Home Health
BUSINESS REPORT

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A WEEKLY REPORT ON NEWS, TRENDS & STRATEGIES FOR THE HOME HEALTHCARE EXECUTIVE

Rep. Armey predicts home health reform in 106th Congress

By MATTHEW HAY
***HHBR* Washington Correspondent**

WASHINGTON – House Majority Leader Rep. Dick Armey (R-TX) predicted over the weekend that Congress will act to reform the Medicare home healthcare benefit in this session of Congress. "Home healthcare needs addressing," said Armey at a legislative briefing Jan. 17. Armey's remarks regarding home health were brief, but notworthy, given that it was one of only three healthcare items he specifically slated for action. The other areas Armey noted were HMO reform and a tax break for self-insured workers.

Armey also blasted the **Health Care Financing Administration** (Baltimore) for not completing the home health regulations for the Balanced Budget Act of 1997 (BBA). It's been the "tradition of Congress," said Armey, "to leave open ends in the law." Some agencies "overstate the regulations" and bring about "legislative aftershock" while others never get around to writing them at all. "This one of the problems we have in home healthcare today," said Armey. "The Health Care Financing Administration never wrote the regulations pursuant to the Budget Act of 1997 and, of course, it has worked terrible hardship on a lot of families."

Armey, who as Majority Leader has considerable influence over the legislative calendar, said that in all of "the hours and hours and hours" of recent Congressional discussions, impeachment has not dominated Congress' attention. "We are clearly developing a detailed agenda for the next Congress," he said, adding that Social Security reform will be the single most import issue facing the 106th Congress. "I'm not prepared to tell you now what tax package you will see," Armey added, "but I am prepared to tell you there will be a tax package this year, and it will move forward." ■

Home care representatives see latest GAO surety bond study

By MATTHEW HAY
***HHBR* Washington Correspondent**

WASHINGTON – Representatives from several leading home care organizations were invited by the **General Accounting Office** (GAO; Washington) earlier this month to assess the latest version of the GAO's study on surety bonds under the condition these representatives did not divulge the contents of the GAO's draft report.

One industry representative close to the process told *HHBR* the GAO is now working "furiously" to complete the study. Once completed, the GAO will forward its final report to the congressional committees with jurisdiction over Medicare and Medicaid – Senate Finance, House Ways and Means, and House Commerce – where it is expected to be held for 30 days before it is formally released.

Last June, the **Health Care Financing Administration** (HCFA; Baltimore) suspended the effective date for implementing the home health surety bond regulations, which were mandated by the Balanced Budget

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OIG fraud alert for home care and DME raises concerns

By MATTHEW HAY
***HHBR* Washington Correspondent**

WASHINGTON – **Department of Health and Human Services** (Washington) Inspector General June Gibbs Brown issued a Special Fraud Alert last week urging physicians to be certain only to authorize home health services and durable medical equipment (DME) and supplies for Medicare beneficiaries that are medically necessary. Brown expressed concern that some physicians are knowingly or unknowingly ordering home health services and DME inappropriately.

The **Office of Inspector General** (OIG) characterized the Fraud Alert as part of its overall efforts to root out fraud and abuse in the Medicare program. Brown called the Alert part of the OIG's effort to "educate and remind physicians of the legal and programmatic significance of certifications" they make when ordering home health services and DME for Medicare beneficiaries. Some industry observers, however, see it as part of a larger pattern to further rein in

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Bonds

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Act of 1997 (BBA) and had been scheduled to go into effect July 31, 1998. HCFA took this action after industry opposition prompted several key members of congress, notably Sen. Kit Bond (R-MO), Chairman of the Small Business Committee, and Sen. Charles Grassley (R-PA), Chairman of the Special Committee on Aging, to raise serious objections to HCFA's regulations.

Congress already eased the bonding rule for home health agencies that bill less than a combined $334,000 to the Medicare and Medicaid programs by allowing these agencies to secure one combined $50,000 bond. But all agencies would still have been forced to comply with a rule requiring that the bond equal the greater of $50,000 or 15% of annual billings. In the meantime, the GAO was sanctioned by Congress to carry out an independent analysis of the surety bond regulations.

Most industry observers continue to believe HCFA will maintain the toughest surety bond requirement it believes it can sustain. "It's unlikely HCFA will issue any regulations until [the GAO report] comes out, but they are probably privy to the initial findings," said one industry representative close to the process. There is also some speculation that the regulations might not go into effect until September and that HCFA might forgo the formal notice and comment procedure and opt instead to pursue a fairly restrictive administrative procedure when they are issued, the representative added.

"On Capitol Hill, there's a feeling the bond should not be larger than $50,000 and maybe even less than that amount for smaller agencies," the representative told *HHBR*. "It will certainly be a major issue if it is over $50,000 and smaller agencies will have a great deal of trouble even with a $50,0000 bond."

The other major concern of home care representatives is whether the regulation requires a fraud bond or financial guarantee bond. "It will make a huge difference," said the representative. "If it's a fraud bond, HCFA could not go after the bond until fraud has been proven, but if it's a financial guarantee bond, they could call the bond immediately." A financial guarantee bond would create more liability on the part of the bonding agency which would translate into greater personal guarantees and collateral when the agency secures the bond. The current sentiment in Congress appears to be running in favor of a fraud bond, the representative told *HHBR*.

"Even with a financial guarantee bond you have to look at the details," the representative warned. Depending on how the regulations are written, a financial bond could allow HCFA to go after the bond immediately, or it could allow the agency to enter into a repayment program or pursue an appeal before that occurs. "That is a very different kind of program than a program that says the bond is immediately liable," said the representative. "The devil is in the details, and every little detail makes a huge difference."

Under the agreement HCFA reached with Congress last year, home health agencies will have at least 60 days following the publication of a regulation to meet the surety bond requirements. ■

CORPORATE LADDER

• **Amedisys** (Baton Rouge, LA) has promoted Larry Graham to chief operating officer. Graham joined Amedisys in 1996 as vice president of finance and was promoted to senior vice president of operations in 1998.

• **Home Aides of Central New York** (Syracuse, NY) has named Holly Chapman accountant under which she will be responsible for all financial aspects of the agency, including, budgeting, auditing, and financial reporting. Home Aides has offices in Syracuse, Baldwinsville, and Central Square.

• **Lincare Holdings** (Clearwater, FL) has named Angela Bryant the company's general counsel, effective Jan. 1. Bryant has been with Lincare since 1996, most recently as corporate counsel. In her new position, Bryant has responsibility for the company's legal, contractual, and regulatory activities. ■

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COMPANIES IN THE NEWS

Amedisys to implement compliance program

Amedisys (Baton Rouge, LA) said that under its new chief compliance officer, Lynne Shackelford-Bernhard, it will present for approval to its board, a comprehensive corporate compliance program. The program is designed to ensure, both at the corporate and field levels, the company's compliance with the statutes, regulations, and manual provisions that govern healthcare providers. It has been developed to provide efficient controls that promote adherence to applicable federal and state law to detect and prevent fraudulant violations.

Apria shareholder sells shares

An **Apria Healthcare Group** (Costa Mesa, CA) investor, mutual fund group **Franklin Resources**, has unloaded its 5.15% stake in Apria, according to a recent regulatory report, a *Los Angeles Times* report said. Franklin held 2.7 million shares of Apria on Sept. 30, according to a previous filing with the **Securities and Exchange Commission** (Washington).

More FBI documents unsealed in Columbia case

A **Columbia/HCA Healthcare** (Nashville, TN) office in El Paso, TX, made false billings for hospital supplies and set up a shell medical laboratory to funnel kickbacks to doctors, according to the latest documents unsealed in the federal investigation of the company, reports the *Associated Press*. The newest accusations were revealed in an FBI affidavit for search warrants filed in July 1997, and made public last week, in response to an order from a federal judge in Tampa. About a dozen pages in the 74-page document remained unsealed, reported the *AP*.

Columbia, along with some of its executives, have been the targets of a two-year federal investigation into its Medicare billing practices involving both its home care operations and a large group of its hospitals.

"The issues in [last week's] unsealing really are nothing new," said Columbia spokesman Jeff Prescott. "The home care and physician relations issues are things we've been in discussion with the government for a year."

According to a *Los Angeles Times* report, the court document names Debra Wertzberger, former head of Columbia's home health division who resigned in October 1997, and Michael Rusnak, who is listed in the documents as Columbia Homecare senior vice president. Neither Wertzberger nor Rusnak faces any criminal charges, the paper reported. Wertzberger, Rusnak, and five other former Columbia executives "conspired with others to submit false Medicare, Medicaid, and CHAMPUS hospital cost reports and false claims" to collect payments under the three government health programs, the affidavit says. So far, four Columbia executives have been indicted on criminal fraud charges, and their case focuses on allegations of wrongdoing in Florida, the *Times* reported.

HealthCor gets new symbol

HealthCor Holdings (Dallas), effective Jan. 8, now trades under the symbol HCOR.

Interwest reports improved 4Q98, FY98 results

Interwest Home Medical (Salt Lake City) saw increased revenues from FY97 to FY98 ended Sept. 30. For the year, Interwest reported revenues of $28.6 million, compared to FY97 revenues of $24.8 million, an increase of 15%.

FY98 net income was $1.4 million, 35 cents per share, compared to FY97 net income of $656,564, 17 cents per share. The year's income, Interwest said, included a one-time gain from the sale of undeveloped real estate of $575,193, 15 cents per share, and the one-time accounting charge of $750,000, 19 cents per share, in 4Q98.

In 4Q98, revenues increased 22%, to $7.7 million, from 4Q97 revenues of $6.3 million. Interwest reported a net income in 4Q98 of $376,762, 9 cents per share, compared to a 4Q97 net loss of $283,012, 7 cents per share.

Both the FY98 and 4Q98 results, said Interwest President/CEO James Robinson, reflect the benefits of the company's focus on its respiratory/oxygen business, which he said the company expects to continue.

Invacare, GF settle lawsuits

Invacare (Elyria, OH) said last week that it has settled all lawsuits with **Graham-Field Health Products** (GF; Hauppauge, NY). As part of the settlement of the lawsuits, Invacare and GF entered into a cross-licensing agreement with respect to certain patents owned by each of the companies. In addition, GF entered into a three-year agreement with the Invacare's wholly owned **Dynamic Controls** subsidiary to supply **Everest & Jennings**, a GF company, with electronic controls for motorized wheelchairs. Invacare also agreed to a two-year agreement to supply LaBac seating systems to providers under a single invoice program. In addition, Invacare received $2.2 million from GF associated with prior product purchases.

In other news, Invacare has been recognized by *CFO Magazine* in its Selling, General and Administrative (SG&A) Expenses Survey of the companies with the lowest SG&A in their respective industries. In the survey, Invacare was ranked number three in the category of Scientific, Photo, and Control Equipment companies. Invacare's 1994-1997 average was 21.5%; its 1997 percentage was 20.2%.

Matria to buy Gainor Medical

Matria Healthcare (Marietta, GA) has agreed to acquire **Gainor Medical Management**, a diabetes-management company, for $130 million. Matria said last week

that the acquisition will bolster its diabetes business through expanded services and products, a larger patient base, and enhanced relationships with self-insured companies, managed care organizations, and key diagnostics companies.

McKessonHBOC begins operations

McKessonHBOC (San Francisco), the company recently formed from the purchase by **McKesson Corp**. (San Francisco) of **HBO & Co**. (HBOC; Atlanta), began operations last week. The newly formed company provides pharmaceutical supply management and information technologies across the entire continuum of healthcare, including market-leading businesses in pharmaceutical and medical-surgical distribution, information technology for healthcare providers, services for payers, and outsourcing.

The company serves 750 home care agencies, as well as 5,000 hospitals, 25,000 retail pharmacies, 20,000 physicians, 10,000 long term care sites, 600 healthcare payers, 450 pharmaceutical manufacturers, and 2,000 medical-surgical manufacturers.

Four former HBOC executives have joined McKesson's existing corporate officers on the new McKessonHBOC executive operating committee, including Charles McCall, chairman of the McKessonHBOC board, formerly HBOC chairman/CEO; Albert Bergonzi, group president of healthcare information technology, formerly HBOC president; David Schenk, senior vice president of the affiliation team, formerly senior vice president of enterprise services for HBOC; and Christine Rumsey, senior vice president of human resources and administration, formerly HBOC senior vice president of human resources.

The merger of the two companies will be accounted for as a pooling of interests. McKessonHBOC will have a fiscal year end of March 31, and the quarter ending March 31, 1999, will be the company's first quarter of combined financial results and will include a charge for merger-related costs.

NuMed, Turkey Vulture Fund reach agreement

NuMed Home Health Care (Clearwater, FL) and its board have reached an agreement with **Turkey Vulture Fund XIII** to settle all outstanding litigation and present to NuMed's stockholders a combined slate of nominees to the board for the upcoming stockholders meeting on Jan. 28.

Pursuant to the settlement agreement, the committee for a new NuMed will withdraw its proxy statement and the Fund will enter into a stock purchase agreement to purchase 744,680 shares of NuMed common stock for $350,000 in cash. Management will recommend in its proxy for the stockholders' meeting a slate of the following six directors: Susan Carmichael, Thomas Chema, Michael Gorman, Richard Osborne, Thomas Smith, and Jugal Taneja. Additionally, parties to the settlement agreement have agreed to vote all of their shares which are eligible to vote in favor of the foregoing slate. Taneja, the former chairman/CEO, is not eligible to vote at the January meeting the 744,680 shares he received in connection with the execution of his termination, noncompetition, and mutual release agreement. Finally, the parties to the settlement agreement have agreed to enter into a standstill agreement on proxy fights through the 2000 annual stockholders meeting. ■

REGIONAL DIGEST

• House democrats in the Tennessee Legislature have propelled home healthcare and community-based care to the top of their agenda this session, according to a recent *Commercial Appeal* of Memphis, TN, editorial, reported *American Health Line*. In response to the state's ranking as 49th in state funding per resident for such long term care, Gov. Don Sundquist has proposed allocating $10 million to a long term care pilot program. But the pilot "is dwarfed by the $750 million in annual state subsidies to nursing homes," prompting the paper to call for a better balance between institutionalized care and home or community-based care. Further, the paper says that Tennessee expects a $4.8 billion windfall from the national tobacco settlement over the next 25 years, which could fund "other worthwhile uses related to healthcare." The *Commercial Appeal* also calls for tighter oversight of TennCare amid "disturbing allegations that an external reviewer provided an unjustifiably sunny assessment of TennCare Partners, the troubled state program of mental healthcare."

• **Home Care Medical** (Milwaukee), one of Wisconsin's largest providers of home medical and supplies, infusion therapy, and respiratory care, has recently made several staff changes. Kathleen Kuchler, formerly director of managed care, has reduced her status to part-time and assumed the new position of contracts manager. Jeanne Langlois, formerly director of business development, has assumed responsibility for the sales department and is now director of sales and business development. Dean Schmalfelt, formerly manager of client accounts, has been promoted to the newly created position of manager of senior financial analyst. He has been replaced by Tim Brown who assumes the new position of manager of client accounts and corporate compliance. Prior to joining Home Care Medical, Brown was director of patient accounts for **All Saints Healthcare System** (Racine, WI).

• The union representing 12,000 Saskatchewan healthcare workers last week had to go back into negotiations after a one-day, province-wide strike, reported The *London Free Press*. Negotiators for the **Canadian Union of Public Employees** and the **Saskatchewan Association of Healthcare Organizations** are to resume contract talks with the aid of conciliator Terry Stevens. The SAHO says it has been given assurances from the union that there will be no further work stoppages as long as bargaining is continuing. ■

MANAGED CARE REPORT

• **HealthPlan Services Corp**. (Tampa, FL) has signed a five-year agreement with **Merck-Medco Managed Care**, effective Dec. 31, to provide pharmacy benefits for its for its small business and large self-insured companies. Merck-Medco manages prescription drugs for more than 51 million Americans. HealthPlan Senior Vice President Jeff Markle said the company's objective in developing the agreement is to leverage its size, aggressively manage program costs, and create added value for its member companies and their employees. In addition, HealthPlan said it will not sign a contract with the **Prudential Insurance Company of America** in the near future because Prudential is continuing to evaluate its current situation in its merger agreement with **Aetna U.S Healthcare**, which has agreed to acquire **Prudential HealthCare**.

• Shares of **Mid Atlantic Medical Services** (MAMSI; Rockville, MD) rose 7.3% one day last week to close at their highest level in more than seven months after an announcement the week before that George Jochum had resigned as chairman/CEO, reported The *Washington Post*. Since October, Jochum had been fighting to keep his job as head of one of the Washington area's largest HMO companies, but he recently bowed to pressure from board members who had been trying to oust him. MAMSI's board has appointed a committee to search for a new CEO and has appointed board member Mark Groban interim chairman. A board member told The *Post* last week that one of the company's top priorities will be to develop a more respectful and compassionate posture toward healthcare professionals.

• **Managed Care Solutions** (MCS; Phoenix) saw increased net income in 2Q99 ended Nov. 30 of 194% to $492,000, 9 cents per share, from $167,000, 4 cents per share, in 2Q98. Revenues for 2Q99 rose 28% to $20.6 million from $16.1 million in 2Q98. Chairman/CEO Michael Hernandez attributes the successful quarter to the development and implementation of two new health plans managed by MCS in Texas and New Mexico. In the past year, he said, membership in the company's plans has increased more than 65% to roughly 130,000 members.

• **Humana** (Louisville, KY) has filed a request for an injunction in a Broward County, FL, circuit court against **Columbia/HCA Healthcare** (Nashville, TN) following Columbia's refusal to treat a number of Humana Health Plan members in some of its Florida hospitals. The injunction asks the court to require Columbia to treat Humana's members in Columbia's Florida hospitals through March 31, 1999, as specified in a contract between the two companies. The injunction, Humana officials said, stems from the expiration of a statewide contract between Humana and Columbia in Florida that expired Jan. 1, but allowed for a run-off period of three months, ending March 31, 1999, during which Columbia hospitals would continue to treat Humana Health Plan members. In the lawsuit, Humana states that Columbia breached its contractual agreement by initially withholding hospital care in at least 27 instances since Dec. 31. Humana promptly expedited the necessary care through alternative means, the company said.

• **Foundation Health Systems**' (FHS; Los Angeles) northeast health plan subsidiary, **Physicians Health Services of New York** (PHS), recently signed long-term commercial and Medicare provider agreements with the **Montefiore Integrated Provider Association** (MIPA; Bronx, NY) and with Manhattan-based **University MSO**, a joint venture between **NYU Hospitals Center** and **University Physicians Network**. Under the full-risk agreements with PHS, University MSO and MIPA will be responsible for pharmacy, medical, and hospital services. NYU Hospitals Center and the physicians affiliated with University Physicians Network became part of PHS' provider network on Jan. 1. The new agreement with MIPA formalizes and expands an existing relationship between PHS, the medical center, and its affiliated physicians. These agreements include about 1,700 physicians in PHS' New York provider network.

• **Tufts Health Plan** (Waltham, MA) has announced some changes to its assisted reproductive technology network, which will now include **Baystate Health Systems IVF Clinic**, **Boston IVF**, **Brigham and Women's Hospital Center for Reproductive Medicine**, **Massachusetts General Hospital Vincent IVF Unit**, **Reproductive Science Center of Boston**, and **Women's and Infant's Reproductive Therapies Program**. To become part of Tufts Health Plan's network, these centers had to meet a list of quality standards, including demonstrating ongoing quality assurance and improvement initiatives and having a designated percentage of board-certified reproductive endocrinologists on staff and meet other staffing requirements, among others.

• **Coventry Health Care** (Bethesda, MD) has closed the previously announced transaction between Coventry and **Blue Cross and Blue Shield of Florida**'s (BCBSFL; Jacksonville, FL) HMO, Health Options, providing for BCBSFL's acquisition of Coventry's **Principal Health Care of Florida** subsidiary for $95 million in cash. The proceeds, said Coventry President/CEO Allen Wise, will allow the company to eliminate all of its bank debt and further strengthen its capital structure.

• **Blue Cross and Blue Shield of Minnesota** (BCBSMN; St. Paul, MN) said last week it will reinforce its focus on health plan operations by discontinuing its role as the Medicare Part A intermediary for Minnesota and redirecting its resources to areas of the company that offer greater growth potential. While the effective date has not yet been set, BCBSMN says it is likely there will be a nine-month transition. ■

WHAT THEY'RE SAYING

• Steve Keener, president/CEO of **Medical Depot** (Englewood, CO), a medical equipment retailer, recently made a statement regarding the HME industry in Colorado. In his statement, Keener said, "In 1999, the Colorado home medical equipment industry will save the state's taxpayers millions of dollars, millions that Medicare and other agencies would have paid to physicians, nurses, and hospitals to provide care within the four walls of a hospital. Technology is now such that much of what has in the past been done in the hospital can now be provided at home at a great saving to whoever is paying the bill." In the same way, Keener said, "the home healthcare industry also saves money for those of us who have private medical insurance. The lower costs to an HMO, PPO, or other health insurance organization, the lower the premium for its policy holders." Keener further said that despite such savings, the federal government has targeted the home care industry for huge cuts that threaten the integrity of the industry as a whole. He said the reason the government does this is "because those who make a living from the ill and infirm are easy to malign. Paying big money for an expensive piece of equipment, or having to forgo the best technology because an HMO doesn't want to pay for it, creates a certain negative image in the consumer's mind." Keener stated that, when asked who's to blame, he says, "For most consumers it's the supplier".

• A recent *Los Angeles Times* editorial calls President Clinton's recent announcement that the biggest domestic item in his budget this year will be $5.5 billion set aside to provide a $1,000 yearly tax credit for people with severe disabilities and relatives who take care of them a "spark of good news" among fast-rising costs of caring for disabled elderly in their homes. "This is not the first time Washington has recognized the problem," the editorial stated. "In the late 1980s, noting that home care is more economical and humane that institutionalization, the government allowed Medicare dollars to be used for the first time for nursing visits to people's homes. Because of the change, federal payments for home healthcare costs have mushroomed tenfold in the last decade, far more than necessary."

• Pete du Pont, policy chairman of the **National Center for Policy Analysis** and former governor of Delaware, recently wrote in a letter to the editor of *The Washington Times* that President Clinton's recent long term care proposal for patients and their families "sounds like a helpful way to defray the costs of chronic and nursing home care." In fact, he wrote, the proposal, if passed, "would take us in the wrong direction by encouraging people to wait until a loved one needs long term care rather than insuring against the problem beforehand. While there is a need to help families meet the exploding costs of long term care, there is a better way to do it." He further wrote that with families more scattered and with seniors living longer than they used to, making the decision to take in an elderly relative is more of a commitment than it used to be. As a result, he wrote, many Americans turn to nursing homes or assisted living residences for help. But this costs a lot of money, he wrote, and many middle class Americans cannot afford this type of care. He said, further, that most families go on welfare to be able to afford it. "President Clinton's proposal would offset some of the costs of long term care by making available a $1,000 tax credit to be used against long term care expenses," he wrote. "But his plan would only exacerbate current policy that encourages people to go unprepared for nursing home expenses and then turn to the government for help from Medicaid when the crisis arrives. If we are going to use the tax system for healthcare needs, let's use it to encourage people to purchase health insurance before they are faced with the catastrophic medical costs."

• A recent editorial in *The San Francisco Chronicle* said some aspects of President Clinton's long term care package are patterned after the successful Caregiver Resource Centers in California, which provide information, education, and support to caregivers of adults with brain disorders. "Although the $6.2 billion proposal is the largest new domestic initiative in what will be Clinton's 1999-2000 budget plan, the amount is modest compared to need," the editorial said. "The average cost of staying in a nursing home is now $47,000 a year. And hiring in-home aides quickly adds up." The editorial further states that the proposal is still significant for focusing attention on what could be a national catastrophe if ignored and for recognizing the necessity of federal help for the elderly and those who care for them. ■

CALENDAR

• The **Joint Commission on Accreditation of Healthcare Organizations** (Oakbrook, IL) will host three public forums, two this month and one in February, to hear consumer ideas about healthcare quality and quality oversight. The forums, which will be from 9 a.m. to 4:30 p.m., are scheduled for Friday, Jan. 22 in Chicago at the Chicago Marriott on Michigan Ave.; Friday, Jan. 29 in Los Angeles at the L.A. Airport Hilton and Towers; and Monday, Feb. 1 in Washington at the Doubletree Hotel on Rhode Island Ave. Feedback from participants will also help the Joint Commission determine how best to make information about healthcare quality available to the public.

• The **Illinois Home Care Council** (Chicago) will hold its 1999 annual conference and exposition on March 3-5 in Sprinfield, IL. The council expects more than 350 healthcare providers to attend this year's meeting, entitled "Putting the Pieces Together." The conference will offer three workshops and more than 60 exhibitors. ■

OIG

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utilization of home healthcare and DME. "My question is whether or not this is part of an effort to chill physician involvement in home health," remarked one veteran industry observer. "It is impossible to look at everything else that has transpired in home health over the last 18 months and not see a trend."

Under the Medicare program, physicians who prescribe home healthcare or DME (such as hospital beds, wheelchairs, and oxygen) must certify that these services or items are medically necessary and that the beneficiary meets the requirements to qualify for the benefit.

But the OIG's critics noted that even Brown admitted physician fraud in this area is "infrequent" and said the evidence she cited was largely anecdotal.

According to the OIG, recent audits have revealed that physicians sometimes order home health services without properly assessing patient needs and that others have authorized unnecessary DME. To buttress these claims, the OIG cited several examples, including:

• A physician knowingly signs a number of forms provided by a home health agency that falsely represent that skilled nursing services are medically necessary;

• A physician certifies that a patient is confined to the home even though the patient tells the physician that her only restrictions are due to arthritis in her hands;

• At the prompting of a DME supplier, a physician signs a stack of blank certificates of medical necessity (CMN) for transcutaneous electrical nerve stimulators units which are later completed with false information;

• A physician signs CMNs for respiratory medical equipment falsely representing that the equipment was medically necessary;

• A physician signs CMNs for wheelchairs and hospital beds without seeing the patients, then falsifies his medical charts to indicate that he treated them, and;

• A physician accepts anywhere from $50 to $400 from a DME supplier for each prescription he signs for oxygen concentrators and nebulizers.

"A physician is not personally liable for erroneous claims due to mistakes, inadvertence, or simple negligence," said IG Brown. "However, knowingly signing a false or misleading certification or signing with reckless disregard for the truth can lead to serious criminal, civil, and administrative penalties." The criminal penalties could include criminal prosecution and fines as high as $10,000 per false claim, said the OIG. The administrative sanctions could include exclusion from participation in federal healthcare programs, withholding or recovery of payments, and loss of license or disciplinary actions by state regulatory agencies. ■

PPM/MSO NEWS

• **AmeriPath** (Riviera Beach, FL) continues to build on its regional business model by acquiring **Harper Pathology Group** (San Antonio, TX). The practice had annual net revenues of $1.8 million in 1997. Terms of the transactions were not disclosed. The Harper Pathology Group is AmeriPath's seventh acquisition in Texas and the second in the San Antonio area, officials said. The hospital-based practice employs three physicians who provide inpatient services at St. Luke's Baptist Hospital in San Antonio, as well as operates an outpatient lab that serves the local physician community.

• **PhyCom Corp**. (Kirkland, WA) and **ValuMed Systems** (city, ST) have formed a wide-ranging strategic partnership aimed at enhancing both companies' medical management product solutions and distribution channels to the managed care marketplace. PhyCom will incorporate the ValuMed Medical Management Guidelines into PhyCom CarePartner, a fully integrated utilization, referral, and case management system that supports medical management across the continuum of care. As part of the agreement, PhyCom will also offer the ValuMed Medical Management System, a decision support tool used to conduct data mining and analytic reporting for utilization, cost, and quality improvement, to its growing customer base.

• **ProMedCo** (Fort Worth, TX) has signed a letter of intent to affiliate with **Prism Medical Group** (Boca Raton, FL). Prism, a 12-physician, multi-specialty group, provides the southern Palm Beach County market with physician services, including internal medicine, nephrology, gastroenterology, cardiology, and OB/GYN through two clinical locations in Boca Raton. Terms of the transaction, which is subject to final physician shareholder approval, were not announced.

• **American Oncology Resources** (AOR; Houston) has added 29 physicians to its network of affiliated oncologists in 4Q98. The largest transaction of the quarter involved **Oncology & Hematology Associates of Southwest Virginia**, (Roanoke, VA) an eight-physician oncology practice. The practice, with seven sites of service in the western Virginia area, has a well-established and active clinical research program, AOR officials said. In addition to the Oncology & Hematology transaction, AOR completed six other transactions in 4Q98. These transactions represented same market expansion in Arizona, Colorado, Florida, Texas, and Virginia.

• **Physicians' Specialty Corp**. (PSC; Atlanta) has amended its management services agreement with **Cleveland Ear, Nose & Throat Center** (Cleveland, OH). Under the terms of the amended, 40-year agreement, PSC will receive a mangement fee of 12.5% of Cleveland ENT revenue, payable monthly. ■