathology codes, leaves the potential for the contractor to also reprice common assays as well as new tests and leaves labs with the possibility of significant reimbursement disruption, notes XIFIN on its blog.

The two LCDs are scheduled to take effect Feb. 27, 2012, and the comment period on them ends Dec. 5. The LCD for molecular diagnostic tests states that to be considered for reimbursement, specific MDx tests must be explicitly covered by a national coverage determination (NCD), an LCD, or a Palmetto coverage article.

The second LCD deals with laboratory-developed tests (LDTs). Similar to the LCD on molecular diagnostic tests, it would not allow labs to submit claims for all nonstandardized organ or disease-oriented LDTs that meet the following criteria:

- ❏ Are not Food and Drug Administration cleared;
- ❏ Are performed or marketed by a sole source, hospital, or reference laboratory;
- ❏ Have not received a specific AMA CPT code;
- ❏ Have not obtained an NCD or LCD from Palmetto.
- ❏ Require multiple CPT codes in order to submit a claim for a single assay or test.

Circumvents Appeals Process

The LCDs and MolDx could affect a large number of the molecular diagnostic tests in use today and could essentially circumvent the current process that labs can use to appeal denials, notes Wolf. For those tests that are not covered under the new policy, labs would not be able to submit claims and thus would have no opportunity to appeal a denial.

"By forcing labs to obtain a Z code prior to submission of any claim and by defining tests with non-coverage as investigational, Palmetto is effectively attempting to close the loop for providers utilizing the appeal process to obtain coverage," she writes on the XIFIN blog. "With the MolDx program guidelines, Palmetto's second LCD (non-standardized organ panels) targeting molecular diagnostics tests by eliminating any coding that requires more than one CPT code to report, is even more deliberate in its attempt to eliminate adherence to established coding guidelines and consequently, the use of the Medicare laboratory and physician fee schedules."

While the laboratory industry understands the rights of Palmetto and other payers to know what they are being asked to pay for, Wolf notes that the AMA just spent two years coming up with a new coding modality to address the issue of identification of molecular tests. The AMA process did allow for input from stakeholders, including Palmetto. "The codes already exist," she says. "It's not the laboratory industry's fault that CMS has not established pricing yet."

In fact, says Wolf, the final physician fee schedule for 2012 specifically states that Medicare contractors are to continue to accept claims with stacked codes and pay accordingly.

Expect the Palmetto policy to be watched closely by other Medicare contractors and by private payers. Some could decide to tackle something similar. It could easily spread, analysts note, since Palmetto already serves as the Medicare contractor for North Carolina, South Carolina, West Virginia, and Virginia as well the states and territories in A/B MAC Jurisdiction 1.

Genomic Health Delivers Solid Third-Quarter Results

Genomic Health in November reported third-quarter revenue of $52 million, which was an increase of about 13 percent over the third quarter of 2010 and in line with analysts' consensus estimates.

Net income was $3.2 million during the quarter, compared with net income of $3.7 million in the same quarter of 2010. Management updated net income guidance to $8 million for the year from the previous guidance of $3 million to $5 million but reiterated revenue guidance of $200 million to $210 million for the year. Earnings per share for the quarter were 11 cents, which handily beat consensus estimates of 4 cents per share.

Genomic Health reported test volume of 16,980 for the quarter, an increase of 15 percent over the same quarter the previous year, and is projecting test volume of 63,000 to 66,000 for the entire year (growth of 10 percent to 15 percent).

Total revenue for the nine months ended Sept. 30, 2011, was $152.7 million, compared with $131 million for the first nine months of 2010. Net income was $5.3 million for the first nine months of 2011 compared with net income of $2.6 million for the same period last year.

International Growth

The company continues to gain traction internationally. The Irish HSE National Cancer Control Programme (which covers 50 percent of the population) signed a reimbursement agreement for node-negative, estrogen receptor-positive Oncotype breast test, marking the company's first public payer contract in Europe. The company also expanded reimbursement in the United Kingdom to include all major private payers, representing 15 percent of the country's population or approximately 10 million lives, established its first reimbursement contract in France at a hospital in Clermont Ferrand, established distribution agreements to provide Oncotype DX in Argentina and Uruguay, and completed decision impact studies in Australia and British Columbia.

Genomic Health is planning to launch a test for DNA mismatch repair (MMR) gene function in December, which can be used as a gating factor for Oncotype DX in colon cancer testing. According to studies, if a tumor is MMR-deficient, it suggests a significantly lower recurrence risk. Thus, if the sample is not MMR-deficient, it can be reflexed to Oncotype DX automatically. There are about 15 percent of stage II colon cancer patients who have MMR-deficient tumors. The company plans to offer the test in addition to Oncotype colon with a list price of $300.

The addition of chemotherapy benefit is critical to the widespread adoption of the colon test (as was the case for breast), believes Amanda Murphy, an equity analyst with William Blair & Co. She notes that Genomic Health began a trial evaluating oxaliplatin benefit in the second quarter, expects to start a validation study next year, and is targeting commercial launch of an assay that provides both recurrence and predictive power (oxaliplatin sensitivity) information by 2013. This indication would also expand the addressable market to phase III patients (the test currently applies only to phase II patients).

"We believe the colon test could start ramping up in 2012, driven by publication of QUASAR and CALGB studies (accepted by the *Journal of Clinical Oncology*) and given the recent reimbursement coverage by Palmetto." Palmetto GBA recently announced that it will reimburse the Oncotype colon tests at $3,000, a slight discount to the list price of $3,280.

Myriad Reports Revenue Growth of 20%; Improves Days Sales Outstanding

Myriad Genetics (Salt Lake City) reported revenues of $110.5 million for the first quarter of fiscal 2012, a 20 percent increase over the $91.9 million reported in the first fiscal quarter of 2011. Operating income for the quarter, ending Sept. 30, 2011, was $41.5 million, an increase of 17 percent from the prior-year period.

Molecular diagnostic revenue in the first quarter totaled $104 million, an increase of 13 percent compared to the same period last year. The increase was driven by strong growth across the company's segments and products. Oncology revenue equaled $74.2 million, an increase of 12 percent, and women's health revenue totaled $29.8 million, an increase of 15 percent.

Revenue from the BRACAnalysis test, which represented 81 percent of the total revenue for the first quarter, was $89.5 million, compared to $80.7 million in the same period the prior year. Myriad's remaining molecular diagnostic tests contributed $4.9 million to first-quarter revenue, an increase of 20 percent, and accounted for 4.4 percent of total revenue.

Companion diagnostic service revenue in the first fiscal quarter from newly acquired subsidiary Myriad RBM (Rules-Based Medicine), equaled $6.5 million and represented 5.9 percent of total company revenue.

Operating income grew by 17 percent to $41.5 million, while net income grew by about 12 percent. The company repurchased 1.7 million shares of its common stock during the quarter under its previously announced repurchase programs.

Days sales outstanding for Myriad's account receivables improved to 37 days, compared with 44 days in the same period of the previous year. Bad-debt expense also continued to improve to 3.9 percent of revenue for the first fiscal quarter, compared with 4.7 percent in the same period the previous year.

Radiologists Object to Cuts in Imaging Under 2012 Physician Fee Schedule Rule

Radiologists are calling a final rule that would cut Medicare payments for diagnostic imaging by 25 percent "potentially dangerous," despite a move by the Centers for Medicare and Medicaid Services (CMS) to temper the cut from an earlier proposal.

"There is no publicly available evidence to support a 25 percent reduction to physician interpretation payments," the American College of Radiology (ACR) said in statement. The CMS final rule, released Nov. 1, was published in the Nov. 28 *Federal Register*.

Currently, when multiple surgical, nuclear medicine, or specified imaging procedures are performed together, Medicare pays the full price for the most expensive procedure but pays 50 percent less for the other procedures.

For imaging services, this multiple procedure cut applies only to the technical component (TC), while a 20 percent multiple procedure payment reduction (MPPR) is applied to the practice expense portion of certain therapy services.

In July, CMS said in the proposed physician fee schedule that it also would include the professional component (PC) in the 50 percent payment reduction formula for multiple procedures.

Specifically, CMS proposed that full payment would be made for the PC and TC of the highest-paid procedure, and payment would be reduced by 50 percent for the PC and TC for each additional procedure furnished to the same patient in the same session.

However, in the final rule, CMS said that "based on our further analysis and in response to comments, we believe that a 25 percent reduction" would be more appropriate for second and subsequent imaging services furnished by the same physician or group to the same patient in the same session on the same day.

Same Group Practice

In addition to the 25 percent cut, ACR objected to the "unanticipated" expansion of the reduction to include multiple providers within the same group practice.

"As a general policy, when multiple scans are conducted on a patient in the same session, we would generally consider the interpretations of those scans to be furnished in the same session, including cases when furnished by different physicians in the same group practice," CMS said.

However, ACR said that "no efficiencies in care support a funding cut when different physicians in a group practice interpret separate imaging scans for the same patient."

The group asked that CMS rescind it immediately, saying that it "violates the spirit of the rulemaking process and indicates that CMS fundamentally misunderstands the practice of medicine."

Lab Index Loses October's Gains, Down 7% for Year

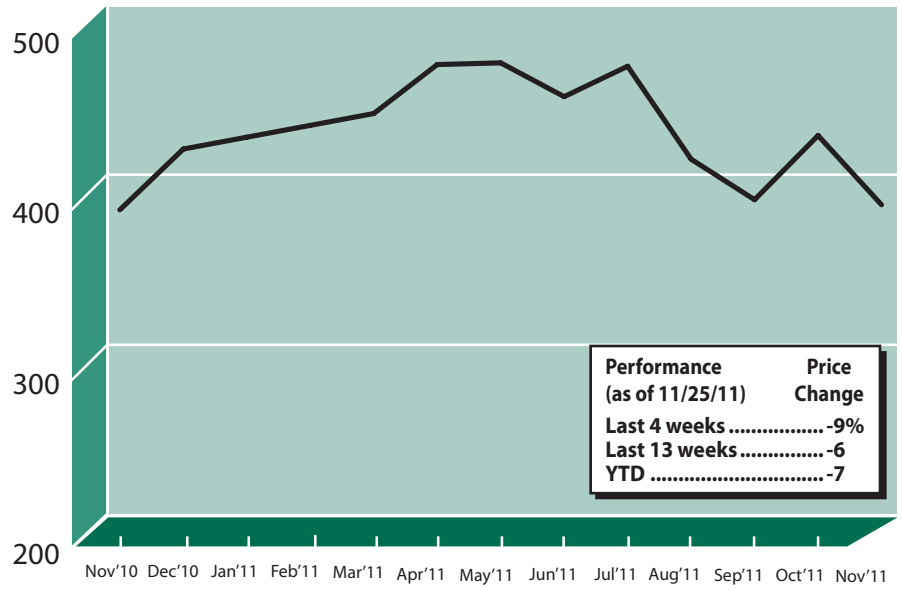
The G2 Intelligence Laboratory Stock Index fell 9 percent in the four weeks ended Nov. 25, 2011, giving up almost all of its October gains. Of the 10 stocks in the index, only two gained in value. Since the beginning of the year, the index is down 7 percent. In comparison, both the Nasdaq composite and the S&P 500 have fallen 8 percent.

Shares of **Bio-Reference Laboratories** (Elmwood Park, N.J.) lost 41 percent of their value during the period, falling to $12.03 following an attack by a blog called "The Street Sweeper," whose operators were shorting the stock. Following publication of two hypercritical articles by the blog, Jefferies dropped coverage of Bio-Reference. Subsequently, the company authorized a stock repurchase program of up to 1 million shares.

"The company has been under attack from various short sellers—who have promoted claims based largely on inaccuracies, half truths, and complete fabrications through their own scurrilous blog site—and the latest market activity on the stock is a reflection of that," said President and CEO Mark Grodman, M.D., in announcing the share buy-back. "The company consistently has posted 20 percent gains in profits and revenue growth year to year and will successfully weather this attack through continued strong results."

Shares of **Psychemedics** (Acton, Mass.) fell 1 percent to $8.86. The company in early November announced quarterly revenues of $6.3 million for the third quarter, a 24 percent increase over revenues of $5.1 million for the same period the previous year. Net income for the quarter ended Sept. 30, 2011, was $1.1 million, or 21 cents per diluted share, compared with $817,000, or 16 cents per diluted share, for the comparable period in 2010. For the first nine months of 2011, the company's revenue increased 24 percent, from $15 million in 2010 to $18.5 million.

G2 Laboratory Stock Index



Source: The G2 Laboratory Stock Index is tabulated weekly by Laboratory Industry Report *from the average percentage change of 10 laboratory testing service stocks.*

Percent Price Change, Five weeks ended 11/25/2011

	Price	*Percent Change*
UP		
Genomic Health	$25.44	22%
Neogenomics	1.38	5
DOWN		
Bio-Reference	12.03	-41
Enzo Biochem	1.99	-31
LabCorp	80.70	-7
Medtox	12.77	-14
Myriad Genetics	19.52	-10
Orchid Cellmark	2.68	-1
Psychemedics	8.86	-1
Quest Diagnostics	54.43	-6

INDUSTRY BUZZ

Bio-Reference GPO Agreement Good for Business

Bio-Reference Laboratory's new purchasing agreement with the Onmark Group Purchasing Organization (GPO) is expected to provide the lab with access to thousands of additional clinics and physicians nationwide.

Onmark is owned by McKesson Specialty Care Solutions and represents 3,000 clinics and 5,500 physicians nationwide. McKesson recently acquired US Oncology, which is affiliated with 1,300 community-based oncologists (or just over 10 percent of the oncologists in the United States). While the agreement with Onmark is not exclusive, analysts say it could provide an avenue for Bio-Reference Labs to penetrate new physician accounts with its GenPath oncology testing services.

The vast majority of Onmark's GPO-associated physicians are expected to be new customers for Bio-Reference Labs (80 percent or more). Inclusion of Bio-Reference in McKesson's GPO network provides support for the company as a lab partner, which runs counter to recent investor concern about the company's business practices.

Shares of Bio-Reference have taken a tumble in the past month in response to two critical articles published by the owners of a blog that shorted the stock. However, Amanda Murphy, an analyst with equity research firm William Blair & Co., believes that while management may need to make some changes over the next year to bolster confidence in its financial controls, the company remains a viable, growth business.

References

Aetna 800-694-3258

American Clinical Laboratory Association 202-637-9466

Bio-Reference Laboratories 201-791-3600

Deutsche Bank 212-250-2629

Enzo Biochem 800-522-5052

Genomic Health 866-662-6897

LabCorp 336-436-5274

Myriad Genetics 801-584-3600

Palmetto GBA 866-931-3903

Quest Diagnostics 800-222-0446

UnitedHealth Group 800-339-5380

William Blair & Co. 312-236-1600

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