

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEWS OF CLINICIANS
ASSOCIATED WITH HIGH
CUMULATIVE PAYMENTS COULD
IMPROVE MEDICARE PROGRAM
INTEGRITY EFFORTS**

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Inspector General

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Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

Of the 303 clinicians who each furnished more than \$3 million of Medicare Part B services during 2009, existing procedures identified 104 for improper payment reviews and resulted in \$34 million in total overpayments identified as of December 31, 2011. Three of these clinicians had their medical licenses suspended and two were indicted.

WHY WE DID THIS REVIEW

Medicare paid more than \$65 billion for Part B services in each calendar year (CY) from 2008 through 2011. In each of these 4 years, approximately 2 percent of clinicians were responsible for almost 25 percent of all Part B payments with annual payments of more than \$500,000 per clinician. These clinicians were responsible for average annual payments of approximately \$1 million. Clinicians generating high Part B payments represent a greater risk to Medicare if they bill incorrectly or commit fraud. For this review, we define “high cumulative payments” as total annual payments of more than \$3 million for Part B services furnished by an individual clinician. From CY 2008 to CY 2011, both the number of Medicare Part B clinicians generating high cumulative payments and the total dollar amount of those payments increased almost 78 percent.

Our objectives were to determine (1) how many individual clinicians who were responsible for high cumulative payments were reviewed by Medicare administrative contactors (MACs) or Zone Program Integrity Contractors (ZPICs) to identify improper payments and (2) the outcomes of those reviews.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) administers Medicare Part B, which covers medical services, such as office visits, diagnostic tests, and drugs and biologicals, that are furnished by physicians and other clinicians. The Medicare Integrity Program encompasses a range of activities intended to prevent and detect improper payments. CMS contracts with MACs and ZPICs, which are responsible for identifying and reviewing potential improper payments.

WHAT WE FOUND

Of the 303 clinicians who each furnished more than \$3 million of Part B services during CY 2009, MACs and ZPICs identified 104 (34 percent) for improper payment reviews. As of December 31, 2011, the MACs and ZPICs had completed reviews of 80 of the 104 clinicians and identified \$34 million in overpayments. In addition, three of the clinicians had their medical licenses suspended and two were indicted. The results of these reviews demonstrate that identifying clinicians who are responsible for high cumulative payments could be a useful means of identifying possible improper payments. Although existing procedures may identify some of these clinicians for review, the procedures were not designed specifically to identify all clinicians

whose payments exceed an established threshold. In addition, existing procedures may not always identify clinicians responsible for high cumulative payments in a timely manner.

WHAT WE RECOMMEND

We recommend that CMS:

- establish a cumulative payment threshold—taking into consideration costs and potential program integrity benefits—above which a clinician’s claims would be selected for review and
- implement a procedure for timely identification and review of clinicians’ claims that exceed the cumulative payment threshold.

CMS COMMENTS

In written comments on our draft report, CMS stated that it partially concurred with both of our recommendations. In response to our first recommendation, CMS stated that it would work with its contractors to research and develop an appropriate cumulative payment threshold that considers costs and potential benefits when determining which claims and providers should be selected for review. Furthermore, CMS stated that in developing any thresholds, it would consider other factors, including service type and provider specialty, to “inform the appropriate threshold levels.” In response to our second recommendation, CMS stated that it would develop a procedure for the timely identification and review of clinicians’ claims that exceeded the cumulative payment threshold on the basis of the results of its research and our review. CMS acknowledged that reviewing claims from providers with high cumulative payments could be a valuable screening tool and that it is one of many factors MACs consider when deciding to place a provider or supplier on manual medical review.

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INTRODUCTION

WHY WE DID THIS REVIEW

Medicare paid more than \$65 billion for Part B services in each calendar year (CY) from 2008 through 2011.¹ In each of these 4 years, approximately 2 percent of clinicians² were responsible for almost 25 percent of all Part B payments with annual payments of more than \$500,000 per clinician. (See Appendix A, Table 1.) These clinicians were responsible for average annual payments of about \$1 million. Clinicians generating high Part B payments represent a greater risk to Medicare if they bill incorrectly or commit fraud. For this review, we define “high cumulative payments” as total annual payments of more than \$3 million for Part B services furnished by an individual clinician.³ From CY 2008 to CY 2011, both the number of Medicare Part B clinicians and the total dollar amount of payments increased approximately 13 percent, but both the number of clinicians generating high cumulative payments and the total dollar amount of those payments increased almost 78 percent. (See Appendix A, Table 2.)

OBJECTIVES

Our objectives were to determine (1) how many individual clinicians who were responsible for high cumulative payments were reviewed by Medicare administrative contactors (MACs) or Zone Program Integrity Contractors (ZPICs) to identify improper payments and (2) the outcomes of those reviews.

BACKGROUND

CMS administers Medicare, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. Medicare Part B covers medical services, such as office visits, diagnostic tests, and drugs and biologicals, that are furnished by physicians and other clinicians. Individual clinicians who furnish services to Medicare beneficiaries must include their NPI numbers on their Medicare claims.

Characteristics of High Cumulative Payment Clinicians

All of the clinicians who each furnished more than \$3 million of Part B services in CY 2009 were physicians. Over 75 percent represented three primary specialties: internal medicine

¹ This is according to the Centers for Medicare & Medicaid Services' (CMS) National Claims History data.

² For purposes of this report, “clinicians” includes physicians, nurse practitioners, and physician’s assistants. The clinician may not have been the billing provider and may not have received the payments.

³ We identified clinicians by their National Provider Identification (NPI) numbers. The NPI is the standard unique identifier for approximately 1 million health care providers, about half of whom are physicians who actively bill Medicare. The NPI does not carry information about the health care provider, such as the State in which he or she practices or the provider type or specialization but does identify whether a health care provider is an individual clinician. The NPI is the only number that identifies total Part B payments for services furnished by an individual clinician, but it does not identify the individual or entity that received payment for those services.

(55 percent), radiation oncology (12 percent), and ophthalmology (11 percent). The majority practiced in Florida (28 percent), California (8 percent), New Jersey (7 percent), Texas (7 percent), New York (6 percent), and Illinois (6 percent).

Center for Program Integrity

The Medicare Integrity Program (MIP) encompasses a range of activities intended to prevent and detect improper payments.⁴ The Center for Program Integrity (CPI) is responsible for oversight of CMS efforts to prevent and detect improper and fraudulent payments.⁵ Improper payments can result from a variety of circumstances—from mistakes, such as incorrectly coded claims (errors), to intentional deception, such as billing for services that were not provided (fraud). To accomplish its mission, CPI recommends modifications to policies, regulations, and guidance; conducts proactive data analyses, including predictive analytics; monitors provider enrollment activities; and works with other CMS components,⁶ Medicare contractors, the Office of Inspector General (OIG), and the Department of Justice. The Fraud Prevention System (FPS), implemented by CPI in 2011, is a new technology that relies on predictive analytics to prevent and detect improper Medicare payments.

Medicare Administrative Contractors and Zone Program Integrity Contractors

CMS contracts with MACs to process and pay Medicare claims. In addition, MACs are responsible for identifying and reviewing potential improper payments to prevent or detect the errors that pose the greatest financial risk to Medicare. MACs perform two types of reviews: simple reviews, which do not require clinical reviews of medical records to reach a determination, and complex reviews, which involve medical record reviews by licensed nurses or physicians to reach a determination. MACs refer instances of suspected fraud to the appropriate ZPIC for further review.⁷

ZPICs are responsible primarily for reviewing improper payments involving instances of suspected fraud, waste, and abuse. ZPICs identify and review instances of potential fraud within their jurisdictions and investigate allegations of fraud made by beneficiaries, providers, and others. ZPICs refer cases of suspected fraud to OIG's Office of Investigations so it can determine whether sufficient evidence of fraud exists to pursue criminal or civil cases or administrative sanctions. However, not all ZPIC reviews identify improper payments that are suspected fraud. In these instances, the ZPIC coordinates with the appropriate MAC so the MAC can recover any overpayments, educate providers, or do both.

⁴ Social Security Act § 1893.

⁵ *Center for Program Integrity, New Strategic Direction and Key Antifraud Activities*, Nov. 3, 2011.

⁶ CMS, Office of Financial Management, also detects improper payments through utilization of prepayment edits, Medicare Fee-for-Service Recovery Audits, and educational efforts.

⁷ CMS created seven program integrity zones based on MAC jurisdictions and created ZPICs to perform program integrity functions in these zones for Medicare.

HOW WE CONDUCTED THIS REVIEW

We identified 303 clinicians who were each responsible for more than \$3 million⁸ in Part B payments during CY 2009 (for a total of \$1.28 billion). We then determined the number of these clinicians whom the MACs and ZPICs had already selected for improper payment reviews and the outcomes of the reviews. Selecting CY 2009 as the audit period provided us with reasonable assurance that the MACs and ZPICs had sufficient time to complete the reviews so that we could determine the outcomes.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains the details of our scope and methodology.

FINDINGS

Of the 303 clinicians who each furnished more than \$3 million of Part B services during CY 2009, MACs and ZPICs identified 104 (34 percent) for improper payment reviews.⁹ As of December 31, 2011, the MACs and ZPICs had completed reviews of 80 of the 104 clinicians and identified \$34 million in overpayments.¹⁰ In addition, three of the clinicians had their medical licenses suspended and two were indicted. The results of these reviews demonstrate that identifying clinicians who are responsible for high cumulative payments could be a useful means of identifying improper payments.

MEDICARE CONTRACTORS SELECTED SOME, BUT NOT ALL, CLINICIANS WITH HIGH CUMULATIVE PAYMENTS FOR IMPROPER PAYMENT REVIEW

MACs and ZPICs selected for improper payment review 104 of the 303 clinicians who were each responsible for Part B services for which Medicare reimbursed more than \$3 million in CY 2009. To identify these 104 clinicians, MACs and ZPICs:

- analyzed Part B billing data to identify significant increases in payments or the number of services in a day for individual clinicians;
- compared individual clinicians to their peers to evaluate parameters such as hours billed per day and services furnished per beneficiary;

⁸ We selected this amount because it identified 303 clinicians versus the over 5,000 clinicians who were each responsible for more than \$1 million in payments during CY 2009.

⁹ The OIG Office of Investigations had ongoing or closed cases on 28 of the 104 clinicians in our review.

¹⁰ The remaining 24 reviews are ongoing.

- focused on selected issues, such as the location of provided services or a specific service;
- analyzed Medicare claims data for known fraud patterns and suspected fraud trends; and
- monitored the use of compromised provider and beneficiary information and provider enrollment screenings.¹¹

In addition, CMS and OIG each maintain hotlines that allow individuals to report suspected instances of fraud, waste, and abuse. In some instances, hotline leads are forwarded to the ZPICs and may result in improper payment reviews. Although existing contractor procedures may identify clinicians who generate high cumulative payments for review, the procedures are not designed specifically to identify all clinicians whose payments exceed an established threshold.

CPI's new FPS was also not designed to identify all clinicians who are responsible for high cumulative payments. We generated a list of 476 clinicians who each furnished over \$3 million in paid Part B services during CY 2011 (the first year that FPS was operational). Of that 476, CPI's FPS predictive analytics models identified 58 for further evaluation. CPI has preliminarily evaluated eight of these providers and considered five of these "suspect."

RESULTS AND TIMING OF IMPROPER PAYMENT REVIEWS

As of December 31, 2011, of the 104 clinicians identified for reviews, MACs and ZPICs closed reviews of 48 without findings, and 24 reviews are ongoing. Of the remaining 32 clinicians, 13 were responsible for overpayments totaling more than \$34 million, 11 received educational letters,¹² 6 must participate in prepayment reviews, and 3 had their medical licenses suspended.¹³ In addition, two of the clinicians in the ongoing reviews were indicted, but their cases have not yet been resolved.

However, existing procedures may not always identify clinicians responsible for high cumulative payments in a timely manner. For five clinicians whom the MACs and ZPICs identified for improper payment review, we compared the months and years they were identified for review to the CY 2009 month that their Medicare Part B payments were at least \$250,000.¹⁴ The length of time between when the clinicians' CY 2009 monthly payments met or exceeded \$250,000 and when existing contractor procedures identified them for review ranged from 7 to 21 months.

¹¹ Medicare provider and beneficiary information is compromised when provider identifiers or Medicare numbers are stolen or used without provider or beneficiary knowledge. This information is also compromised when a provider or beneficiary is complicit, receiving payment for the use of his or her provider identifier or Medicare number. In addition, contractors perform additional verification procedures when processing certain provider enrollment transactions to identify instances of potential identity theft or other fraudulent activity.

¹² Educational letters address the providers' specific coding, coverage, claims, or billing issues that were identified by the review and include written educational materials that address the identified issues.

¹³ The sum of the results of remaining reviews totals 33 because 1 clinician was responsible for an overpayment and had his or her medical license suspended.

¹⁴ Monthly payments of \$250,000 are equivalent to \$3 million annually.

Part B payments to the individual clinicians during this time ranged from approximately \$2.4 million to \$4.9 million, for a total of nearly \$17 million. (See Appendix A, Table 3.) Of these five clinicians, three were responsible for overpayments, one was excluded from participating in Medicare, and one was indicted but the review is ongoing.

CONCLUSION

We recognize that CMS must use its resources in the most cost-effective manner and should establish procedures that balance potential benefits and workload considerations. However, timely identification of incorrect billing, which may be the result of fraud waste, or abuse, is essential to CMS's ongoing program integrity efforts. These results illustrate that reviews of individual clinicians associated with high cumulative payments have contributed to Medicare program integrity efforts.

RECOMMENDATIONS

We recommend that CMS:

- establish a cumulative payment threshold—taking into consideration costs and potential program integrity benefits—above which a clinician's claims would be selected for review and
- implement a procedure for timely identification and review of clinicians' claims that exceed the cumulative payment threshold.

CMS COMMENTS

In written comments on our draft report, CMS stated that it partially concurred with both of our recommendations. In response to our first recommendation, CMS stated that it would work with its contractors to research and develop an appropriate cumulative payment threshold that considers costs and potential benefits when determining which claims and providers should be selected for review. Furthermore, CMS stated that in developing any thresholds, it would consider other factors, including service type and provider specialty, to “inform the appropriate threshold levels.” In response to our second recommendation, CMS stated that it would develop a procedure for the timely identification and review of clinicians' claims that exceeded the cumulative payment threshold on the basis of the results of its research and our review. CMS acknowledged that reviewing claims from providers with high cumulative payments could be a valuable screening tool and that it is one of many factors MACs consider when deciding to place a provider or supplier on manual medical review. CMS's comments, excluding three technical comments that we addressed as appropriate, are included as Appendix C.

APPENDIX A: MEDICARE PART B HIGH CUMULATIVE PAYMENTS

Table 1: Medicare Part B Payments for Services Rendered by Individual Clinicians CYs 2008 Through 2011								
Payment Range	Percentage of Individual Clinicians				Percentage of Payments			
	CY08	CY09	CY10	CY11	CY08	CY09	CY10	CY11
\$500,000 or Less	98.00%	97.99%	98.07%	98.04%	75.44%	75.38%	75.32%	74.73%
More Than \$500,000	2.00%	2.01%	1.93%	1.96%	24.56%	24.62%	24.68%	25.27%
Total	100%	100%	100%	100%	100%	100%	100%	100%

Table 2: Growth in High Cumulative Payments, CYs 2008 Through 2011					
	CY08	CY09	CY10	CY11	% Change CY08 to CY11
Total Part B Payments	\$65.8 B	\$68.7 B	\$72 B	\$74.8 B	13.68%
Total Number of Part B Clinicians	850,928	877,861	914,017	957,579	12.53%
Payments for Clinicians Furnishing More Than \$3 Million in Part B Services	\$1.15 B	\$1.28 B	\$1.59 B	\$2.04 B	77.39%
Number of Clinicians Furnishing More Than \$3 Million in Part B Services	268	303	374	476	77.61%

Table 3: Payments Made Before Identifying Individual High-Cumulative Clinicians					
Clinician	Month Payments Met or Exceeded \$250,000	Month Identified for Improper Payment Review	Number of Months Until Identification	Payments Made Before Identification	Action Taken
A	May 2009	Jan 2010	7	\$2,391,082	Exclusion from Medicare
B	Feb 2009	Jun 2010	15	3,147,207	Identified overpayment
C	Mar 2009	Dec 2010	21	4,912,029	Indicted
D	Feb 2009	Jan 2010	10	3,447,937	Identified overpayment
E	Jan 2009	Aug 2009	7	3,077, 181	Identified overpayment
Total				\$16,975,436	

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 303 clinicians who each furnished services for which Medicare reimbursed more than \$3 million for Part B services (for a total of \$1.28 billion) during CY 2009. Selecting CY 2009 as the audit period provided us with reasonable assurance that Medicare contractors had sufficient time to complete improper payments reviews so that we could determine the outcomes of those reviews. The objective of our review did not require that we determine whether the Medicare reimbursement amounts to these clinicians were appropriate.

Our objectives did not require an understanding or assessment of the overall internal control structure of Medicare's Part B payment system. Therefore, we limited our review of internal controls to obtaining an understanding of the CMS controls to those that related to our audit objectives.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- used CMS's National Claims History file to determine Part B payments for services furnished by individual clinicians for CYs 2008 through 2011;
- identified 303 clinicians who each furnished more than \$3 million of Part B services in CY 2009;
- contacted 8 MACs, 7 ZPICs, and the OIG Office of Investigations to determine whether they had reviewed any of the 303 clinicians, how they identified clinicians for review, and what the results of completed reviews were;
- contacted OIG's Office of Investigations to determine whether any of 303 clinicians had been investigated and the outcome of those investigations; and
- contacted CMS to discuss how to identify payments made on behalf of individual clinicians and to obtain an understanding of program integrity activities.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: CMS COMMENTS



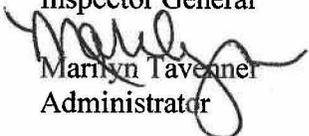
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 19 2013

TO: Daniel R. Levinson
Inspector General

FROM: 
Marilyn Tavenner
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Reviews of Clinicians Associated With High Cumulative Payments Could Improve Medicare Program Integrity Efforts (A-01-11-00511)

Thank you for the opportunity to review and comment on the above-referenced OIG draft report. The purpose of this report is to determine how many individual clinicians who were responsible for high cumulative payments were reviewed by Centers for Medicare & Medicaid Services (CMS) contractors, specifically Medicare Administrative Contactors (MAC) or Zone Program Integrity Contractors (ZPIC), in order to identify improper payments and determine the outcomes of those reviews.

High cumulative payments are not necessarily indicative of improper payments or fraud. However, CMS does acknowledge that reviewing claims from providers with high cumulative payments could be a valuable screening tool and is one of many factors MACs consider when deciding to place a provider or supplier on manual medical review. MACs target error-prone claim types and use their resources where they believe review will be most effective to address billing issues and reduce improper payments. CMS instructs MACs to conduct data analysis of claims. Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate potential problems. Such data analysis includes other factors, ranging from the identification of aberrancies in billing patterns within a homogeneous group of providers, suppliers, or claims to more sophisticated detection of patterns within claims or groups of claims that might suggest improper billing or payment. ZPICs consider a variety of factors in determining whether to investigate a provider or supplier, including but not limited to, high dollar billing in comparison to historic billing patterns.

The CMS appreciates the time and resources OIG has invested to review this issue. Our response to each of the recommendations follows.

OIG Recommendation

The CMS should establish a cumulative payment threshold--taking into consideration costs and potential program integrity benefits--above which a clinician's claims would be selected for review.

CMS Response

The CMS partially concurs with the recommendation. CMS will work with our contractors to research and develop an appropriate, cumulative payment threshold that considers costs, as well as potential benefits in determining which claims and providers should be selected for review. In developing any threshold CMS would need to consider other factors including service type and provider specialty to inform the appropriate threshold levels.

OIG Recommendation

The CMS should implement a procedure for timely identification and review of clinicians' claims that exceed the cumulative payment threshold.

CMS Response

The CMS partially concurs with the recommendation. To address this recommendation, CMS will review the results of the contractor's reviews based on the OIG-identified clinicians who each furnished Part B services that were reimbursed more than \$3 million in calendar year 2009. CMS will take the results from our research as well as these reviews into account when developing a procedure for timely identification and review of clinicians' claims that exceed the cumulative payment threshold.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.