CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3965	**Date: February 2, 2018**
	Change Request 10433

SUBJECT: Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System from CR 9911

I. SUMMARY OF CHANGES: Through this CR, the Common Working File will re-activate "Trailer 51" for dual status codes for QMB benefits. Additionally, we will resume the former practice of including deductible and coinsurance amounts on the Medicare Remittance Advice.

EFFECTIVE DATE: July 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 2, 2018 - For claims processed on or after this date

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/200/Qualified Medicare Beneficiary (QMB) Program

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3965	Date: February 2, 2018	Change Request: 10433

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I. GENERAL INFORMATION

A. Background: Federal law bars Medicare providers and suppliers from billing an individual enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2015, 7.2 million individuals (more than one out of 10 beneficiaries) were enrolled in the QMB program.

Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States may limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.

Change Request (CR) 9911 is part of the Centers for Medicare & Medicaid Services' (CMS) ongoing effort to give providers tools to comply with the statutory prohibition on collecting Medicare A/B cost-sharing from QMBs. To help providers more readily identify the QMB status of their patients, CR 9911 incorporated QMB notifications in the Medicare Remittance Advice (RA) and the Medicare Summary Notice (MSN) for the first time.

With the implementation of CR 9911, the Common Working File (CWF) began transmitting a new auxiliary file ("Trailer 51") to the claims processing systems if the State Medicare Modernization Act (MMA) dual status codes from the Enrollment Database (EDB) designate that a beneficiary has active QMB status (Dual Status Codes "01" and "02"). Return of Trailer 51 initiated changes to the RA and MSN for QMB claims to reflect the beneficiary's QMB status and lack of liability for Medicare Parts A/B cost-sharing.

In particular, CMS modified the RA so that Claim Adjustment Group Code "Patient Responsibility" (PR) would be replaced by Group Code "Other Adjustment" (OA). Additionally, on the outbound Medicare RA:

CMS zeroed out the deductible and coinsurance amounts associated with Claim Adjustment Reason Code (CARC) 1 (deductible) and/or 2 (coinsurance) and used a different Claim Adjustment Reason Code (CARC) 209 – ("Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to the patient if collected. (Use only with Group code OA).")

- CARC 209 appeared with two (2) new associated Alert Remittance Advice Remark Codes (RARCs): N781 ("No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible.") and N782 ("No

coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance.")

However, the CR 9911 RA changes caused unforeseen issues affecting the processing of QMB cost-sharing claims directly submitted by providers to states and other payers secondary to Medicare. Providers rely on RAs to bill State Medicaid Agencies and other secondary payers outside the Medicare claims crossover process. States and other secondary payers generally require RAs that separately display the Medicare deductible and coinsurance amounts with the Claim Adjustment Group Code "PR" and associated CARC codes and could not process claims involving the RA changes from CR 9911. Barriers to the processing of secondary claims have additional implications for institutional providers that claim bad debt under the Medicare program since they must obtain a Medicaid Remittance Advice to seek reimbursement for unpaid deductibles and coinsurance as a Medicare bad debt for QMBs.

To address these issues, on December 8, 2017, CMS suspended the CR 9911 system changes by having CWF deactivate Trailer 51. Disabling Trailer 51 caused the claims processing systems to discontinue the RA and MSN changes for QMB claims under CR 9911.

B. Policy: Effective with this instruction, the CWF will re-activate Trailer 51 for beneficiaries with active QMB status (Dual Status Codes "01" and "02"). When the CWF returns Trailer 51 to the Medicare claims processing systems, these systems shall resume the former practice of outputting Claim Adjustment Group Code "PR" along with CARC 1 and/or 2, as applicable, with monetary values expressed on outbound Medicare 835 Electronic Remittance Advices (ERAs) and on standard paper remittance advices (SPRs), as applicable. The shared systems shall discontinue the practice of outputting Claim Adjustment Group Code OA with CARC 209 and reflecting the CARC 1 and 2 monetary amounts as zero. The shared systems shall include the revised "alert" N781 and N782 RARCs in association with CARCs 1 and/or 2 on the RA. These RARCs designate that the beneficiary has QMB eligibility status and may not be billed for these amounts. Additionally, upon receipt of Trailer 51, the Part A and B shared systems shall include the revised alert RARC N781 in association with CARC 66 (blood deductible). Systems-generated MSNs shall continue to generate indicating that the beneficiary has zero cost-sharing liability due to having QMB eligibility status.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10433.1	CWF shall reactivate 'Trailer 51' for the dual status codes for QMB benefits for all applicable claim types.								X	
10433.2	Effective with this instruction, when CWF returns Trailer 51 to the Medicare shared systems, the indicated shared systems and MAC shall resume the former practice of outputting Claim Adjustment Group Code "PR" along with CARC 1 and/or 2, as applicable, with monetary values expressed on outbound Medicare 835 ERAs and on SPRs.		X				X	X		RRB-SMAC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10433.2.1	Effective with this instruction, when CWF returns a 51 trailer to the Part A shared system, it shall resume the former practice of outputting Claim Adjustment Group Code “PR” along with CARC 1 and/or 2, as applicable, with monetary values expressed on outbound Medicare 835 ERAs.					X				
10433.2.2	All shared systems shall discontinue the practice of outputting Claim Adjustment Group Code OA with CARC 209 and reflecting the CARC 1 and 2 monetary amounts as zero on the ERAs and on SPRs, as applicable.		X		X	X	X	X		
10433.3	When the shared systems receive Trailer 51 from CWF, they shall include the following **revised** "alert" RARCs in association with Claim Adjustment Group Code 1 and/or 2 deductible or coinsurance amounts: • N781 - Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer. • N782 – Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.		X		X	X	X			
10433.3.1	In addition, when they receive Trailer 51, the Part A and B shared systems shall include the revised N781 RARC in association with Claim Adjustment Group Code “PR” and reflecting CARC 66 (blood deductible amount) on the ERA and SPR, as applicable.		X			X	X			
10433.4	The Part A shared system shall ensure that the PS&R system is made aware of a beneficiary's QMB status.					X				
10433.4.1	The Part A shared system shall ensure it makes PS&R aware of any new field name changes made in association with 10433.4.					X				PS&R
10433.5	Contractors shall test MSN changes with their print center to ensure the changes will process and print as intended.	X	X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10433.6	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
10433.2	Since FISS made no changes to the SPR related to CR 9911, FISS continues to display the deductible and coinsurance amounts on the outbound SPRs.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): LuAnn Miller, 410-786-4441 or LuAnn.Miller@cms.hhs.gov , Diana Motsiopoulos, 410-786-3379 or Diana.Motsiopoulis@cms.hhs.gov , Kim Glaun, 410-786-3849 or Kim.Glaun@cms.hhs.gov , Brian Pabst, 410-786-2487 or Brian.Pabst@cms.hhs.gov , Wilfried Gehne, 410-786-6148 or Wilfried.Gehne@cms.hhs.gov , Bridgitte Davis-Hawkins, 410-786-4573 or bridgitte.davis-hawkins@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

Table of Contents
(Rev.3965, Issued: 02-02-18)

200-Qualified Medicare Beneficiary (QMB) Program

(Rev.3965, Issued: 02-02-18, Effective: 07-01-18, Implementation: 07-02-18)

The Qualified Medicare Beneficiary (QMB) Program is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. Federal law bars Medicare providers from billing an individual enrolled in QMB for Medicare deductibles, coinsurance, or copayments, under any circumstances. See section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997.

Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States –may limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.

Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.)

Note: providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt. Before a provider can be reimbursed for bad debts related to dual-eligible beneficiaries, Medicare policy under CMS Pub. 15-1, Chapter 3, Section 312 of the Provider Reimbursement Manual (PRM) requires a determination and documentation of the state's liability for any cost sharing amounts. To effectuate this, Medicare requires the provider to bill the state to determine that the state is not liable for payment, even if the Medicare provider is not enrolled or the service is not covered under the state's Medicaid plan.

To aid compliance with QMB billing prohibitions, the Medicare claims processing system will generate notifications to Medicare providers (via the Remittance Advice) and beneficiaries (via the Medicare Summary Notice) that indicate the beneficiary's QMB status and lack of liability for cost-sharing. The Medicare Claims Processing System will use the Common Working File (CWF) to receive QMB status via the Eligibility Database (EDB). The QMB indicators will be transmitted to the shared systems with the applicable QMB START and END dates. The two indicators that apply to QMB individuals are Dual Status Code "01" Qualified Medicare Beneficiaries without other Medicaid (QMB-only), and Dual Status Code "02" Qualified Medicare Beneficiaries plus full Medicaid (QMB-Plus). CWF will transmit the QMB indicator if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims; and outpatient institutional and Skilled Nursing Facility (SNF) claims. CWF will transmit the QMB indicator if the discharge date falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims.

QMB indicators will initiate messages on the Remittance Advice that reflect the beneficiary's QMB status and lack of liability for Medicare cost-sharing with Remittance Advice Remark Codes (RARCs) that are specific to those enrolled in QMB.

Effective July 2, 2018, for QMB claims the shared systems will use:

- *Group Code "PR" along with CARC 1 and/or 2, 66, as applicable, with monetary values expressed on outbound Medicare 835 Electronic Remittance Advices (ERAs) and on standard paper remittance advices (SPRs), as applicable.*
- *Additionally, the shared systems shall include Alert Remittance Advice Remark Codes (RARC) on the ERA and SPR, as applicable, that designate that the beneficiary has QMB status and may not be billed for Medicare cost-sharing amounts.*

- *N781 - Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to subsequent payer.*
- *N782 – Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected co-insurance. This amount may be billed to subsequent payer.*

Additionally, the Medicare Summary Notice generated for all QMB individuals will include information regarding their QMB status and lack of liability for Medicare Parts A/B cost-sharing amounts.