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# Medicare: Claim's Review Criteria Revealed ... To a Select Few

Editorial Staff

For years Medicare has been making a computerized review of doctors' claims, seeking to target those claims which they consider "excessive." Such computer findings, although not conclusive evidence of overutilization, initiate medical review of claims and ultimately determines if there is "bilking" of the Medicare system.

Physicians have long campaigned for Medicare to reveal their treatment parameters, thus giving the physician a guideline for treatment.

Secretary Louis W. Sullivan, M.D., of the Department of Health and Human Services (HHS) has announced a study to determine whether physicians' billing practices for Medicare services will be affected if the doctors know what factors are used to trigger medical review of claims. The question under evaluation is whether providing to physicians the specific parameters used for payment screens will enable them to adapt their billing practices in ways that increase Medicare costs.

The demonstration project will be conducted by Medicare carriers in 13 states, i.e. the insurance companies under contract with Medicare to process and pay claims.

The carriers will provide physicians with the "secret" guidelines used by Medicare to screen physicians' bills and determine which claims need further review before payment is made. The carriers will reveal no more than four of the procedures used to trigger medical review.

Gail Wilensky, Ph.D., who directs the Medicare program, as administrator of the Health Care Financing Administration (HCFA), said the one-year study will begin March 1. The study was mandated by Congress in the Omnibus Budget Reconciliation Act of 1990 and is estimated to cost $400,000.

"We are very interested in how physicians will use the information we are providing them. We believe they share our desire for a relationship based on mutual trust," stated Ms. Wilensky.

The study will involve seven different practices; chiropractic services will be included.

A comparison of the physicians' utilization of services and payments will be made between the study year and the previous year. The effect of disclosing the Medicare guidelines on physician billing practices will then be analyzed.

The carriers selected for the project are: Aetna of Georgia; Alabama Blue Shield; Arkansas Blue Shield; Colorado Blue Shield; Equicor of Idaho; Group Health, Inc., Queens County, New York; Indiana Blue Shield; Kansas Blue Shield; Kentucky Blue Shield; Texas Blue Shield; TransAmerica Occidental, Southern California; Travelers of Connecticut; and Wisconsin Physicians Service.

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