

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PAYMENTS
MADE ON BEHALF OF
DECEASED BENEFICIARIES
IN 2011**



Daniel R. Levinson
Inspector General

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EXECUTIVE SUMMARY: MEDICARE PAYMENTS MADE ON BEHALF OF DECEASED BENEFICIARIES IN 2011
OEI-04-12-00130

WHY WE DID THIS STUDY

Prior Office of Inspector General (OIG) studies and audit reports have identified Medicare payments made on behalf of deceased beneficiaries. The Centers for Medicare & Medicaid Services (CMS) implemented safeguards to address this vulnerability. Health care fraud schemes have involved providers or suppliers submitting fraudulent claims to Medicare, including claims for deceased beneficiaries.

HOW WE DID THIS STUDY

We identified Medicare beneficiaries who, according to the Social Security Administration, died from 2009 to 2011. We then identified Medicare Part A and B claims and Part C and D payments from 2011 associated with these deceased beneficiaries. We also analyzed paid and unpaid Part B claims with service dates after beneficiaries' deaths to identify providers and suppliers associated with high numbers of these claims.

WHAT WE FOUND

CMS has safeguards to prevent and recover Medicare payments made on behalf of deceased beneficiaries; however, it inappropriately paid \$23 million (less than one-tenth of a percent of total Medicare expenditures) in 2011 after beneficiaries' deaths. Part C accounted for 86 percent of these improper payments. Additionally, 11 percent of these improper payments resulted from missing or incorrect dates of death. Further, we identified 251 providers and suppliers that had high numbers of paid and/or unpaid Part B claims with service dates after beneficiaries' deaths.

WHAT WE RECOMMEND

We recommend that CMS (1) improve existing safeguards to prevent future improper Medicare payments after beneficiaries' deaths, (2) take appropriate action on improper Medicare payments made on behalf of deceased beneficiaries and correct inaccurate dates of death, (3) monitor both paid and unpaid Part B claims with service dates after beneficiaries' deaths, and (4) take appropriate action on providers and suppliers that had high numbers of paid and/or unpaid Part B claims with service dates after beneficiaries' deaths. CMS concurred with all four recommendations.

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OBJECTIVES

1. To identify and describe Medicare payments made on behalf of deceased beneficiaries.
2. To determine the accuracy of the Centers for Medicare & Medicaid Services' (CMS) information on beneficiaries' dates of death.
3. To identify providers and suppliers with paid and/or unpaid Part B claims with service dates after beneficiaries' deaths.

BACKGROUND

Medicare should not pay for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.¹ Medically necessary services cannot occur after a beneficiary's death. Therefore, payments for services provided after a beneficiary's death are inappropriate.

Prior Office of Inspector General (OIG) studies and audit reports have identified Medicare payments for claims with service dates after beneficiaries' deaths. For example, OIG found that Medicare paid \$20.6 million in 1997 for Parts A and B services that started after beneficiaries' deaths.² Additionally, health care fraud schemes have involved providers or suppliers submitting fraudulent claims to Medicare, including claims for deceased beneficiaries. For example, an individual was indicted on charges of health care fraud in 2008 because his durable medical equipment company submitted approximately \$2.1 million in fraudulent Medicare claims for services that were not rendered, including 10 claims for deceased beneficiaries.³ This individual fled to Cuba in 2008 and was arrested as he attempted to enter the United States in June 2012.

The Medicare Program

CMS administers Medicare, a Federal health insurance program for the elderly and disabled.⁴ In 2011, total Medicare benefit outlays were

¹ Social Security Act § 1862(a)(1)(A), 42 U.S.C. § 1395y(a)(1)(A).

² Department of Health and Human Services (HHS) OIG, *Medicare Payments for Services After Date of Death* (OEI-03-99-00200), March 2000.

³ HHS OIG, *Captured Fugitives: CAPTURED: Miguel Cabello*, June 2012. Accessed at https://oig.hhs.gov/fraud/fugitives/captured_profiles.asp on March 13, 2013.

⁴ CMS, *Medicare Program – General Information: Overview*, December 2005.

\$541.3 billion.⁵

Medicare has two components: hospital insurance, otherwise known as Part A, and supplementary medical insurance, which consists of Parts B and D.⁶ Medicare also has Part C (i.e., Medicare Advantage), which serves as an alternative to the traditional fee-for-service approach of Parts A and B.⁷ Individuals who are eligible for Part A may enroll in Part B or join Medicare Advantage. Additionally, individuals who are enrolled in Part A, Part B, or Medicare Advantage are eligible for prescription drug coverage under Part D. Table 1 provides a description and expenditures in 2011 for each Part of Medicare.

Table 1: Description and Benefit Outlays by Part of Medicare, 2011

Part of Medicare	Description	2011 Medicare Expenditures	Percentage of Total 2011 Medicare Expenditures
Part A	Helps pay for hospital, home health, skilled nursing facility, and hospice care	\$188.3 billion	35%
Part B	Helps pay for physician outpatient hospital, home health, and other health services, including durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)	\$162.6 billion	30%
Part C	Offers beneficiaries the option to enroll in and receive care from private Medicare Advantage plans and certain other health insurance plans that contract with Medicare	\$123.7 billion	23%
Part D	Provides subsidized access to drug insurance coverage on a voluntary basis for all beneficiaries and premium and cost-sharing subsidies for low-income enrollees	\$66.7 billion	12%
Total		\$541.3 billion	100%

Source: See footnote 5 below.

Part A services are furnished mainly by organizational providers (e.g., hospitals, home health agencies, skilled nursing facilities, and hospices).

⁵ Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2012 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, April 23, 2012.

⁶ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), P.L. 108-173, Title I, established the Part D prescription drug benefit.

⁷ The Balanced Budget Act of 1997, P.L. 105-33, § 4001, established the Medicare+Choice program, also known as Medicare Part C. Title II of the MMA revised Part C and established the Medicare Advantage program in place of Medicare+Choice.

Individual providers (i.e., physicians, nonphysician practitioners, and other qualified professional personnel) furnish most Part B services to Medicare beneficiaries. Other Part B services, such as home health services and outpatient therapy, may be furnished by or under the supervision of an organizational provider. Suppliers generally provide DMEPOS items to beneficiaries under Part B.

For certain Part A and B services and items, individual providers must order, refer, or certify the service or item for the beneficiary. For example, individual providers must order certain nonphysician Part B items or services (e.g., DMEPOS, clinical laboratory services) for beneficiaries. Additionally, individual providers certify home health services for beneficiaries under Part A.⁸ Ordering/referring providers are listed on these nonphysician and home health claims even though suppliers or other providers are the entities that submit the claims to Medicare for payment.

For Part C, beneficiaries may choose to enroll in Medicare Advantage plans (e.g., health maintenance organizations, preferred provider organizations) offered by private insurance companies (i.e., Medicare Advantage organizations). Each Medicare Advantage organization can offer more than one plan to its beneficiaries. Similarly, beneficiaries may choose to enroll in prescription drug plans to receive drug benefits subsidized by Part D. Private insurance companies (i.e., prescription drug plan sponsors) provide drug coverage to beneficiaries who choose to enroll. Each sponsor typically offers more than one prescription drug plan to its beneficiaries.

Medicare Payment Processing

Parts A and B. CMS relies on contractors to process and pay Parts A and B claims. Claims processing contractors enter Medicare claims submitted by providers and suppliers into their processing systems, perform “edits” (system processes) on the claims, and calculate payment amounts. Edits validate claims data by detecting errors or potential errors and verifying that certain data are consistent and appropriate.⁹ Edits are performed either before or after payment is made, depending on the type of edit.

⁸ CMS, *Medicare Enrollment Guidelines for Ordering/Referring Providers* (Medicare Learning Network), September 2012. Accessed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf on February 8, 2013.

⁹ CMS, *Medicare Administrative Contractor Workload Implementation Handbook (Legacy-to-MAC)*, February 2012. Accessed at <http://www.cms.gov/Medicare/Medicare-Contracting/MedicareContractingReform/Downloads/Handbooks/Legacy2MACImp.pdf> on March 6, 2013.

The claims processing contractor then sends the claim to the Common Working File, where a series of edits are performed for consistency, entitlement, and duplication of services.¹⁰ Once the Common Working File completes its edits, the system authorizes the claims processing contractor to pay the claim, reject the claim, or hold the claim until more information is obtained.

Parts C and D. At the beginning of each month, CMS makes payments on behalf of beneficiaries to Medicare Advantage organizations and prescription drug plan sponsors.^{11, 12} Payment amounts may differ for each enrolled beneficiary on the basis of demographic and health status information.¹³ CMS calculates payment amounts using the most current information available.

If CMS receives demographic or health status information that would increase or decrease previous monthly Part C and/or D payments, it makes retroactive adjustments to correct the payment amount.¹⁴ For deceased beneficiaries, CMS corrects the payment amount for the months in which the individuals had, before their deaths, been enrolled in the Medicare Advantage plan or prescription drug plan. The Medicare Advantage and Prescription Drug (MARx) system maintains information as to when beneficiaries enroll in or disenroll from a Medicare Advantage plan or a prescription drug plan.

Date-of-Death Information

To identify Medicare payments made on behalf of deceased beneficiaries, CMS relies on information in its Enrollment Database. The Social Security Administration (SSA) and the Railroad Retirement Board (RRB) are CMS's primary sources of information about deceased

¹⁰ The Common Working File contains all Medicare beneficiary information and Part A, Part B, and DMEPOS claims transactions. CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 27, § 10.

¹¹ For Part C, 42 CFR § 422.304. For Part D, 42 CFR § 423.315.

¹² For Part D, most beneficiaries are responsible for certain costs, which may include a monthly premium, an annual deductible, and coinsurance or copayments. However, certain low-income beneficiaries are eligible to receive a subsidy that pays some or all of these costs. 42 CFR § 423.780 and 42 CFR § 423.782.

¹³ For Part C, 42 CFR § 422.308(c). For Part D, 42 CFR § 423.315.

¹⁴ For Part C, 42 CFR §§ 422.308 and 422.310(f). CMS adjusts the payments monthly, as necessary, on both a prospective and retrospective basis to the beginning of the year. For Part D, 42 CFR §§ 423.315 and 423.343. After the end of each year, CMS reconciles levels of enrollment, risk factors, levels of incurred allowable drug costs, reinsurance amounts, and low-income subsidies to determine reconciliation payment adjustments.

beneficiaries.^{15, 16} SSA and RRB learn of beneficiaries' deaths in a number of ways, including reports from relatives, funeral homes, and the U.S. Postal Service. Death notifications are processed by SSA and RRB as follows:

- SSA processes death notifications through its Death Alert, Control, and Update System, which matches against the Master Beneficiary and Supplemental Security Records.¹⁷ SSA records the resulting death information in its Numerical Identification System (the Numident).¹⁸ SSA then uses information from the Numident to create a national record of death information called the Death Master File.¹⁹
- RRB processes death notifications through its Application Express System, which then populates the Medicare Information Recorded, Transmitted, Edited and Logged (MIRTEL) System.²⁰

CMS receives death information daily from SSA's Master Beneficiary Record and RRB's MIRTEL System. When SSA or RRB has a specific date of death, CMS considers the date of death entered into the Enrollment Database to be verified for that Medicare beneficiary. When SSA or RRB does not have a specific day of death, only a month of death, the last day of the month of death is entered into CMS's Enrollment Database. CMS considers this date unverified because the database contains a default date of death. Unverified death information in the Enrollment Database is updated as CMS, SSA, and RRB receive more specific (i.e., verified) information on beneficiaries' dates of death.

The Enrollment Database is the authoritative source of Medicare beneficiary information and contains personal identifiers (e.g., name, Social Security number), demographic data (e.g., date of birth, date of death), and entitlement information (e.g., benefit start date).²¹ The Enrollment Database is used to update beneficiary information in CMS

¹⁵ RRB administers the retirement/survivor and unemployment/sickness insurance benefit programs for railroad workers and their families under the Railroad Retirement Act and the Railroad Unemployment Insurance Act.

¹⁶ Other sources for date-of-death information are institutional providers.

¹⁷ SSA, Programs Operations Manual System, GN 02602.060 (May 13, 2011). The Master Beneficiary Record is an electronic record of all Title II (of the Social Security Act) beneficiaries. The Supplemental Security Record is an electronic record of all Title XVI (of the Social Security Act) beneficiaries.

¹⁸ Ibid. The Numident contains personally identifiable information for each individual issued a Social Security number.

¹⁹ SSA, Programs Operations Manual System, GN 02602.060.B.1 (May 13, 2011).

²⁰ RRB OIG, *Audit of the Application Express (APPLE) System's Date of Death Reliability* (Report No. 12-06), March 2012.

²¹ CMS, *Data Directory*. Accessed at <http://aspe.hhs.gov/datacncl/datadir/cms.htm> on February 3, 2012.

systems, including the Common Working File and the MARx system. Once beneficiaries' dates of death are entered in the Common Working File, any claims submitted with service dates after beneficiaries' deaths are denied. Similarly, once beneficiaries' dates of death are entered in the MARx system, the system disenrolls the deceased beneficiary from the Medicare Advantage plan or prescription drug plan at the end of the month in which the death occurred.

Postpayment Review To Recover Improper Payments

Beneficiary information may not always be accurate as a result of delays between the date a beneficiary dies and the date SSA learns of that death. Therefore, CMS may make improper payments after beneficiaries' deaths; however, it retroactively recovers these payments once death information is received. CMS identifies these improper payments differently depending on the Part(s) of Medicare in which the beneficiary is enrolled.

Parts A and B. To identify and prevent payment for Part A and B services after beneficiaries' dates of death, CMS implemented an "informational unsolicited response" process in April 2011.²² This process reviews all Part A and B claims approved for payment in the claims history and identifies claims with service dates up to 3 years after the beneficiary's date of death.²³

For example, if a beneficiary died on April 30, 2011, and the Common Working File system received notification of this beneficiary's death on May 16, 2012, the system will:

- identify paid claims with service dates of April 30, 2011, to May 16, 2012,
- prompt an "informational unsolicited response"—i.e., an automated notification—to claims processing contractors for these identified paid claims with service dates after a beneficiary's date of death, and
- prevent any future improper payments for claims with service dates up to 3 years after the beneficiary's date of death.

Claims processing contractors receive a report of identified claims for deceased beneficiaries on which they are required to take action and

²² CMS, *Change Request 7123, Transmittal 804*, Pub. 100-020 One-Time Notification, November 2010. Accessed at <https://www.cms.gov/transmittals/downloads/R804OTN.pdf> on February 4, 2013. The automatic adjustment process of the "informational unsolicited response" retroactively adjusts certain paid claims when subsequent claims or other subsequent actions are the first indicator that payment was inappropriate.

²³ Ibid.

perform additional review, if necessary, to determine whether payment was inappropriate.²⁴

Parts C and D. When a beneficiary enrolled in a Medicare Advantage plan or prescription drug plan dies, the last payment should be for the month in which the beneficiary died. CMS systems automatically disenroll deceased beneficiaries to prevent improper payments to Medicare Advantage organizations and prescription drug plan sponsors for the months following the deaths of enrolled beneficiaries. CMS recoups any payments made to Medicare Advantage organizations and prescription drug plan sponsors on the behalf of deceased beneficiaries for such months.

For example, if a beneficiary died in April 2011 and CMS received notification of this beneficiary's death in June 2011, the MARx system will automatically disenroll this beneficiary in June 2011 to prevent future improper payments. Additionally, CMS will recoup the payments made to the Medicare Advantage organization and/or prescription drug plan sponsor for May and June.

Related Work

Prior studies and audit reports have identified Medicare payments after beneficiaries' deaths, as well as issues with date-of-death information. In 2012, OIG reported that Medicare inappropriately paid \$208,311 in 2010 for home health services occurring after beneficiaries' deaths.²⁵ Similarly, OIG found that Medicare paid \$20.6 million in 1997 for Part A and B services with service dates after beneficiaries' deaths.²⁶ Additionally, OIG found that in 2006 and 2007, Medicare paid \$8.2 million for Part B claims with service dates after beneficiaries' deaths,²⁷ \$4.4 million on behalf of deceased beneficiaries enrolled in Medicare Advantage plans,²⁸ and \$3.6 million on behalf of deceased beneficiaries enrolled in prescription drug plans.²⁹

²⁴ HHS OIG, *Review of Medicare Parts A and B Services Billed With Dates of Service After Beneficiaries' Deaths* (A-01-09-00519), September 2010. See CMS's comments.

²⁵ HHS OIG, *Inappropriate and Questionable Billing by Medicare Home Health Agencies* (OEI-04-11-00240), August 2012.

²⁶ HHS OIG, *Medicare Payments for Services After Date of Death* (OEI-03-99-00200), March 2000.

²⁷ HHS OIG, *Review of Medicare Parts A and B Services Billed With Dates of Service After Beneficiaries' Deaths* (A-01-09-00519), September 2010.

²⁸ HHS OIG, *Review of Medicare Payments to Managed Care Plans on Behalf of Deceased Enrollees* (A-07-07-01046), March 2009.

²⁹ HHS OIG, *Review of Medicare Payments to Prescription Drug Plans on Behalf of Deceased Enrollees* (A-05-09-00027), May 2011.

Other Federal programs have also made payments after beneficiaries' deaths. For example, SSA OIG found that SSA made payments to more than 6,000 beneficiaries for months or years after receiving notification that the beneficiaries were deceased.³⁰ Similarly, RRB OIG found that the postpayment review of Part B claims with service dates after the deaths of Railroad Retirement beneficiaries was inadequate to identify fraud and potential overpayments.³¹ Additionally, SSA OIG found that the Numident did not include death information for approximately 1.2 million beneficiaries who died between 1980 and 2010.³²

METHODOLOGY

We identified individuals who, according to SSA's Death Master File, died between January 1, 2009, and December 31, 2011. We then used CMS's Enrollment Database to determine whether these individuals had been enrolled in Medicare.³³

We identified Medicare Part A and B claims and Part C and D payments associated with these deceased beneficiaries from 2011.³⁴

- For Part A, we analyzed outpatient, inpatient, home health, hospice, and skilled nursing facility claims from CMS's National Claims History Part A Standard Analytic Files for 2011. We limited our analysis to Part A claims with reimbursement amounts greater than zero (i.e., paid claims).³⁵
- For Part B, we analyzed claims for physician and nonphysician services and DMEPOS items from CMS's National Claims History Part B and DMEPOS Files for 2011.³⁶ We analyzed Part B claims

³⁰ SSA OIG, *Payments to Individuals Whose Numident Record Contains a Death Entry* (A-06-08-18095), June 2009.

³¹ RRB OIG, *Railroad Medicare Services Billed with Dates of Service after the Beneficiaries' Dates of Death* (Report No. 10-13), September 2010.

³² SSA OIG, *Title II Deceased Beneficiaries Who Do Not Have Death Information on the Numident* (A-09-11-21171), July 2012. Of those deceased beneficiaries whose deaths were not listed on the Numident, 15,506 died in 2009 and 14,724 died in 2010.

³³ We used Social Security numbers to link deceased individuals from SSA's Death Master File to Medicare beneficiaries in CMS's Enrollment Database.

³⁴ We used the health insurance claim number to link deceased Medicare beneficiaries from the Enrollment Database to Part A and B claims and to Part C and D payments.

³⁵ Medicare reimbursement amounts are the amount of the payment made to a Part A provider by Medicare only (i.e., does not include any amounts paid by the beneficiary). Because we identified few Part A claims for deceased beneficiaries with reimbursement amounts of zero—i.e., unpaid claims—we analyzed only paid Part A claims.

³⁶ Typically, a Part B provider or supplier bills for a set of services or items on one claim, listing each service or item as a separate line item on that claim. For the purposes of this report, we refer to line items on claims as "claims."

with allowed amounts greater than or equal to zero (i.e., paid and unpaid claims).^{37, 38}

- For Parts C and D, we analyzed monthly payments from the MARx system for 2011.³⁹

In this report, we use the term “Medicare payments” to refer to reimbursement amounts from Part A claims, allowed amounts from Part B claims, and monthly Part C and D payments.

Confirming Date-of-Death Information

We compared the date-of-death information from SSA’s Death Master File and CMS’s Enrollment Database for each beneficiary. For instances in which SSA and CMS listed different dates of death, we used Accurint—a commercial data depository—to confirm whether these beneficiaries were deceased and the dates on which they died.⁴⁰ When SSA and CMS date-of-death information did not match, we used the date of death listed in Accurint for our analysis.

Identifying Medicare Claims and Payments Made on Behalf of Deceased Beneficiaries

Part A. We analyzed outpatient, inpatient, home health, skilled nursing facility, and hospice claims data to determine the number of claims with service dates after beneficiaries’ dates of death. We did not consider a claim to be inappropriate if it had a discharge code indicating that the beneficiary died during the stay and the beneficiary’s date of death was 1 day prior to the end-service date.⁴¹ For Part A claims in which the beneficiaries’ dates of death preceded the service dates, we summed payment amounts to calculate the overall amount that Medicare inappropriately paid for these services.

³⁷ Medicare-allowed amounts are 100 percent of the payment made to a Part B provider or supplier by both Medicare and the beneficiary. Generally, Medicare pays 80 percent of allowed charges, and the beneficiary is responsible for the remaining 20 percent.

³⁸ The National Claims History Files do not contain all unpaid claims. For example, claims may have been submitted with service dates after beneficiaries’ deaths that were denied by claims processing contractors and were not processed further.

³⁹ Includes retroactive adjustments of monthly Part C and D payments through August 2012.

⁴⁰ Accurint is a LexisNexis data depository that contains more than 20 billion records from more than 10,000 data sources. Accurint’s primary source for dates of death is SSA’s Death Master File. Accurint also contains death information from obituaries and State death records. We matched across beneficiaries’ social security numbers, first and last names, and dates of birth.

⁴¹ On the claim, the discharge status code indicates the beneficiary status at discharge. When a beneficiary dies prior to discharge, one of the following codes is entered: 20 (expired), 40 (expired at home), 41 (expired in a medical facility), or 42 (expired, place unknown).

Part B. Because of programmatic differences within Part B, we analyzed claims for physician and nonphysician services and claims for DMEPOS items differently. Specifically:

- We analyzed Part B claims for physician and nonphysician services to determine the number of claims with service dates after beneficiaries' dates of death. We did not consider claims to be inappropriate if they had modifier Q3⁴² or modifier QL,⁴³ were for discharge services 1 day after the beneficiary died,⁴⁴ were for services on the same day as a discharge service that was 1 day after a beneficiary's death,⁴⁵ or were for interpretation of tests up to 10 days after the beneficiary's death.⁴⁶
- We analyzed Part B claims for DMEPOS items to determine the number of claims with service dates after beneficiaries' deaths. To account for the refill and rental requirements of certain DMEPOS items, we did not consider claims to be inappropriate if service dates were within 30 days of a beneficiary's date of death.⁴⁷

For Part B claims in which the beneficiaries' dates of death preceded the service dates, we summed payment amounts to calculate the overall amount that Medicare inappropriately paid for these services and items. We also analyzed these Part B claims associated with deceased beneficiaries by procedure codes and modifiers.

⁴² CMS, *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 11, § 80.4. Modifier Q3 indicates that expenses for physicians' services to the kidney donor are to be treated as though the recipient had incurred them. If the recipient dies, donor expenses actually incurred after death of the recipient will be treated as incurred before the death of the recipient.

⁴³ NHIC, Corp. (J14 A/B MAC), *Modifier Billing Guide*, June 2011, p. 9. Modifier QL indicates that the patient was pronounced dead after the ambulance was called and that the ambulance base rate should be paid with no mileage adjustment or rural adjustment.

⁴⁴ NHIC, Corp., *Evaluation and Management Services Billing Guide*, March 2011, p. 17. Discharge services are billed using procedure codes 99238 and 99239 for hospital settings and 99315 and 99316 for nursing facility settings. In other settings, a brief evaluation and management service code is used; however, we did not consider evaluation and management service codes to be discharge codes for our analysis. **The five character codes and descriptions included in this study are obtained from Current Procedural Terminology (CPT®), copyright 2012 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this study should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

⁴⁵ NHIC, Corp., *Evaluation and Management Services Billing Guide*, March 2011, p. 25. Reasonable and necessary medical services rendered up to and including pronouncement of death by a physician are covered diagnostic and therapeutic services.

⁴⁶ Interpretation of tests is allowable after a beneficiary's death when the physician could not have known that the beneficiary had died. To account for these instances, we searched procedure code descriptions using the phrase "interpretation and report only."

⁴⁷ CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 20, § 30.5.4.

Parts C and D. We analyzed monthly payments to Medicare Advantage organizations and prescription drug plan sponsors to identify those made after the beneficiaries' months of death. For Part C and D payments for which the beneficiaries' months of death preceded the monthly payment, we summed payment amounts to calculate the overall amount that Medicare inappropriately paid on behalf of these deceased beneficiaries. We also analyzed Part C and D payments made on behalf of deceased beneficiaries by Medicare Advantage organization and prescription drug plan sponsor.

Identifying deceased beneficiaries with improper payments across Medicare. We identified deceased beneficiaries for whom improper payments were made across Medicare. We identified deceased beneficiaries with Part A and B payments after their deaths. In addition, we identified deceased beneficiaries with Part A and B payments after their deaths that had also Part D payments. We identified deceased beneficiaries for whom both Part C and D payments were made after their months of death.

Identifying Providers and Suppliers With High Numbers of Paid and/or Unpaid Part B Claims With Service Dates After Beneficiaries' Deaths

Separately, we analyzed paid and unpaid Part B claims for physician and nonphysician services and DMEPOS items for deceased beneficiaries to identify providers and suppliers that submitted claims with service dates after beneficiaries' deaths in 2011.⁴⁸ In total, we identified 245,559 such claims submitted by 39,082 providers and 8,556 suppliers.

Ninety-eight percent (239,598) of claims were not paid by Medicare and were submitted by 37,550 providers and 8,543 suppliers. The remaining 2 percent (5,961) of these claims were paid by Medicare and were submitted by 2,468 providers and 254 suppliers. About 3 percent (1,177) of providers and suppliers had both paid and unpaid claims with service dates after beneficiaries' deaths.

For each provider, we calculated the total number of paid and unpaid Part B claims with service dates after beneficiaries' deaths. Similarly, for each supplier, we calculated the total number of paid and unpaid Part B claims with service dates at least 30 days after beneficiaries' deaths. We also calculated, for each provider and supplier, the total number of deceased beneficiaries associated with paid and unpaid Part B claims.

⁴⁸ We did not conduct this analysis on Part A because there were few unpaid claims with service dates after beneficiaries' deaths and a small number of Part A providers that submitted both paid and unpaid claims. Because of programmatic differences, this analysis could not be applied to Parts C and D.

Providers and suppliers with a high number of paid and/or unpaid Part B claims for deceased beneficiaries raise concerns, especially if their billing for deceased beneficiaries represents a substantial proportion of their overall Medicare billing. To determine how the billing for deceased beneficiaries compared to providers' and suppliers' overall Medicare billing, we analyzed all Part B claims submitted in 2011 by providers and suppliers associated with the most paid and/or unpaid claims with service dates after beneficiaries' deaths.

Geographic Analysis

For Part A and B claims with service dates after beneficiaries' deaths, we identified the Core Based Statistical Areas (CBSAs) in which providers or suppliers were located using their business address ZIP Codes.⁴⁹ We identified CBSAs with the most Part A and B payments made on behalf of deceased beneficiaries.⁵⁰ We also identified CBSAs with providers and/or suppliers with the most paid or unpaid Part B claims with service dates after beneficiaries' deaths.

Limitations

We did not independently verify the accuracy of CMS's date-of-death information when it matched that in SSA's Death Master File.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

⁴⁹ United States Census Bureau, *Metropolitan and Micropolitan*, May 2012. Accessed at <http://www.census.gov/population/metro/> on December 20, 2012. CBSAs are both metropolitan and micropolitan areas as defined by the Office of Management and Budget. A metropolitan area contains a core urban area of 50,000 or more in population, and a micropolitan area contains an urban core of at least 10,000 (but less than 50,000) in population.

⁵⁰ We did not conduct a geographic analysis of Part C and D payments made on behalf of deceased beneficiaries because the geographic coverage of plans offered by Medicare Advantage organizations and prescription drug plan sponsors varies. Some plans are localized on the level of a county or region within a State, whereas other plans can cover multiple States or be nationwide.

FINDINGS

CMS has safeguards to prevent and recover Medicare payments made on behalf of deceased beneficiaries; however, it inappropriately paid \$23 million in 2011 after beneficiaries' deaths

CMS inappropriately paid less than one-tenth of a percent (\$23 million) of total Medicare expenditures in 2011 to providers, suppliers, Medicare Advantage organizations, and prescription drug plan sponsors on behalf of beneficiaries who died in 2009, 2010, or 2011. CMS has safeguards to prevent and recover Medicare payments made on behalf of deceased beneficiaries. For Parts A and B, CMS implemented a process in April 2011 to prevent improper payments for services and items billed after beneficiaries' deaths. For Parts C and D, CMS automatically disenrolls an individual from a Medicare Advantage plan or prescription drug plan upon his or her death. These safeguards, however, did not prevent all improper payments.

Part C accounted for the most improper payments (\$20 million) in 2011. Part A had the highest average payment per deceased beneficiary (\$8,468). Table 2 shows total and average improper payments per deceased beneficiary by Part of Medicare. Appendix A shows improper payments made on behalf of deceased beneficiaries by Part of Medicare and year of beneficiary death from 2009 to 2011.

Table 2: Medicare Payments After Beneficiaries' Deaths by Part of Medicare, 2011

Part of Medicare	Description	Medicare Payments After Beneficiaries' Deaths	Number of Deceased Beneficiaries*	Average Medicare Payment for Deceased Beneficiary
Part C	Offers the option to enroll in and receive care from private Medicare Advantage plans	\$19,906,805	11,835	\$1,682
Part D	Offers subsidized access to drug insurance coverage	\$1,049,444	5,101	\$206
Part A	Helps pay for hospital, home health, skilled nursing facility, and hospice care	\$1,634,280	193	\$8,468
Part B	Helps pay for physician and nonphysician services, including DMEPOS items	\$592,823	1,541	\$385
Total		\$23,183,352	17,403	\$1,332

*Column sum exceeds total because some deceased beneficiaries had payments in multiple parts of Medicare.
Source: OIG analysis of Part A and Part B claims data and Part C and D payments from the MARx system, 2013.

Of the 17,403 deceased beneficiaries associated with improper Medicare payments in 2011, 58 percent (10,025) had less than \$1,000 in improper

Medicare payments after their deaths. However, 12 deceased beneficiaries had over \$50,000 each in improper Medicare payments after their deaths. Of these, Medicare paid over \$100,000 each for two beneficiaries that died in 2009 and 2010. These two beneficiaries accounted for \$256,689 in improper Part A, B, and D payments in 2011.

Medicare Parts C and D accounted for 90 percent of improper payments in 2011 made on behalf of deceased beneficiaries

Medicare Parts C and D accounted for \$21 million of the \$23 million (90 percent) in improper payments after beneficiaries' deaths in 2011. CMS initially paid \$610 million to Medicare Advantage organizations and prescription drug plan sponsors on behalf of deceased beneficiaries. However, it retroactively recovered 97 percent (\$589 million) of these payments. At the time of our review, CMS had not recovered the remaining 3 percent (\$21 million) inappropriately paid on behalf of 15,838 deceased beneficiaries. About 7 percent (1,098) of deceased beneficiaries were associated with both improper Part C and D payments in 2011.

Nearly 86 percent (\$20 million) of improper Medicare payments made on behalf of deceased beneficiaries were made to 514 Medicare Advantage organizations. Fifteen organizations accounted for 31 percent (\$6.2 million) of improper Part C payments after beneficiaries' deaths in 2011. Specifically, Medicare paid \$1.1 million to 1 organization on behalf of 592 deceased beneficiaries. This organization received the most improper payments on behalf of the most deceased beneficiaries of all Medicare Advantage organizations in 2011. Nearly all (11,767 of 11,835) deceased beneficiaries who were associated with improper Part C payments in 2011 also died in 2011.

Approximately \$1 million in improper Medicare payments made on behalf of deceased beneficiaries were made to 398 prescription drug plan sponsors. Twelve sponsors accounted for 70 percent (\$735,224) of improper Part D payments after beneficiaries' deaths in 2011. Specifically, Medicare paid \$162,880 to 1 sponsor on behalf of 465 deceased beneficiaries and \$140,505 to another sponsor on behalf of 758 beneficiaries. These two sponsors had the most improper payments on behalf of the most deceased beneficiaries of all prescription drug plans in 2011. Thirty-nine percent of improper Part D payments were made on behalf of beneficiaries who died in 2010.

Medicare Parts A and B accounted for 10 percent of improper payments in 2011 made on behalf of deceased beneficiaries

Medicare Parts A and B accounted for \$2 million of the \$23 million (10 percent) in improper payments after beneficiaries' deaths. CMS inappropriately paid approximately \$2.2 million in 2011 for Part A and B claims with service dates after the deaths of 1,626 beneficiaries. About 7 percent (108) of these were associated with both Part A and B payments in 2011. Additionally, 26 of the 108 beneficiaries who had both Part A and B payments after their deaths also had Part D payments.

Seventy-five percent (\$1.7 million) of improper Part A and B payments were made on behalf of beneficiaries who died before the effective date of the informational unsolicited response process, which CMS developed to identify and prevent payment for Part A and B services after beneficiaries' dates of death. However, 25 percent (\$560,440) of these improper payments were associated with 378 beneficiaries who died after the effective date of this process.

Claims for Part A services had service dates an average of 216 days after beneficiaries' deaths. For Part B, claims for physician and nonphysician services had service dates an average of 158 days after beneficiaries' deaths, and claims for DMEPOS items had service dates an average of 119 days after beneficiaries' deaths. Certain procedure codes and modifiers were associated with a high number of Part B claims with service dates after beneficiaries' deaths. For example, 80 percent of DMEPOS items associated with deceased beneficiaries were rental items (e.g., oxygen concentrators, nebulizers, wheelchairs), indicated by modifier RR. Appendix B provides information on these procedure codes and modifiers for Part B claims.

In 2011, 10 CBSAs accounted for 50 percent (\$1.1 million of \$2.2 million) of Part A and B payments for claims with service dates after beneficiaries' deaths. Table 3 shows the improper Medicare payments, the number of deceased beneficiaries, and the number of Part A or B providers and suppliers as broken down by these 10 CBSAs. New York City had the most improper Part A and B payments made on behalf of deceased beneficiaries (nearly \$200,000) and the most deceased beneficiaries for whom services were billed (142 of 1,626) in 2011. Overall, Part A and B providers and suppliers billed for deceased beneficiaries in 376 of 955 CBSAs.

Table 3: Part A and B Payments After Beneficiaries' Deaths by CBSA, 2011

CBSA	Medicare Payment Amount	Number of Deceased Beneficiaries	Number of Claims	Number of Providers/Suppliers
New York City, NY	\$192,476	142	354	226
Indianapolis, IN	\$150,330	12	287	103
Philadelphia, PA	\$140,523	61	334	135
Boston, MA	\$127,430	47	189	99
St. Louis, MO	\$116,408	14	128	53
Providence, RI	\$102,687	13	189	35
Baton Rouge, LA	\$100,563	8	146	67
Chicago, IL	\$69,590	93	229	123
Houston, TX	\$62,978	42	132	60
Jackson, MS	\$58,927	9	40	19
Total	\$1,121,912	431*	2,028	920

Note: The remaining 366 CBSAs accounted for \$1.1 million.

*Column sum exceeds total because some deceased beneficiaries were associated with providers/suppliers in different CBSAs.

Source: OIG analysis of Part A and Part B claims data, 2013.

Eleven percent of improper Medicare payments made on behalf of deceased beneficiaries resulted from missing or incorrect dates of death

Eighty-eight percent of improper Medicare payments made on behalf of deceased beneficiaries in 2011 were associated with beneficiaries who had matching dates of death in CMS's Enrollment Database and SSA's Death Master File. However, 11 percent (\$2.6 million of \$23 million) of improper payments were attributable to missing or incorrect dates of death in CMS's Enrollment Database in 2011.⁵¹

When beneficiaries' dates of death in CMS's Enrollment Database and SSA's Death Master File did not match, we used Accurant to independently confirm whether beneficiaries were deceased and the dates on which they had died. Dates of death in CMS's Enrollment Database were inaccurate largely because:

⁵¹ The remaining 1 percent of improper Medicare payments were associated with deceased beneficiaries who had default dates of death in CMS's Enrollment Database but who had Medicare payments after their dates of death as listed in Accurant.

1. no date of death was listed for a deceased beneficiary, or
2. the date of death was incorrect; however, CMS considered it verified (i.e., CMS's Enrollment Database contained a specific day of death instead of a default date of death).

CMS did not have dates of death for 375 deceased beneficiaries, resulting in \$2.5 million in improper Medicare payments

Of the 17,403 deceased beneficiaries associated with improper Medicare payments after their deaths, CMS did not have dates of death for 375 beneficiaries who died before or during 2011. As a result, CMS made \$2.5 million in improper payments. For almost all (374 of 375) of these deceased beneficiaries, the SSA Death Master File contained the correct dates of death. However, no dates of death were in CMS's Enrollment Database.

Conversely, CMS's Enrollment Database correctly did not list dates of death for 401 living beneficiaries even though they had dates of death in SSA's Death Master File. For 88 of the 401 beneficiaries, the incorrect dates of death listed in SSA's Death Master File were those of spouses or relatives. Additionally, 17 beneficiaries died in 2012 but were incorrectly listed in SSA's Death Master File as having died between 2009 and 2011.

CMS had incorrect dates of death for 105 deceased beneficiaries, resulting in \$84,500 in improper Medicare payments

For 105 deceased beneficiaries, CMS inappropriately paid \$84,519 in 2011 because the verified dates of death were incorrect. When CMS receives a report of a specific day of death, it considers the date of death entered into CMS's Enrollment Database to be verified. For 99 percent (104 of 105) of these beneficiaries with incorrect dates of death in the Enrollment Database, SSA's Death Master File contained the correct dates of death.

On average, incorrect verified dates of death in CMS's Enrollment Database were incorrect by 105 days. Seventeen percent (18 of 105) of incorrect verified dates of death were incorrect by exactly 1 year (365 days). Nearly 29 percent (30 of 105) of incorrect verified dates of death were incorrect by 1 month (30 or 31 days), and 7 percent (7 of 105) were incorrect by 1 day.

In 2011, 251 providers and suppliers had high numbers of paid and/or unpaid Part B claims with service dates after Medicare beneficiaries' deaths

Most providers and suppliers with Part B claims with service dates after beneficiaries' deaths had 1 paid or unpaid claim in 2011; however, 251 providers and suppliers had a high number of paid claims and/or unpaid claims with service dates after beneficiaries' dates of death. Four providers had high numbers of both paid and unpaid Part B claims with service dates after beneficiaries' deaths. Even though most Part B claims with service dates after beneficiaries' deaths—in particular those for DMEPOS items—were not paid by Medicare, providers and suppliers with high numbers of unpaid claims may be attempting to obtain payment for services that were not provided. Providers and suppliers with high numbers of paid and/or unpaid Part B claims with service dates after beneficiaries' dates of death may indicate fraud, waste, or abuse.

Sixty-five providers and suppliers had 10 or more paid Part B claims with service dates after beneficiaries' deaths in 2011

Of the 2,722 providers and suppliers associated with paid claims with service dates after beneficiaries' deaths, 61 providers and 4 suppliers had 10 or more of these claims in 2011. Medicare inappropriately paid these providers and suppliers \$101,068. Fourteen of these 65 providers and suppliers were located in Los Angeles, Philadelphia, or Springfield (Illinois). Six providers had over 50 paid Part B claims associated with deceased beneficiaries; 1 provider had 116 paid claims with service dates after beneficiaries' dates of death. Medicare inappropriately paid this provider \$5,224 in 2011 for Part B services provided to deceased beneficiaries. Ninety-eight percent (2,657) of providers and suppliers with paid claims with service dates after beneficiaries' deaths had fewer than 10 such claims; most had 1 paid claim with a service date after the beneficiary's date of death.

In 2011, 190 providers and suppliers had over 100 unpaid Part B claims with service dates after beneficiaries' deaths

Of the 46,093 providers and suppliers associated with unpaid claims for deceased beneficiaries in 2011, 190 had over 100 unpaid Part B claims with service dates after beneficiaries' dates of death; 75 percent (143) were suppliers. Of these providers and suppliers, one-fourth (48 of 190) were located in New York City, Los Angeles, or Miami. These CBSAs align

with geographic areas where Federal investigators and analysts have historically focused efforts to combat Medicare fraud, waste, and abuse.⁵²

Fourteen providers and suppliers had over 500 unpaid Part B claims with service dates after beneficiaries' deaths; 1 supplier had 2,288 of these unpaid claims. Thirty percent of the claims submitted in 2011 by this supplier were not paid. Additionally, unpaid claims for deceased beneficiaries represented nearly 6 percent of this supplier's total unpaid claims in 2011. Table 4 shows the number of providers and suppliers by number of unpaid Part B claims with service dates after beneficiaries' deaths.

Table 4: Providers and Suppliers by Number of Unpaid Part B Claims With Service Dates After Beneficiaries' Deaths, 2011

Number of Unpaid Part B Claims With Service Dates After Beneficiaries' Deaths	Number of Providers	Number of Suppliers
1–100	37,503	8,400
101–200	32	98
201–300	5	23
301–400	5	10
401–500	2	1
501–600	2	5
601–700	1	3
701–800	0	2
2,288*	0	1
Total	37,550	8,543

*One supplier had over 800 unpaid Part B claims with service dates after beneficiaries' deaths.
Source: OIG analysis of Part B claims data, 2013.

Seventy of these 190 providers and suppliers had over 100 unpaid Part B claims for over 50 deceased beneficiaries. Thirteen suppliers had unpaid Part B claims for over 100 deceased beneficiaries, and 2 of these suppliers had unpaid claims associated with more than 400 deceased beneficiaries. For one of these two suppliers, 7 percent of the beneficiaries for whom it had unpaid claims were deceased. Nearly 4 percent of total beneficiaries for whom the same supplier had paid or unpaid claims in 2011 were deceased.

⁵² Two of these three CBSAs—Los Angeles and Miami—are among the nine cities targeted by the Medicare Strike Force. The third CBSA—New York City—includes Brooklyn, another city where the Strike Force operates. The Strike Force is part of HEAT (the Health Care Fraud Prevention and Enforcement Action Team), a joint effort of HHS and the Department of Justice, to prevent, deter, and aggressively prosecute health care fraud.

CONCLUSION AND RECOMMENDATIONS

Prior OIG studies and audit reports have identified improper Medicare payments after beneficiaries' deaths. Consequently, CMS implemented safeguards to address this vulnerability. These safeguards appear to have prevented or recovered most Medicare payments made on behalf of deceased beneficiaries; however, they did not prevent all improper payments. In this review, we found that CMS inappropriately paid \$23 million (less than one-tenth of a percent of total Medicare expenditures) in 2011 after beneficiaries' deaths. Part C accounted for 86 percent of these improper payments. Additionally, 11 percent of the \$23 million in improper payments made on behalf of deceased beneficiaries resulted from missing and incorrect dates of death.

Health care fraud schemes have involved providers or suppliers submitting fraudulent claims to Medicare, including claims for deceased beneficiaries. We identified 251 providers and suppliers that had high numbers of paid and/or unpaid Part B claims with service dates after beneficiaries' deaths. These providers and suppliers—in particular, those with a high number of unpaid Part B claims—were located primarily in geographic areas historically known for health care fraud. Although most claims with service dates after beneficiaries' deaths submitted by these providers and suppliers were not paid by Medicare, these providers and suppliers may be attempting to obtain payment for services that were not provided and warrant further scrutiny.

We recommend that CMS:

Improve Existing Safeguards To Prevent Future Improper Medicare Payments After Beneficiaries' Deaths

CMS should determine why its existing safeguards did not prevent all improper payments made on behalf of deceased beneficiaries with dates of death in its Enrollment Database. Although CMS has made progress in preventing and recovering improper Medicare payments associated with deceased beneficiaries through the “informational unsolicited response process” in Parts A and B and through automatic disenrollment in Parts C and D, it made approximately \$23 million in improper payments in 2011 after beneficiaries' deaths. Eighty-eight percent of these improper payments were associated with beneficiaries who had matching dates of death in CMS's Enrollment Database and SSA's Death Master File. CMS should address any issues it identifies and improve existing safeguards to prevent future improper Medicare payments after beneficiaries' deaths.

Take Appropriate Action on Improper Medicare Payments Made on Behalf of Deceased Beneficiaries and Correct Inaccurate Dates of Death

In a separate memorandum, we will refer to CMS for appropriate action information associated with the approximately \$23 million in improper Medicare payments made on behalf of deceased beneficiaries identified in this report. CMS should recover these improper payments, as appropriate. Additionally, we will refer to CMS information on the 480 deceased beneficiaries with missing or incorrect dates of death identified in this report. CMS should correct these inaccurate dates in its Enrollment Database. To fully prevent improper Medicare payments after beneficiaries' deaths, CMS must have accurate beneficiary dates of death in its systems. CMS should also determine why dates of death were inaccurate for these deceased beneficiaries and resolve the issue.

Monitor Both Paid and Unpaid Part B Claims With Service Dates After Beneficiaries' Deaths

CMS should monitor both paid and unpaid Part B claims with service dates after Medicare beneficiaries' deaths to identify providers and suppliers associated with high numbers of such claims. These providers and suppliers may be attempting to obtain payment for services that were not provided. CMS could incorporate this analysis into its predictive analytic work and develop thresholds to identify providers and suppliers for further review. For providers and suppliers that exceed these thresholds, CMS could initiate prepayment review of providers' or suppliers' claims and/or conduct site visits to ensure the legitimacy of these providers or suppliers.

Take Appropriate Action on Providers and Suppliers That Had High Numbers of Paid and/or Unpaid Part B Claims With Service Dates After Beneficiaries' Deaths

In the aforementioned memorandum, we will also refer to CMS for appropriate action the 251 providers and suppliers we identified that had 10 or more paid Part B claims and/or over 100 unpaid Part B claims with service dates after Medicare beneficiaries' deaths. Appropriate action may include: determining whether these providers and suppliers should be placed on prepayment review, conducting site visits, and/or referring them to benefit integrity contractors for further examination.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all four of our recommendations. CMS is committed to preventing and recovering Medicare payments made on behalf of deceased beneficiaries. For this reason, CMS has implemented safeguards to address this vulnerability and will improve its existing safeguards to prevent further Medicare payments after a beneficiary's death.

With regard to our first recommendation, CMS concurred in principle and stated that it needs to analyze the details on the improper payments to determine whether there is an issue with the data and what aspects of its systems need to be modified. We will send this information, as well as information regarding inaccurate dates of death, under separate cover.

With regard to our second recommendation, upon receiving information on improper payments identified in this report, CMS will analyze each case to determine whether it can pursue recovery consistent with agency policies and procedures. CMS will review the inaccurate dates of death identified in this report and work with SSA to make corrections, should they be required.

With regard to our third recommendation, CMS is conducting analyses to determine whether it is feasible to build a model identifying providers submitting claims with dates of service that occurred after beneficiaries' deaths. If this model is viable, CMS anticipates launching it into the Fraud Prevention System in the spring of 2014.

With regard to our fourth recommendation, CMS will take appropriate action upon receiving information regarding providers and suppliers described in this report. Appropriate action may include conducting site visits, revalidations, or additional investigations, if warranted.

Finally, CMS noted that it provided us with feedback on our use of SSA's Death Master File in its comments on a preliminary version of this report, stating that its accuracy is not guaranteed. CMS further noted that the only official record of death information is SSA's Master Beneficiary Record, which sends information daily to the Enrollment Database. In response to these preliminary comments, we clarified the difference between the Death Master File and the Master Beneficiary Record in the background of this report and indicated in the report that CMS receives its death information from the Master Beneficiary Record. We did not recollect or reanalyze data to compare SSA's Death Master File to its Master Beneficiary Record.

We support CMS's efforts to address these issues and encourage continued progress. For the full text of CMS's comments, see Appendix C.

APPENDIX A

Medicare Payments Made on Behalf of Deceased Beneficiaries by Year of Beneficiary Death

Table A-1. Part A Payments for Services After Beneficiaries' Deaths, 2011

Type of Part A Service	Year of Beneficiary Death	Medicare Payments	Number of Claims	Number of Providers	Number of Deceased Beneficiaries
Outpatient	2009	\$45,936	76	13	6
	2010	\$16,154	65	31	22
	2011	\$46,012	158	105	92
	Total	\$108,116*	300*	141[†]	121*
Inpatient	2009	\$125,693	12	4	3
	2010	\$212,513	17	12	9
	2011	\$939,011	70	67	58
	Total	\$1,277,216**	99	79[†]	70
Home Health	2009	\$0	0	0	0
	2010	\$8,694	5	5	5
	2011	\$26,395	16	15	15
	Total	\$35,089	21	20	20
Skilled Nursing Facility	2009	\$0	0	0	0
	2010	\$76,815	11	6	6
	2011	\$66,268	13	8	8
	Total	\$143,083	24	14	14
Hospice	2009	\$0	0	0	0
	2010	\$14,773	8	3	3
	2011	\$56,001	32	29	29
	Total	\$70,774	40	32	32
Grand Total		\$1,634,280**	484	254[†]	193[†]

* According to Accurant, the date of death for one beneficiary was in 2002. This beneficiary and the payments associated with him or her are included in the totals.

** Column sum does not equal total because of rounding.

[†]Column sum exceeds total because some providers and beneficiaries had multiple types of Part A services.

Source: Office of Inspector General (OIG) analysis of Part A claims data, 2013.

APPENDIX A (CONTINUED)

Table A-2. Part B Payments for Services and Items After Beneficiaries' Deaths, 2011

Type of Part B Service	Year of Beneficiary Death	Medicare Payments	Number of Claims	Number of Providers/Suppliers	Number of Deceased Beneficiaries
Physician and Nonphysician Services	2009	\$59,834	610	162	11
	2010	\$77,200	1,242	320	66
	2011	\$411,139	3,535	2,065	1,219
	Total	\$548,368*	5,390*	2,468[†]	1,297*
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	2009	\$1,044	19	4	4
	2010	\$26,637	324	141	131
	2011	\$16,773	228	130	123
	Total	\$44,454	571	254[†]	258
Grand Total		\$592,823	5,961	2,722	1,541[†]

*According to Accurant, the date of death for one beneficiary was in 2002. This beneficiary and the payments associated with him or her are included in the totals.

[†]Column sum exceeds total because some beneficiaries had multiple types of Part B services.

Source: OIG analysis of Part B claims data, 2013.

Table A-3. Part C and D Payments on Behalf of Deceased Beneficiaries, 2011

Part of Medicare	Year of Beneficiary Death	Medicare Payments	Number of Contracts*	Number of Deceased Beneficiaries
Part C	2009	\$62,338	12	13
	2010	\$753,379	47	55
	2011	\$19,091,087	514	11,767
	Total	\$19,906,805**	514[†]	11,835
Part D	2009	\$79,742	27	67
	2010	\$403,424	64	172
	2011	\$564,632	393	4,861
	Total	\$1,049,444***	398[†]	5,101***
Grand Total		\$20,956,249	576[†]	15,838[†]

* For Part C, the term "contracts" refers to Medicare Advantage organizations. For Part D, the term "contracts" refers to prescription drug plan sponsors.

** Column sum does not equal total because of rounding.

*** According to Accurant, the date of death for one beneficiary was in 2002. This beneficiary and the payments associated with him or her are included in the totals.

[†]Column sum exceeds total because some contracts and beneficiaries had both Part C and D payments.

Source: OIG analysis of Part C and D payments from the MARx system, 2013.

APPENDIX B

Procedure Codes and Modifiers on Medicare Part B Claims With Service Dates After Beneficiaries' Deaths

Table B-1. Procedure Codes on Part B Claims for Physician and Nonphysician Services With Service Dates After Beneficiaries' Deaths, 2011

Procedure Code	Description	Number of Claims	Number of Deceased Beneficiaries	Number of Providers	Average Day Count Between Date of Death and Service Date
99232*	Subsequent hospital care/day 25 minutes	587	246	372	59
99233	Subsequent hospital care/day 35 minutes	354	178	241	37
71010	Radiologic examination, chest; single view, frontal	340	135	235	85
99291	Critical care ill/injured patient init 30-74 min	236	120	160	37
99231	Subsequent hospital care/day 15 minutes	151	99	116	19
A0425	Ground mileage, per statute mile	129	82	88	114
99223	Initial hospital care/day 70 minutes	120	85	115	84
36415	Collection of venous blood by venipuncture	117	47	49	345
93010	Electrocardiogram report	114	30	63	403
Total		2,148	651[†]	1,273[†]	--

Note: The remaining 566 procedure codes on deceased beneficiaries' Part B claims for physician and nonphysician services were each on fewer than 100 claims.

***The five character codes and descriptions included in this study are obtained from Current Procedural Terminology (CPT®), copyright 2012 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this study should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

[†]Column sum exceeds total because some providers and beneficiaries were associated with multiple procedure codes.

Source: Office of Inspector General (OIG) analysis of Part B claims data, 2013.

APPENDIX B (CONTINUED)

Table B-2. Modifiers on Part B Claims for Physician and Nonphysician Services With Service Dates After Beneficiaries' Deaths, 2011

Modifier	Description	Number of Claims	Number of Deceased Beneficiaries	Number of Providers
26	Professional component	834	252	531
GC	Resident/teaching physician service	146	57	97
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	134	74	95
59	Distinct procedural service	134	50	58
GP	Services delivered under an outpatient physical therapy plan of care	116	4	4
Total		1,296[†]	319[†]	709[†]

Note: The remaining 65 modifiers on deceased beneficiaries' Part B claims for physician and nonphysician services were each listed fewer than 100 times.

[†]Column sum exceeds total because some providers, beneficiaries, and claims were associated with multiple modifiers.

Source: OIG analysis of Part B claims data, 2013.

APPENDIX B (CONTINUED)

Table B-3. Procedure Codes on Part B Claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies With Service Dates At Least 30 Days After Beneficiaries' Deaths, 2011

Procedure Code	Description	Number of Claims	Number of Deceased Beneficiaries	Number of Suppliers	Average Day Count Between Date of Death and Service Date
E0570	Nebulizer, with compressor	84	67	65	73
E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	78	51	50	120
K0001	Standard wheelchair	54	39	37	60
E0260	Hospital bed, semi-electric (head and foot adjustments), with any type side rails, with mattress	45	29	28	97
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	37	21	21	132
K0195	Elevating leg rests, pair (for use with capped rental wheelchair base)	34	20	20	74
K0003	Lightweight wheelchair	24	15	15	65
K0004	High strength, lightweight wheelchair	23	13	13	97
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips	22	9	8	330
A4259	Lancets, per box of 100	21	8	7	320
Total		422	209[†]	206[†]	--

Note: The remaining 52 procedure codes on deceased beneficiaries' Part B claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) were each on fewer than 20 claims.

[†]Column sum exceeds total because some suppliers and beneficiaries were associated with multiple procedure codes.

Source: OIG analysis of Part B claims data, 2013.

APPENDIX B (CONTINUED)

Table B-4. Modifiers on Part B Claims for DMEPOS Items With Service Dates At Least 30 Days After Beneficiaries' Deaths, 2011

Modifier	Description	Number of Claims	Number of Deceased Beneficiaries	Number of Suppliers
RR	Rental	459	223	214
KX	Documentation on file	332	145	140
KJ	DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, 4 th to 15 th months	295	156	151
MS	6-month maintenance and servicing fee for reasonable and necessary parts and labor that are not covered under any manufacturer or supplier warranty	31	26	26
KI	DMEPOS item, second or third month rental	30	25	25
Total		544[†]	253[†]	247[†]

Note: The remaining 17 modifiers on deceased beneficiaries' Part B claims for DMEPOS items were each listed fewer than 30 times.

[†]Column sum exceeds total because some suppliers, beneficiaries, and claims were associated with multiple modifiers.

Source: OIG analysis of Part B claims data, 2013.

APPENDIX C

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20201

DATE: AUG 30 2013

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report--"CMS Prevented or Recovered Most Medicare Payments Made on Behalf of Deceased Beneficiaries in 2011"
(OEI-04-12-00130)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above-referenced OIG draft report. The purpose of this report is to identify and describe Medicare payments made on behalf of deceased beneficiaries, determine the accuracy of CMS' information on beneficiaries' dates of death, and identify providers and suppliers with paid or unpaid Part B claims with service dates after beneficiaries' deaths.

The CMS is committed to preventing or recovering Medicare payments made on behalf of deceased beneficiaries. CMS has implemented safeguards to address this vulnerability. For example, CMS put into place an informational unsolicited response process for Parts A and B to prevent improper payments for services and items billed after a beneficiary's death. This process reviews all Part A and B claims approved for payment in the claims history and identifies claims with service dates up to 3 years after the beneficiary's date of death. For Parts C and D, CMS instituted a system to automatically disenroll an individual from a Medicare Advantage plan or prescription drug plan upon the beneficiary's death. In 2011, CMS retroactively recovered 99 percent of improper Part C and D payments associated with deceased beneficiaries. CMS is committed to working to improve its existing safeguards to prevent further Medicare payments made after a beneficiary's death.

We appreciate OIG's efforts in working with CMS to ensure that appropriate action is taken to address Medicare payments made after a beneficiary's death including improving existing safeguards and monitoring claims with service dates after a beneficiary's death. Our response to each of the OIG recommendations is as follows.

APPENDIX C (CONTINUED)

Page 2 – Daniel R. Levinson

OIG Recommendation

The OIG recommends that CMS improve existing safeguards to prevent future improper Medicare payments after beneficiaries' deaths.

CMS Response

The CMS concurs in principle with this recommendation, but for Medicare Parts A and B, we will require the details on the improperly paid fee-for-service claims that were the basis of the recommendation. For Medicare Parts C and D, CMS will require the details on the improperly paid capitation payments that were the basis of the recommendation. CMS needs to analyze the cases to determine if there is an issue with the data and what aspects of our systems need to be modified.

The CMS further notes that the study includes use of data in the Social Security Administration's (SSA) Master Death File, which SSA indicates is not guaranteed for accuracy, and may include individuals who are alive on the record. Further, CMS notes that Accurint, the application used by OIG to confirm dates of death in the study, is not an official record but appears to be a collection of various materials which may indicate an individual's passing. CMS provided this feedback in the exit conference, indicating that the only official record is on Social Security's Master Beneficiary Record (MBR) which directly feeds CMS' Enrollment Database (EDB). At that time, OIG indicated they would go back and review the data of their study based on this clarification. The draft report does not reflect this subsequent review.

OIG Recommendation

The OIG recommends that CMS take appropriate action on improper Medicare payments made on behalf of deceased beneficiaries and correct inaccurate dates of death.

CMS Response

The CMS concurs with the recommendation to take appropriate action on improper Medicare Part A and B payments. CMS has not received any of the claims the OIG determined were improperly paid. We request that OIG furnish CMS with the claims data that includes, at a minimum, the provider number, the overpayment amount, the Medicare contractor number, the claim paid date, Health Insurance Claim Number, the claims control number, and the date of death as recorded in Social Security's Master Beneficiary Record. Upon the receipt of the data from OIG, CMS will analyze each claim to determine if we can pursue recovery consistent with agency policies and procedures.

The CMS believes the data on the Enrollment Database is the most accurate information available at the time it is received by SSA and the Railroad Retirement Board. CMS currently has a process in place to make corrections to data related to death, for instances when the information was provided to SSA inaccurately or if the data was entered into the system inaccurately. This process occurs in conjunction with SSA to verify and correct files, if necessary, to ensure proper information is in the EDB and proper payments made for Medicare-

APPENDIX C (CONTINUED)

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covered services. CMS will review the cases identified by OIG, and work with SSA to make corrections, should they be required.

OIG Recommendation

The OIG recommends that CMS monitor both paid and unpaid Part B claims with service dates after beneficiaries' deaths.

CMS Response

The CMS concurs with this recommendation. CMS is currently conducting analyses to determine if it is feasible to build a model identifying providers submitting claims with dates of service that occurred after beneficiaries' deaths. If it turns out to be a viable model, CMS anticipates launching it into the Fraud Prevention System in spring 2014.

OIG Recommendation

The OIG recommends that CMS take appropriate action on providers and suppliers that had high numbers of paid and/or unpaid Part B claims with service dates after beneficiaries' deaths.

CMS Response

The CMS concurs with this recommendation. Upon receiving a listing of the providers and suppliers identified by OIG and analyzing the data, CMS will take the appropriate action which may include conducting site visits, revalidations or additional investigations if warranted.

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

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