

# **POSTMORTEM MEDICAID PAYMENTS**

## **Identifying Inappropriate Provider Payments on Behalf of Deceased Clients**

**OIG #97-0193**  
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### **Executive Summary**

In the spring and summer of 1997, the Office of Inspector General compared client death records and Medicaid Management Information System (MMIS) claims. The purpose of the examination was to determine if Medicaid payments are made to providers for medical services with postmortem dates of service.

This study reviewed 963 deaths reported during the fourth quarter of FY 97. We identified \$1,119,269 in inappropriate payments to 94 providers on behalf of 145 deceased clients. 99.3% of all these payments were to long term care facilities. The average overpayment was \$6,866. It is difficult to estimate the annualized effect of not timely documenting clients' deaths. We reviewed three months' reported deaths but found great variances in the data.

The data for this study was primarily collected through July 1997. Additional follow-up has been conducted periodically since then. Many of the discrepant cases have been corrected. Some of the misspent funds have been recovered. However, on average, it took 76 days from the time the Department learned of the client's death until the overpayments had been recaptured. In several cases, it took a full three months.

The majority of these payments were made to long term care (LTC) providers. For cases with postmortem payments, the client's death occurred an average of 171 days before it was reported to the Department. One client died 25 months before the death was reported and three others had been dead for at least one year when the Department was notified. In total, 59 clients died at least six months before the agency learned of their deaths.

Not reporting a client's death is only one example of how inappropriate LTC payments can occur. If not reported timely by the provider *and* handled timely by the local office, other actions could cause similar overpayments. Examples include actions such as discharges from the facility, income changes, payments of lump sums to clients, eligible Medicare stays and reporting bed hold status.

We believe that all misspent funds paid to long term care providers will eventually be recovered through adjustments when case files are brought up to date.

## **Background**

We initiated this project based on a report presented at a meeting of quality control directors from around the country. The presentation described finding significant numbers of Medicaid payments that were being made on behalf of deceased clients. The Bureau of Quality Control (QC) decided to follow-up on this concept and began conducting a review of the Illinois Department of Human Services' (IDHS) Consolidated Death Match Report.

IDHS computer matches client database (CDB) information with records for individuals reported as deceased. To eliminate duplication, the various existing death match reports from Public Health, Social Security and IDPA have been consolidated into a single death match run on a monthly basis. The match criteria is full last name, first three letters of the first name and Social Security Number.

In an average month during 1997, 449 deaths were reported. During the fourth quarter of FY 97, however, only 963 deaths were documented. For purposes of this report, those 963 clients represent the entire universe. The consolidated death match can report death dates from 1980 up to the report's current monthly cut off date, depending upon when the source learns a person is deceased. In the fourth quarter FY 97 death match, the oldest death occurred on February 2, 1995 and was reported in June 1997.

Consolidated Death Match Reports are produced monthly by the Bureau of Research and Analysis and sent to IDHS' Division of Community Operations. IDHS local offices are required to review the Consolidated Death Match Report and make the appropriate changes in MMIS and the client data base. When timely reported and entered, these actions will prevent any additional payments for claims with postmortem dates of service.

The local offices also receive some death notifications from long term care providers on clients who reside within their facilities. The Long Term Care Provider Manual states that "the facility shall promptly notify the Department when it becomes aware of changes in services that may affect Department payment, provided that such notice shall in no event be made more than thirty days after the facility's receipt of any incorrect or incomplete remittance advice(s)." [LTC Provider Manual p.5, C-201.3 (6)]

Long Term Care providers are also advised "in accepting Department payments, the facility warrants that it shall review all remittance advices that accompany payments and shall certify that all services specified therein are a true, accurate and complete record of services rendered by the facility. Furthermore, the facility agrees to review, affix an original signature, and retain in its files the Billing Certification which is the last page of the remittance advice." [LTC Provider Manual p.4, C-201.3 (6)]

### **Selection of Cases**

A Consolidated Death Match Report was requested from the Bureau of Research and Analysis in April 1997. We began reviewing the April report in June 1997 and discovered \$755,406 in inappropriate payments. We therefore requested additional reports for the months of May and June 1997. At the end of our review in July 1997, an additional \$363,863 in inappropriate payments raised the total to \$1,119,269.

### **Review Methodology**

We reviewed IDHS's client database on all 963 cases to determine whether the cases were active or canceled. The CDB shows the present status of the case, along with case specific information such as the demographic make-up of the people within that case. Secondly, we looked at the MMIS eligibility information file to determine if a discharge date corresponding with the death date had been entered. If the case was shown as canceled in the CDB and a discharge date had been entered into the MMIS, we did nothing further. Entering a discharge date into the MMIS LTC system stops all payments unless the service pre-dated the death.

If the discharge date did not reflect the client's date of death, regardless of whether the case was active or canceled, we reviewed all of the MMIS claims history files. We wanted to determine if any payments were made for postmortem services. For those cases, we then compared the death dates from the Consolidated Death Match Report to the death records at the Division of Vital Statistics at Public Health or with the Social Security's Wire Third Party Query (WTPY) system. This was done to verify the reliability of the death match. However, QC also knows that information on reported deaths is not always accurate. We discovered 23 allegedly deceased clients that were very much alive.

At the time of the study, death records at Vital Statistics for Cook County were available only through March 19, 1997 for the April report and records were available only to April 1, 1997 for the May and June reports. Downstate death records were available through December 31, 1996 for all three months.

### **Findings**

Although a total of 94 separately enrolled providers continued to submit claims after the death of the client, only about one-third of them received substantial funds from the state. There really are not even 94 different providers because many of them are owned by the same entities. For example, the largest overpayment (\$223,556) went to a group of five nursing homes with common ownership. On average, clients served by these facilities died 175 days before the Department learned of their deaths. The second highest overpayment (\$130,519) went to just one LTC facility. Clients at that nursing home died an average of 132 days before the Department found out they were dead.

Together, these two entities accounted for 31% of all the misspent funds. 91% of all the payments went to just 26 providers (or groups of related providers). On average, each of those providers (or groups of related providers) received \$39,217. The following list breaks down the distribution of the 963 reported deceased clients.

- 23 clients reported as deceased were discovered to be alive.
- 145 clients with \$1,119,269 in postmortem payments.
- 296 clients whose cases were still active but no postmortem payments had been made.
- 419 clients whose cases had already been canceled and needed no further action.
- 77 clients who had very minor payments or have been otherwise accounted for.

Throughout CY 97, the first month of each quarter reported the highest number of deaths. In three out of four quarters, the first month was substantially higher. Most likely, this reflects some reporting lag that gets adjusted quarterly. The larger overpayments are mostly found in those cases when there was a lengthy delay between death and reporting.

We would have liked to project annualized potential overpayments. However, we found too many as yet unexplained variances in the data reported from month to month to make such a projection.

### **Following Up**

Inappropriate claims from LTC facilities will continue to be voided automatically through the LTC automated adjustment process once the discharge date is entered into the MMIS system. Until that time, IDPA will continue to pay these LTC providers for any additional claims that are generated. Non-institutional provider claims are not part of the mass-to-detail adjustment system and will not be adjusted without a specific review.

QC also reviewed the recipient ledger inquiry in the MMIS to determine if any payments were made toward funerals and/or burials on the original 145 cases. We found one case shown by the MMIS recipient ledger inquiry indicating a payment of \$461.00 toward a client's funeral or burial. The MMIS and the burial/funeral ledger file are not linked. Therefore, IDPA continued paying medical claims for this recipient after IDHS paid for the burial/funeral.

Based on an early draft version of this report, the Division of Community Operations has agreed to cancel the cases discovered through this study. Further, they are conducting a pilot project to increase timely case cancellations. Deaths reported to IDHS for Cook County LTC clients will be handled by a central unit to facilitate updating the client database and MMIS.

QC has referred all inappropriate claims to the Bureau of Medical Quality Assurance for further review. This includes the payments to non-institutional providers. Audits and other corrective actions will take place. Special attention will be given to any long term care provider which accepted payments more than two months post mortem. Even if the facility timely reported the client's death, it should not continue to accept payments.

### **Recommendations**

- IDHS' Division of Community Operations should continue its efforts to centrally cancel the cases of deceased clients to prevent inappropriate payments. This action will compensate for local offices' inability to effectively address the information they have received on the Consolidated Death Match Report in the past.

- IDHS should ensure that a match code is entered in the CDB so that the Bureau of Research and Analysis can continue to track and log the responses.
- IDPA should establish an automated system of adjusting NIPS payments to recover improperly expended funds.
- IDPA, in cooperation with IDHS, should establish an interim solution while in the process of establishing the electronic system in which the LTC providers will report client changes to the central office.
- IDPA, in cooperation with IDHS, should establish an electronic system in which the Long Term Care providers report client changes to the central office in order to expedite the process of updating the MMIS. The Recipient Eligibility Verification for LTC workgroup is already reviewing this area.
- Each long term care facility that accepted payments for deceased clients for more than two months post mortem will be audited as soon as possible.
- The Bureau of Quality Control will monitor the Consolidated Death Match Report and the MMIS to evaluate the effectiveness of the central cancellation initiative and LTC REV.

### **Solutions**

- As a result of this report, the Department of Human Services implemented the Central Cancellation Pilot for Nursing Home Services. Plans to expand this pilot to the entire state are currently underway.
- In addition to sending the IDHS local offices a copy of the DPA 1156, the Long Term Care Facilities will send a copy of this form to the IDHS central office to initiate cancellation of medical eligibility. This DPA 1156 form is used by the LTC facility to notify IDHS of admission, discharge, death or other changes in circumstance of a client which could have an effect on continuing eligibility.
- Information obtained from the computerized Minimum Data Set (MDS) will be utilized to generate central cancellations. Plans are scheduled for July 1998.
- Electronic processing of changes in resident status, directly from the Long Term Care Facilities to the IDPA is planned for the last quarter of the calendar year 1999. This electronic process will be facilitated through REV.